Change 1

HEADQUARTERS
DEPARTMENT OF THE ARMY
Washington, DC, 3 October 1995

AREA SUPPORT MEDICAL BATTALION
TACTICS, TECHNIQUES, AND PROCEDURES

1. Change FM 8-10-24, 13 October 1993, as follows:

Remove old pages	Insert new pages
2-29 through 2-30	2-29 through 2-30
A-15 through A-16	A-15 through A-16

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NO. 8-10-24

HEADQUARTERS
DEPARTMENT OF THE ARMY
Washington, DC, 13 October 1993

AREA SUPPORT MEDICAL BATTALION TACTICS, TECHNIQUES, AND PROCEDURES

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PREFACE

This field manual (FM) provides information on the mission, organization, and operation of the area support medical battalion (ASMB). It is intended to assist the commanders and staffs of the ASMBs operating in both the combat zone (CZ) and the communications zone (COMMZ). It is also designed to be used by subordinate headquarters and support company (HSC) and area support medical company (ASMC) commanders and their staff.

This manual outlines the functions and operations of each section within the ASMB and how the ASMB staff integrates its activities. It includes the health service support (HSS) activities for the corps areas and within the COMMZ. This manual describes the many coordination links the ASMB must maintain with supported and supporting units.

The staffing and organizational structure presented in this publication reflect those established in Living Table of Organization and Equipment Numbers 08456L000 and 08457L000, 1 April 1987. However, staffing is subject to change to comply with manpower requirements criteria outlined in Army Regulation (AR) 570-2 and can be subsequently modified.

This publication implements North Atlantic Treaty Organization (NATO) Standardization Agreement (STANAG) 2931, Orders for the Camouflage of the Geneva Emblem and Red Crescent on Land in Tactical Operations.

Information provided in this manual is based on doctrine found in FMs 8-10, 8-10-6, 8-10-8, 8-55, 100-5, and 100-10. The proponent of this publication is the United States (US) Army Medical Department Center and School (AMEDDC&S). Send comments and recommendations on Department of the Army (DA) Form 2028 directly to Commander, AMEDDC&S, ATTN: HSMC-FCD, Fort Sam Houston, Texas 78234-6100.

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

CHAPTER 1

HEALTH SERVICE SUPPORT FOR ARMY OPERATIONS

1-1. Army Operations Doctrine

The Army's keystone doctrinal manual, FM 100-5, explains how Army forces plan and conduct campaigns, major operations, battles, and engagements, in conjunction with other services and allied forces. While emphasizing conventional military operations, FM 100-5 recognizes that Army forces must be capable of operating effectively in any battlefield environment. The keystone manual for the AMEDD, FM 8-10, explains the purpose of HSS in a theater of operations (TO). It is the primary guide for obtaining and providing HSS in the TO.

1-2. Health Service Support Mission

The HSS mission--to conserve the fighting strength--dictates that casualties be collected, sorted (triaged), treated, and identified as return to duty (RTD) or nonreturn to duty (NRTD) patients as far forward as possible. Additionally, HSS resources must be employed to provide the greatest benefit to the maximum number of personnel in support of the combat mission. The accomplishment of this mission is dependent on the HSS plan and the synchronization of HSS. Synchronization means more than just coordinated action. It results from an all-prevailing unity of effort throughout the force. The action of each element within a command must flow from an understanding of the higher commander's concept and intent. The HSS plan is the primary vehicle for providing the HSS operational information required to support the commander's tactical plan.

1-3. Army Medical Department Battle Rules

The AMEDD has developed medical battle rules to aid in establishing priorities and resolving conflicts for competing priorities within HSS activities.

a. The HSS planner and operator applies the following rules, in order of precedence, when priorities are in conflict:

(1) Maintain medical presence with the soldier.

(2) Maintain the health of the command.

(3) Save lives.

(4) Clear the battlefield.

(5) Provide state-of-the-art care.

(6) Return soldiers to duty as early as possible.

b. For additional information on the AMEDD's Battle Rules, refer to FM 8-55.

1-4. Principles of Health Service Support

a. Conformity. Conformity with the tactical plan involves determining the requirements and planning the support needed to conform to tactical operations. Conformity with the tactical plan is the most fundamental element for effectively providing HSS. Only by participating in the development of the commander's operation plan can the HSS planner ensure adequate HSS at the right time and place. Foremost in all planning is the forward orientation and full use of the HSS system. Additionally, a plan for the rapid reinforcement or replacement of the forward echelons (levels) of the HSS structure is essential. For additional information on planning, refer to FM 8-55.

b. Proximity. Proximity involves placing HSS units and personnel in the right place at the right time to provide HSS to sick, injured, or wounded soldiers. To keep incidence of disease

and mortality to a minimum, HSS resources are placed as close to combat operations as time and distance factors and tactical situations permit. Patients are evacuated to medical treatment facilities (MTFs), or MTFs are moved to areas where patient populations are the greatest. However, medical commanders and staffs must, through continuous coordination, ensure that treatment elements or MTFs are not placed in areas that interfere with combat operations. The location of HSS assets in support of combat operations is dictated by the–

- Mission, enemy, terrain, troops, and time available (METT-T) factors.

- Requirements for far forward stabilization of patients which help maintain the physiology of the wounded or severely injured soldiers.

- Early identification and forward treatment of RTD category patients.

- Forward orientation of evacuation resources, thereby reducing response time.

- Other logistical units/complexes.

c. Flexibility. Flexibility must be maintained to ensure a continuum of HSS. The HSS plan must be supported with alternate plans that provide for shifting HSS resources to meet changing requirements, or as the tactical situation may dictate. Standardized modules provide HSS from the forward line of own troops (FLOT) to the rear boundary of the TO. The ability to rapidly shift HSS resources to areas of greatest need is a cornerstone of the modular medical support system. Health service support planners and staffs must be proactive rather than reactive and aggressively coordinate any changes to the HSS plan.

d. Mobility. Mobility must be maintained to ensure HSS assets remain close enough to support maneuvering combat forces. The mobility of medical elements organic to maneuver elements should equate to the force being supported. Major medical headquarters in the TO (medical group, medical brigade, and medical command [MEDCOM]) continually assess and forecast HSS operations requirements. Health service support units can therefore be reallocated to best support the ongoing tactical operations. Mobility is maintained by echeloning the movement of HSS assets. Rapid evacuation as patients become stable also enhances the mobility status of medical elements.

e. Continuity. The HSS system is a continuum from the FLOT rearward through the continental United States (CONUS). It serves as a primary source of trained replacements during early stages of the operational continuum. The HSS structure is organized into a modular system and procedures are standardized for increased flexibility, rapid reinforcement by like or identical modules, and simplification in tailoring a force for varying situations. The patient evacuation system (integrated ground/air) is an integral part of the HSS system and organized to optimize resource utilization. It is staffed to provide continued care and maintain the physiology of the patient while being transported between MTFs. Medical personnel and units must provide optimum care and treatment to the sick, injured, and wounded in an uninterrupted manner. Continuity in care and treatment is achieved by moving the patient through a progressive, phased HSS system. Each type of HSS element contributes a measured, logical increment appropriate to its location and capabilities. Continuity also requires that a sound preventive medicine (PVNTMED) program be implemented and maintained.

f. Control. This principle ensures that scarce HSS resources are efficiently employed to support the tactical plan and that medical units

are under the command and control (C2) of a single medical manager. Centralized control and decentralized execution permits the medical commander and his staff to rapidly tailor and promptly adjust HSS assets. Assets can be realigned in response to major shifts in the location and volume of casualties, changes in supported unit composition and mission, and changes in the intensity of the battle. Control is achieved through planning, coordinating, and monitoring all HSS activities. Commanders and their staffs must ensure that HSS resources are efficiently employed and support the tactical and strategic plan. Control also ensures that the scope and quality of medical treatment meets professional standards and policies. Control measures include maintaining graphical updates of current routes and boundaries, movement criteria, support priorities, and tactical standing operating procedures (TSOPs).

1-5. Threat

The overt threat to medical units on today's battlefield is virtually no different from that of other types of units. Units are normally provided an overall threat assessment prior to their deployment depending on the availability of time and intelligence information. This threat assessment may be detailed, or in some cases, there may be numerous unknowns. Commanders and medical personnel must have an awareness of the threat and be proactive with countermeasures to reduce or eliminate it. The overall threat includes–

- Enemy weapons systems (direct and indirect fire).
- Enemy combat operations (ground and air).
- Chemical warfare.
- Biological warfare.
- Nuclear warfare.
- Medical threat.
- Endemic disease.
- Environmental injuries (heat and cold).
- Arthropodborne diseases.
- Diarrheal disease (food and water).
- Occupational injuries (such as those caused by carbon monoxide, noise, and petroleum supplies).
- Combat stress.

The threat to medical units and personnel varies according to the intensity, location, and the operational continuum. Threat assessment begins prior to deployment. Continuous threat analysis is initiated upon deployment of a unit and continues until the mission is completed. See FMs 8-10, 8-10-8, and 8-42 for definitive information pertaining to the overall threat which includes the medical threat.

1-6. Modular Medical Support System (Echelons I and II)

Health service support (Echelons I and II) is provided by the modular medical support system that standardizes all medical subunits within the division, corps, and echelons above corps (EAC). This modular system was derived by recognizing that some common medical functions performed at Echelons I and II were the same through the division, corps, and EAC. The modular design enables the HSS resources manager to rapidly tailor, augment, reinforce, or reconstitute the battlefield in areas of most critical need. This system is designed to acquire, receive, and sort

casualties; to provide emergency medical treatment (EMT) and advanced trauma management (ATM); and to provide area HSS for personnel in the corps and COMMZ. The modular medical support system is built around six modules. These modules are oriented to casualty assessment/collection, evacuation, treatment, and resuscitative surgery. They provide greater flexibility, mobility, and patient-care capabilities than were previously available.

a. Combat Medic. The combat medic module consists of one combat medical specialist and his prescribed load of medical supplies and equipment. Combat medics are organic to medical platoons/sections of combat and selected combat support (CS) battalions. They are normally placed under the operational control (OPCON) of platoons/companies/troops of maneuver battalions and squadrons.

b. Ambulance Squad. An ambulance squad is comprised of four medical specialists and two ambulances (two ambulance teams). Ambulance squads are organic to medical platoons or sections in combat battalions, selected CS units, and to the medical companies of the division support command (DISCOM), medical companies (ground ambulance) of the medical evacuation battalion, and medical companies of the ASMB. The squad provides evacuation of patients and ensures the continuity of care en route. Ambulance squads are located in the brigade support area (BSA), division support area (DSA), corps support area (CSA), and in EAC units. Ambulance squads provide direct support (DS) for medical evacuation or they provide medical evacuation on an area support basis throughout the TO. The ambulance teams of a maneuver battalion's medical platoon are placed either in DS of a company/team or are collocated with the treatment squad (battalion aid station [BAS]). In the DS role, they also perform the duties of a combat medic. When collocated, they are dispatched from the BAS to reinforce a team in DS or evacuate from units on an area support basis.

c. Treatment Squad. The treatment squad consists of the medical platoon leader (field surgeon), a physician assistant (PA), three noncommissioned officers (NCOs), and three medical specialists. The squad is trained and equipped to provide ATM to the battlefield casualty. Advanced trauma management is emergency care designed to resuscitate and stabilize the patient for evacuation to the next echelon of care. To maintain contact with the combat maneuver element, each squad has two emergency treatment vehicles. Each squad can split into two trauma treatment teams. These squads are organic to medical platoons/sections in maneuver battalions and designated CS units and medical companies of separate brigades, armored cavalry regiments (ACRs), divisions, and echelons above division ASMCs of the ASMBs. Treatment squads maybe employed anywhere on the battlefield. When not engaged in ATM, these elements provide routine sick call services on an area basis.

d. Area Support Squad. The area support squad is comprised of one Dental Corps (DC) officer, a dental specialist, an x-ray specialist, and a medical laboratory specialist. The squad is organic to the medical companies of separate brigades, divisions, and ASMCs in the corps and COMMZ. The dental officer is ATM-trained and provides additional treatment capabilities to the clearing station during peak patient loads.

e. Patient-Holding Squad. The patient-holding squad consists of two practical nurses and two medical specialists. It is capable of holding and providing minimal care for up to 40 RTD patients; however, in the light infantry divisions, this squad can hold and care for only 20 RTD patients. This squad is organic to the medical companies of separate brigades, divisions, ACRs, and in the ASMCs.

NOTE

When a treatment squad, an area support squad, and a patient-holding squad are collocated, they form an area support section (clearing station). This section provides HSS on an area basis to all forces within a geographical area of responsibility. The area support section normally operates in the BSA, the DSA, and areas of high concentration of troops in the CSA and COMMZ. The area support and patient-holding squads are incapable of independent operations.

f. Medical Detachment (Surgical) and Surgical Squad. The medical detachment (surgical) is a corps asset. It deploys as far forward as necessary to support division/task-force operations. This detachment must collocate with a patient-holding squad for support. Each airborne and air assault division has two surgical squads which are organic to the main support medical company (MSMC) of the main support battalion (MSB). Both the corps medical detachment (surgical) and the surgical squads organic to airborne and air assault divisions have the same basic design. They are organized to provide early resuscitative surgery for seriously wounded or injured casualties, to save lives, and to preserve physical function. Early surgery is performed whenever a likely delay in the evacuation of a patient threatens life or is anticipated to significantly affect the quality of recovery. The task-force medical detachment (surgical) is normally employed in the DSA but may be employed in the BSA during brigade task-force operations. Normally the medical detachment (surgical) is attached to a treatment platoon and collocated with a division clearing station. Post-surgical patients awaiting evacuation are held by the patient-holding squad with intensive nursing care provided by the nurses of the surgical module. Corps-level surgical detachments are available to augment other divisions and/or corps hospitals (mobile army surgical hospital [MASH] or combat support hospital [CSH]).

(1) The mission of the medical detachment (surgical) and organic surgical squads is to provide a rapidly deployable initial surgical service to stabilize nontransportable patients in the division area of operation (AO).

(2) The capabilities of the medical detachment (surgical) and organic surgical squads include–

- Providing limb- and life-saving (initial) surgery in the CZ.
- Providing initial surgery forward in support of division HSS for a period up to 48 hours without resupply of Class VIII.
- Providing initial surgery for critically wounded/injured patients. With its organic medical equipment set (MES), it is capable of performing up to 40 surgical cases without resupply.
- Providing personnel augmentation to CZ hospitals when not task-organized to support other HSS operations.
- Providing preoperative and postoperative care to patients with assistance of the patient-holding squad when attached to Echelon II medical units.

(3) Personnel assigned to the medical detachment (surgical) or Echelon II surgical squads organic to airborne and air assault divisions include–

- General surgeon (one).
- Orthopedic surgeon (one).
- Medical-surgical nurse (one).

- Nurse anesthetist (two).
- Operating room specialist (two).
- Practical nurse (two).

1-7. The Echelons of Medical Care

Health service support is arranged in echelons of medical care.

a. Echelon I. The first medical care a soldier receives is provided at this echelon. This echelon of care includes the following:

(1) Immediate lifesaving measures.

(2) Disease and nonbattle injury (DNBI) prevention.

(3) Combat stress control (CSC) prevention measures.

(4) Casualty collection.

(5) Evacuation from supported units to supporting MTF.

(6) Treatment provided by designated individuals or treatment squad (BAS). Major emphasis is placed on those measures necessary to stabilize and allow for the evacuation of the patient to the next echelon of care. These measures include maintaining the airway, stopping the bleeding, preventing shock, protecting the wound, immobilizing fractures, and performing other emergency measures as indicated.

(a) Those patients not requiring a higher level of care are RTD.

(b) First aid is provided by an individual (self-aid and buddy aid) or combat lifesaver. The combat lifesaver has been taught advanced first-aid procedures. Self-aid, buddy aid, or advanced first aid provided by the combat lifesaver is considered Echelon I care as a continuum of medical treatment.

(c) Medical care is provided by medical personnel who are trained to provide care for injured or wounded soldiers.

(d) Echelon I HSS is provided by the medical platoon/section of combat and CS battalions, by division, separate brigade and ACR medical companies, by corps and COMMZ ASMCs, and by other corps and COMMZ medical units. When Echelon I care is not organic to a unit, this support is provided by Echelon II medical units on an area support basis.

b. Echelon II. This echelon of care includes the following:

(1) Evacuating patients from Echelon I.

(2) Providing care at the clearing station. At this echelon of care, the patient is examined; his wounds and general status are evaluated; and he is treated and RTD, or is prioritized for continued evaluation.

(3) This echelon of support duplicates Echelon I and expands services by adding dental, laboratory, x-ray, and patient-holding capabilities. Emergency care and ATM, including beginning resuscitation, are continued. No general anesthesia is available unless organic or attached surgical squads are present. If necessary, additional emergency measures are instituted; however, they do not go beyond the measures dictated by the immediate needs. Those patients who can RTD within 24 to 72 hours are held for treatment. This is the lowest level of care where blood (Group O packed red blood cells) is found (see Appendix A for blood request/report sample format).

c. Echelon III. This echelon of support expands the capabilities provided at Echelon II. Patients who are unable to tolerate and survive movement over long distances receive surgical care in hospitals as close to the division rear boundary as the tactical situation allows. Surgical care may be provided within the division area under certain operational conditions. Echelon III characterizes care provided by units such as a MASH or a CSH.

d. Echelon IV. This echelon of care is provided in general hospitals (GHs) and field hospitals (FHs) which are staffed and equipped for general and specialized medical treatment, surgical treatment, and rehabilitation services.

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

1-8. Planning for Health Service Support

Planning for HSS is performed at every command level through the TO. In Army operations the extended battlefield stretches HSS capabilities to the maximum. It presents an unprecedented challenge to the HSS planner, as well as to the tactical commander. It is imperative that the HSS planner at every echelon be involved in the initial stages of the tactical and logistical planning processes. It is only through understanding of the tactical commander's plan that the medical commander can continue to provide sustaining HSS in the absence of orders and communications.

The medical planner must know—

- What each support element will do.
- When it will be done.
- How it will be done.
- Where it will be done.
- How routinely supported units operate.

The planner must foresee actions beforehand, plan for responsive support to each element supported, and be able to change the plans if they need to be altered. He must be prepared to meet the requirements for—

- Echelons I and II medical treatment.
- Medical evacuation and regulating.
- Hospitalization.
- Health service logistics, to include blood management.
- Preventive medicine and sanitation.
- Veterinary services.
- Dental services.
- Combat stress control.
- Command, control, communications, computers, and intelligence (C4I).
- Laboratory services.
- Echelons above corps HSS.

Commanders must be able to reallocate HSS resources as tactical situations change. Effective and timely planning is essential to ensure adequate and employable HSS.

a. Theater Army Health Service Support Plan. The Army HSS plan for the TO is developed by the theater Army (TA) surgeon/MEDCOM commander. The TA surgeon is on the special staff of the TA commander. He is the medical staff adviser to the TA commander and is responsible for staff planning and coordinating and developing policies for the HSS of TA forces. The TA surgeon is assisted by the TA surgeon's section which is a part of the MEDCOM.

b. Corps Health Service Support Plan. The HSS portion of the corps operation plan (OPLAN) is developed by the corps surgeon. The corps surgeon is a special staff officer in the corps headquarters. This officer has a small staff section to assist in completing the mission. The corps surgeon has direct access to the corps commander on HSS matters. He keeps the commander and his staff informed concerning the health of the command and the HSS aspects of combat operations and effectiveness. As the principal medical staff officer, he advises the corps commander and staff on all HSS matters related to personnel, intelligence, operations, logistics, and civil-military operations (CMO). He provides technical supervision and guidance as necessary to ensure that all HSS activities are accomplished in accordance with the corps HSS TSOP. The corps surgeon exercises staff supervision over HSS in the corps support command (COSCOM), divisions, and other subordinate corps units. The corps surgeon develops the HSS plan to support the corps commander's decisions based on information provided by the medical brigade/group. The corps surgeon makes long-range plans (96 hours and beyond) for HSS. The commander of the medical brigade/group converts these OPLANs into day-to-day operations for the fulfillment of the HSS mission.

c. Division Health Service Support Plan. The HSS portion of the division OPLAN is developed by the division surgeon in conjunction with the division medical operations center (DMOC). The division surgeon is a special staff officer and is normally under the staff supervision of the division assistant chief of staff (personnel [Gl]). The division surgeon coordinates HSS activities through the G1. Generally, the surgeon's duties are administrative; the division commander charges him with the full responsibility for the technical control of all HSS activities in the command. He is assisted by the division surgeon's section which is assigned to the division headquarters and headquarters company (HHC). This section, along with the DMOC staff, assists the division surgeon with the accomplishment of his duties. The DMOC is a DISCOM element that is assigned to the HHC DISCOM. The DMOC staff develops the division HSS plan under the technical supervision of the division surgeon. The DMOC plays a key role in implementing, coordinating, and monitoring HSS in the division for compliance with the division HSS plan.

d. Brigade Health Service Support Plan. The HSS portion of the brigade operation orders (OPORDs) or OPLANs is developed by the brigade surgeon. The forward support medical company (FSMC) commander in all divisions has a dual responsibility to perform the duties of the brigade surgeon. The brigade surgeon coordinates brigade HSS initiatives with the forward support battalion (FSB) commander and staff, or with the brigade adjutant (S1). The brigade S1 is the primary staff officer responsible for coordinating the HSS plan. The brigade surgeon is responsible for reviewing all brigade OPLANs and contingency plans to identify potential medical hazards associated with geographical locations and climatic conditions. He keeps the brigade commander informed on the medical aspects of the brigade operations. This is accomplished through the FSB commander and brigade S1 or the surgeon may provide periodic update/briefings to the brigade commander. Additional and definitive information pertaining to HSS planning is found in FMs 8-10, 8-10-3, 8-10-4, 8-10-5, 8-10-6, 8-42, and 8-55.

CHAPTER 2

AREA SUPPORT MEDICAL BATTALION

Section I. ORGANIZATION AND FUNCTIONS

2-1. Area Medical Support

Area medical support in the corps and COMMZ is provided by the ASMB. This unit provides Echelon I and Echelon II HSS and medical staff advice and assistance for all assigned and attached elements.

2-2. Organization

The ASMB is organized to provide Echelon II HSS within its assigned AO. The ASMB also provides unit-level (Echelon I) HSS on an area support basis for assigned and attached units operating within its assigned AO. The ASMB is modular in design and consists of a battalion headquarters (Figure 2-1), an HSC (Figure 2-2), and three ASMCs (Figure 2-3). It is normally assigned to a medical brigade in the COMMZ and to a medical group in the corps.

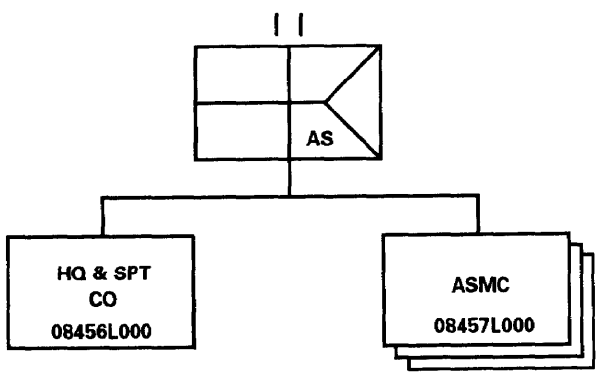


Figure 2-1. Area support medical battalion.

a. Employment in the Theater. In a mature theater, ASMCs are employed primarily in the CSA and support areas of the COMMZ. They are deployed to a geographical area to provide area HSS or may be deployed to provide HSS for designated nondivisional units/troops. The ASMCs also establish clearing stations and provide Echelon I and Echelon II HSS in a wide area (normally, an area or sector of the size established and supported by a corps support group [CSG] or a corps support battalion [CSB]). Medical treatment squads/teams of the ASMCs may be deployed to establish treatment stations and provide Echelon I support to given concentrations of nondivisional units that do not have organic HSS. The modular design of the ASMB and its ASMCs permits its employment across the operational continuum. See Chapter 4 and Chapter 5 for additional information pertaining to employment.

b. Mission. The ASMB provides Echelon I and Echelon II HSS to units located in the battalion's AO. It provides C2 for assigned and attached units and medical staff advice and assistance as required. Its functions are centered around three basic principles: treat and RTD; treat and hold (up to 72 hours); and treat and evacuate. Specific functions of the battalion include–

- Planning and coordinating Echelon I and Echelon II HSS operations, to include staff advice on an area basis for corps and COMMZ units without organic medical assets.
- Advising commanders and staff of supported units on the health of their command.
- Operating clearing stations (Echelon H) with limited short-term holding capability and limited pharmacy, laboratory, and X-ray services.
- Providing daily sick call services on an area basis.

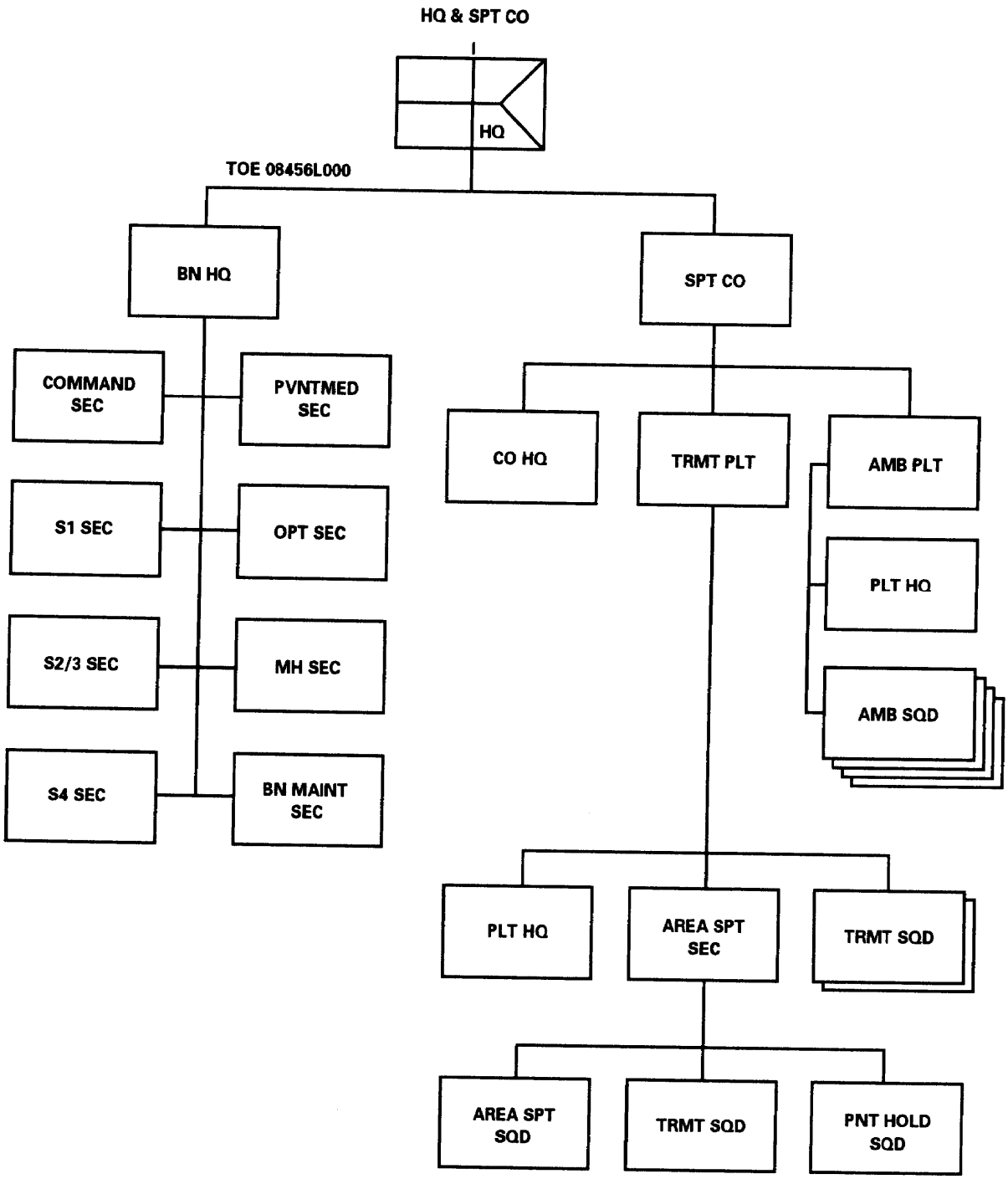


Figure 2-2. Headquarters and support company, ASMB.

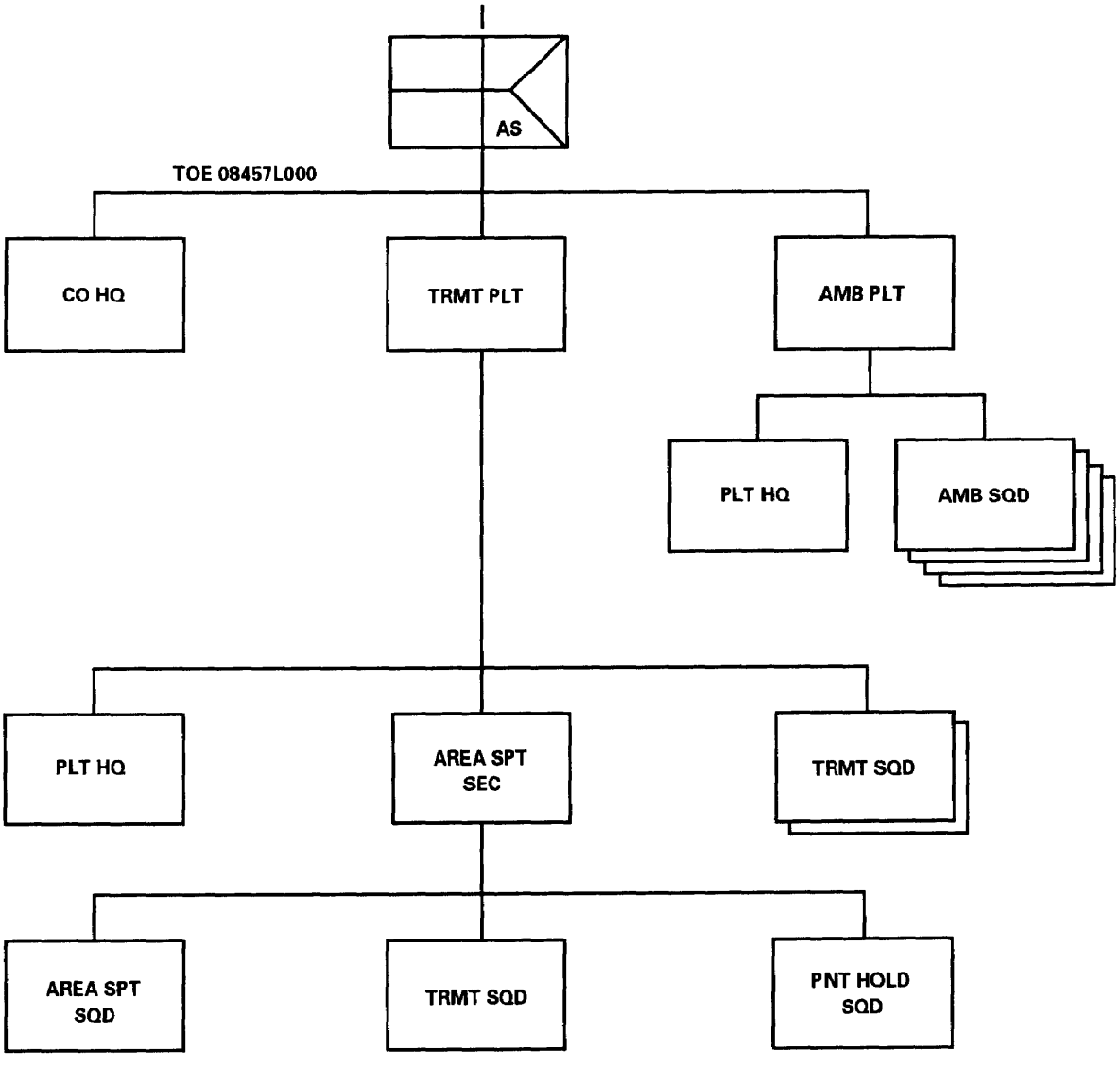


Figure 2-3. Area support medical company.

- Providing ground ambulance evacuation of patients.
- Providing health service logistics to include medical equipment maintenance services.
- Providing trauma and sick call HSS (Echelon I) on an area basis to units without organic medical elements.
- Providing optometry services.
- Providing emergency, sustaining, and limited preventive dentistry services.
- Providing limited neuropsychiatric (NP) services and management of battle fatigue and stress-related casualties.
- Providing consultation service

for patients referred from unit-level medical treatment elements.

- Providing PVNTMED consultation service.

- Reinforcing or reconstituting unit-level medical elements to include technical supervision of PAs in unit-level MTFs without assigned physician(s).

2-3. Command and Technical Relationships

The ASMB commander exercises C2 over the battalion and over medical units/elements attached or assigned to the battalion. He exercises C2 over subordinate elements according to the mission assigned within the framework of the intentions of the next higher command. The ASMB is under the overall command of the medical brigade/group. The ASMB commander, his staff, and subordinate medical commanders employ direct channels of communications on technical and clinical matters. The ASMB commander makes all fundamental decisions in his area of responsibility.

a. Headquarters and Support Company Commander. Headquarters and support company commander exercises C2 over all elements assigned to his company, less OPCON of the battalion headquarters elements.

b. Area Support Medical Company Commander. The ASMC commander exercises C2 over all elements of the ASMC. He serves as the staff surgeon for supported units and provides technical guidance and assistance when required. He provides technical guidance to any Echelon I medical elements operating within his AO. He advises commanders of units without organic HSS on the health and welfare of their commands.

c. Area Support Medical Battalion Staff. The ASMB staff provides the commander with factual and timely information. Staff personnel prepare, analyze, estimate, and recommend feasible courses of actions. The staff translates the commander's decisions into instructions and orders, issues those orders, and supervises their execution. Staff members resolve the problems and make decisions within their functional areas based on the commander's guidance/TSOPs. An efficient, well-organized, and highly motivated staff can accomplish routine things smoothly and effectively. The commander, however, identifies goals, and announces what must be done; the staff supports his decisions and ensures they are carried out.

Section II. COMMUNICATIONS

2-4. Battalion Communications

Effective management and control of battalion HSS operations are dependent on the battalion headquarters' ability to communicate with its subordinate ASMCs, corps medical brigade/group, corps medical elements, supporting elements, and with those units that are being provided HSS. Communication assets available to the ASMB include radios (amplitude modulation [AM] and frequency modulation [FM]) and mobile subscriber equipment (MSE). Communications support is also provided by the signal unit operating in the area of support.

a. Staff Responsibilities. Each staff element of the battalion is responsible for following signal support policies, procedures, and standards in its functional operations. The battalion communications chief and company team chief

must coordinate telecommunications interface requirements with the supporting signal unit. The signal unit integrates signal support systems within and between echelons.

b. Mobile Subscriber Equipment Area Common User Systems. The MSE system is the area common user voice communications system for all US Army corps and divisions (Active and Reserve Components). It is the backbone of the corps system and will be deployed from the corps rear boundary forward to the maneuver battalion's main command post (CP). It provides a secure mobile, survivable communications system capable of passing voice, data, and facsimile (FM) throughout the corps. Additionally, it provides a direct interface to EAC, other services, NATO, combat net radios, and commercial communications systems. This system is composed of multiple communications nodes with network features which will automatically bypass and reroute communications around damaged or jammed nodes. This system integrates the functions of transmission, switching, control, and terminal equipment (voice and data) into one system; it provides the user with a switched telecommunications system extended by mobile radio-telephones and is integrated within the corps/division force structure. Nodes are deployed from the corps rear boundary forward to the maneuver brigade rear area based on geographical and subscriber density factors. Node centers (NCs) make up the system's backbone, and extension switches let wire line terminal subscribers (telephone, FAX, and data) enter into the total area communications system. Radio access units (RAUs) let mobile radio-telephone users communicate with other mobile and wire telephone users throughout the AO. The system control centers (SCCs) provide the processing capability to assist in overall network management. The MSE system lets subscribers communicate with each other using fixed directory numbers, regardless of a subscriber's battlefield location. The MSE system is comprised of the following five functional areas:

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

The ASMB will participate in the first four of the above functional areas.

(1) *Area coverage.* Area coverage means that the MSE system provides common user support to a geographic area, as opposed to dedicated support to a specific unit or customer. These NCs are under the control of the corps signal officer.

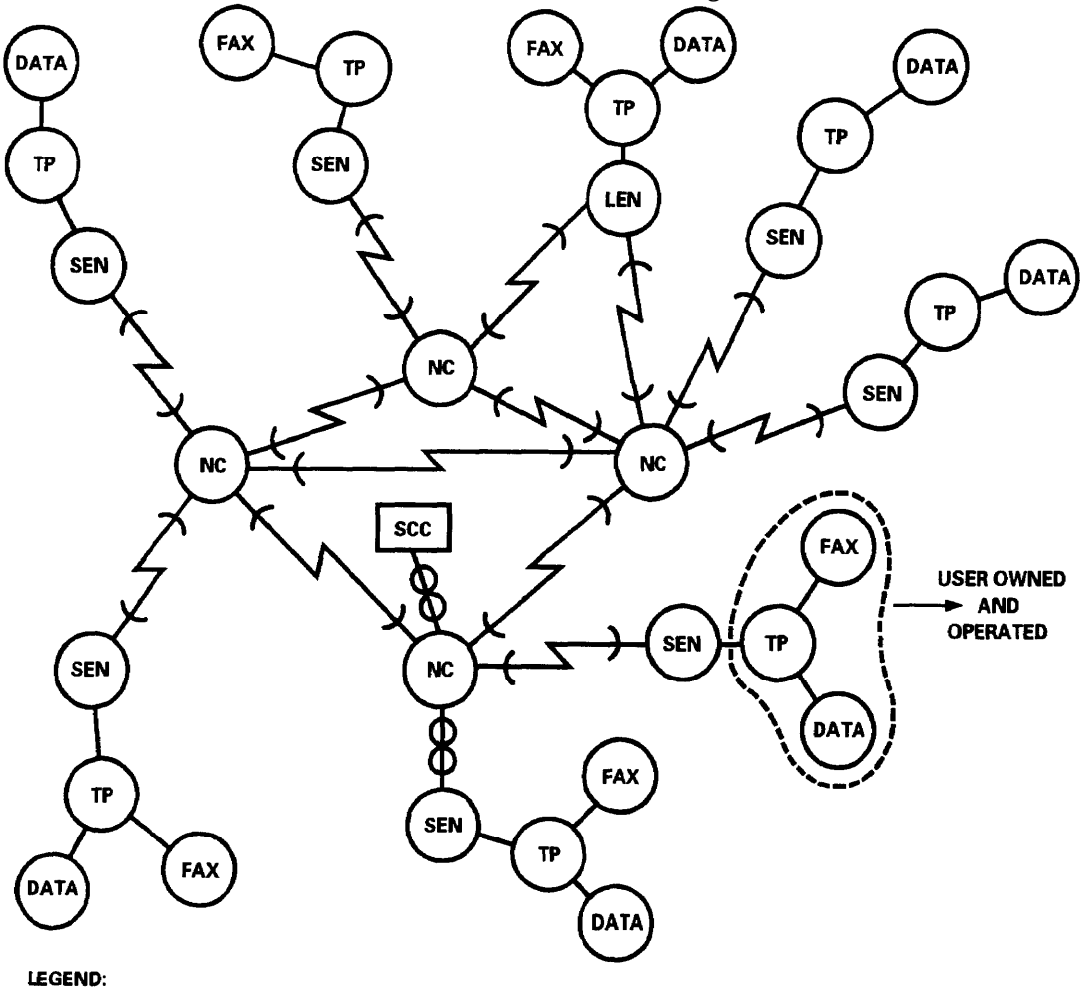
(2) *Subscriber terminal (fixed).* The MSE telephone, mobile radio-telephone, FAXs, and data terminal, as part of the area common user system (ACUS), are user-owned and operated. The ASMB is responsible for running wire to the designated junction boxes. These boxes tie the ASMBMSE telephones into the extension switches which access the system. The subscriber terminals used by the unit are digital telephones providing full duplex, four-wire voice, as well as data ports for interfacing the AN/UXC-7 FAX, the Tactical Army Combat Service Support (CSS) Computer System (TACCS), Army Tactical Command and Control System (ATCCS), and the unit-level computer (ULC) as depicted in Figure 2-4.

(3) *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 the supporting signal unit. Figures 2-5 through 2-7 show the MSE switchboard configurations through which an

ASMB may tie into the area system. The two types of interface equipment are the–

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

Normally the ASMB will interface through the panel. In either case, the ASMB is responsible for installing and operating fixed subscriber terminal instruments. It must also install and maintain the WF-16 field wire from the instruments to the interface points. The WF-16 field wire consists of two pairs of wire. One is olive drab and the other is brown. The olive drab pair has a ridge along the side for night identification.



LEGEND:

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

Figure 2-4. Sample of fixed subscriber terminal.

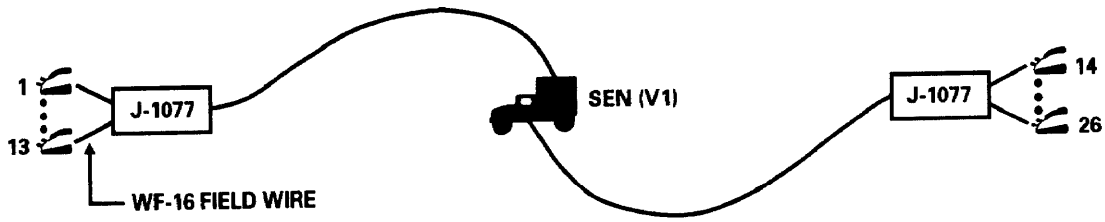


Figure 2-5. Sample small extension node switch interface (V1).

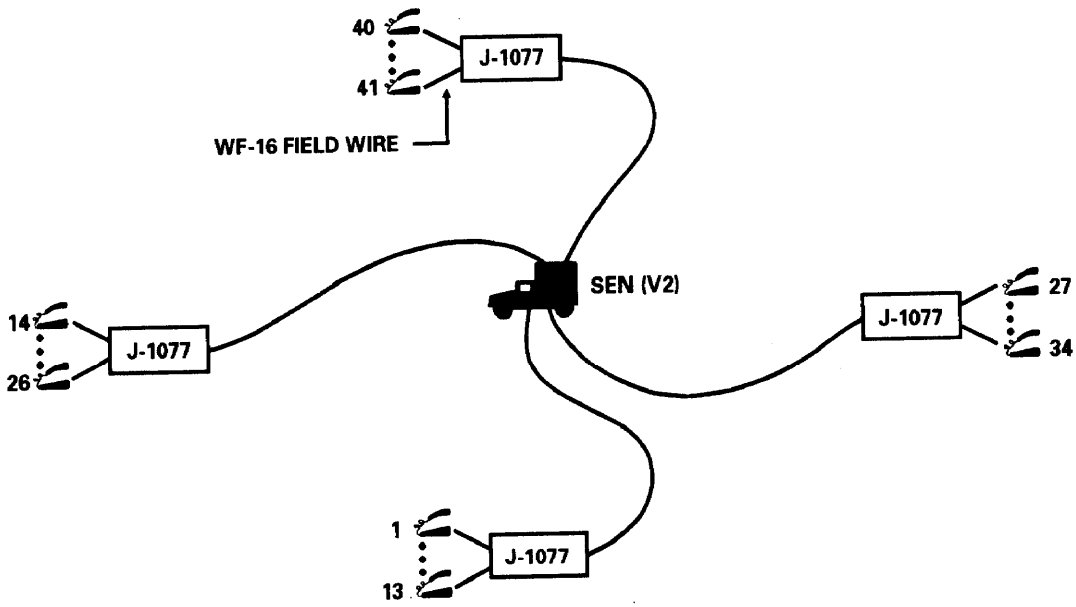


Figure 2-6. Sample small extension node switch interface (V2).

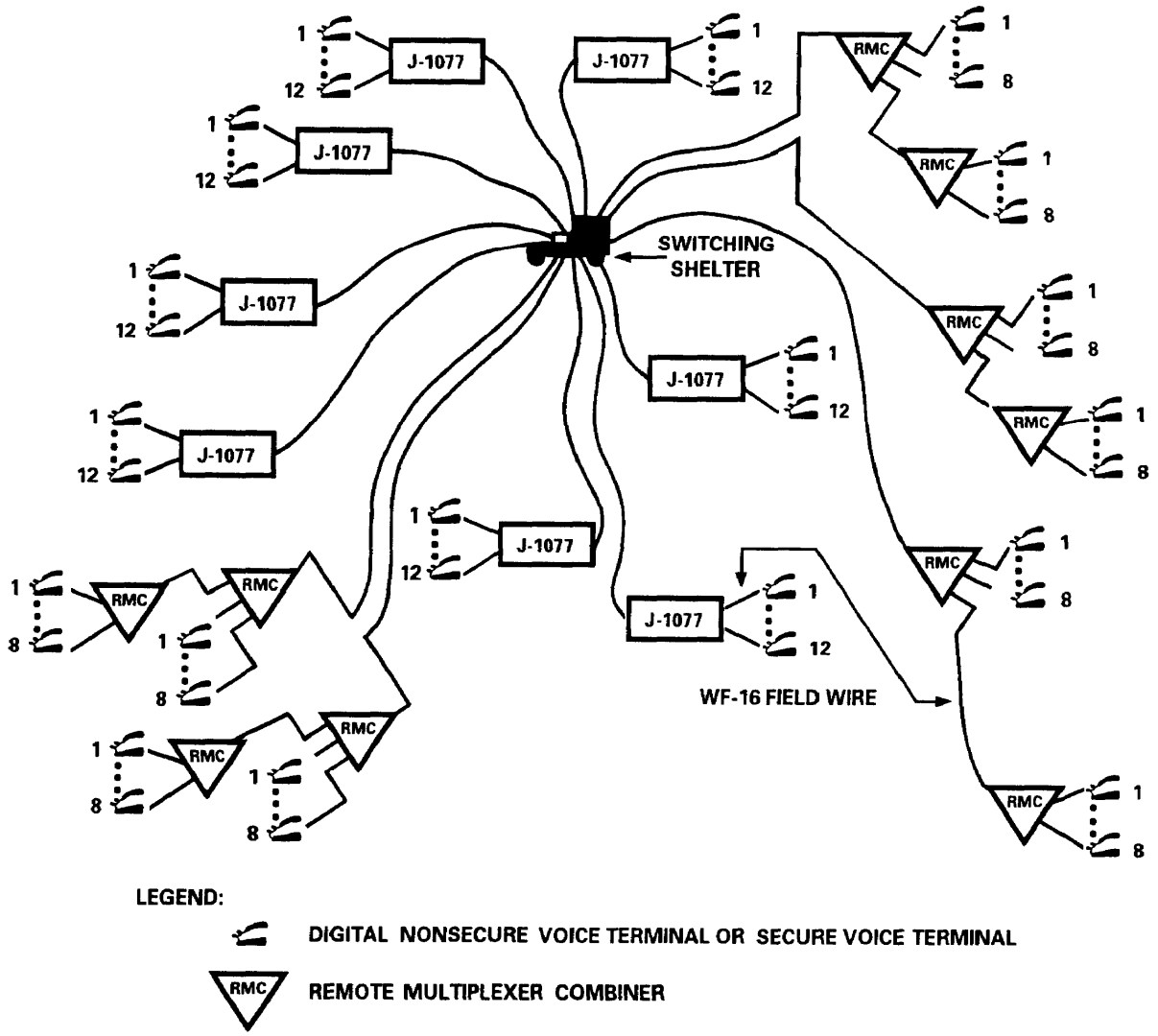


Figure 2-7. Sample large extension node switch interface.

(4) *Mobile subscriber terminal access.* The MSE mobile subscriber terminal is the AN/VRC-97 mobile subscriber radiotelephone terminal (MSRT). 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 RAU. The primary use of the MSRT terminal is to provide mobile subscribers access to the MSE area network. Figure 2-8 is a typical connectivity and 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 MSRT in CP areas based on the possibility of interface with Single Channel Ground and Airborne Radio System (SINCGARS) radios operating in the immediate area. See FMs 11-30 and 11-38 for definitive information pertaining to the MSE area communications system.

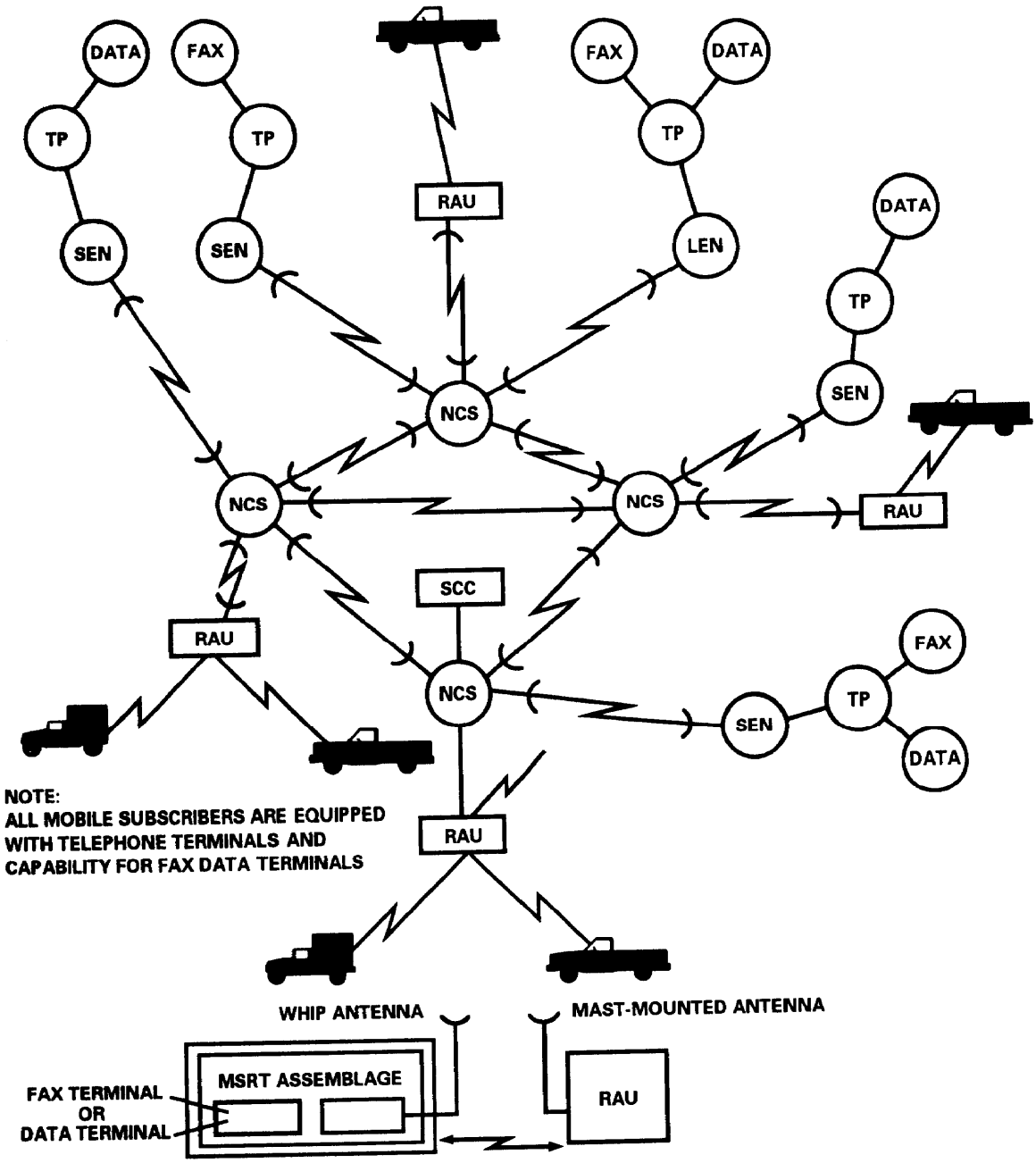


Figure 2-8. Typical MSE connectivity and MSRT interface.

2-5. Combat Net Radio System

Combat net radio equipment in the ASMB will include both the improved high-frequency radio (IHFR) system and the SINCGARS system. These systems will serve as a primary means for voice transmission of C2 information and as a secondary means for data transmission. Data transmission will be required when data transfer requirements cannot be met by the MSE system. Improved high-frequency radio series and AM radios provide mid- to far-range communications capability. They interface with other AM high-frequency radios, are antijamming/frequency hopping, provide secure voice and data capability, and have push-button frequency selection. Single channel ground and airborne radio series and FM radios use a 16-element keypad for push-button tuning which allows for simple and quick operation. They are capable of short-range operation for voice or digital data communications. They are capable of single-channel operation for interface with the AN/VRC- 12 series or other FM radios. They also can operate in a jam-resistant, frequency-hopping node which can be changed as needed.

2-6. Area Support Medical Battalion Radio Nets

The medical battalion headquarters and its subordinate medical companies depend on both AM and FM radios and area communications systems in order to operate. The medical battalion command FM radio net is shown in Figure 2-9. The net control station (NCS) of this net is the Intelligence Officer (S2)/Operations and Training Officer (S3) section which is located in the battalion CP. In addition, ASMB headquarters personnel or sections monitor the following nets:

- ASMB commander–medical brigade and medical group command and operations nets.
- ASMB S2/S3–
  - Area support group or battalion command and operations nets.
  - Medical evacuation battalion command and operations nets.
  - ASMB Supply Officer (S4)/ medical supply–medical brigade administration and logistics net.

a. Area Support Medical Company's Command Nets-FM. The ASMCs nets (Figures 2-10) provide C2 for medical treatment and evacuation throughout the ASMB AO. Dual-net capability is provided at the platoon and squad level for coordination with supported units and aeromedical evacuation support.

b. Area Support Medical Battalion Operations Nets-AM-IHFR. The medical operations net (Figure 2-11) uses an AN/GRC 213 radio. This net is used to facilitate patient management, air and ground evacuation, and medical regulating of patients to corps hospital. This net links the ASMB and ASMCs with the medical brigade/group which is the NCS for the corps HSS operations net. The ASMB and ASMC wire nets are depicted in Figures 2-12 and 2-13.

2-7. Signal Security

Signal security is included in the ASMB's overall security program. All ASMB elements must consistently practice signal security. A vital consideration is the siting of transmitting antennas. Sites must enable communications while minimizing the enemy's ability to intercept and locate transmissions. Considerations include–

- Placing antennas away from CPs by at least 1 kilometer.

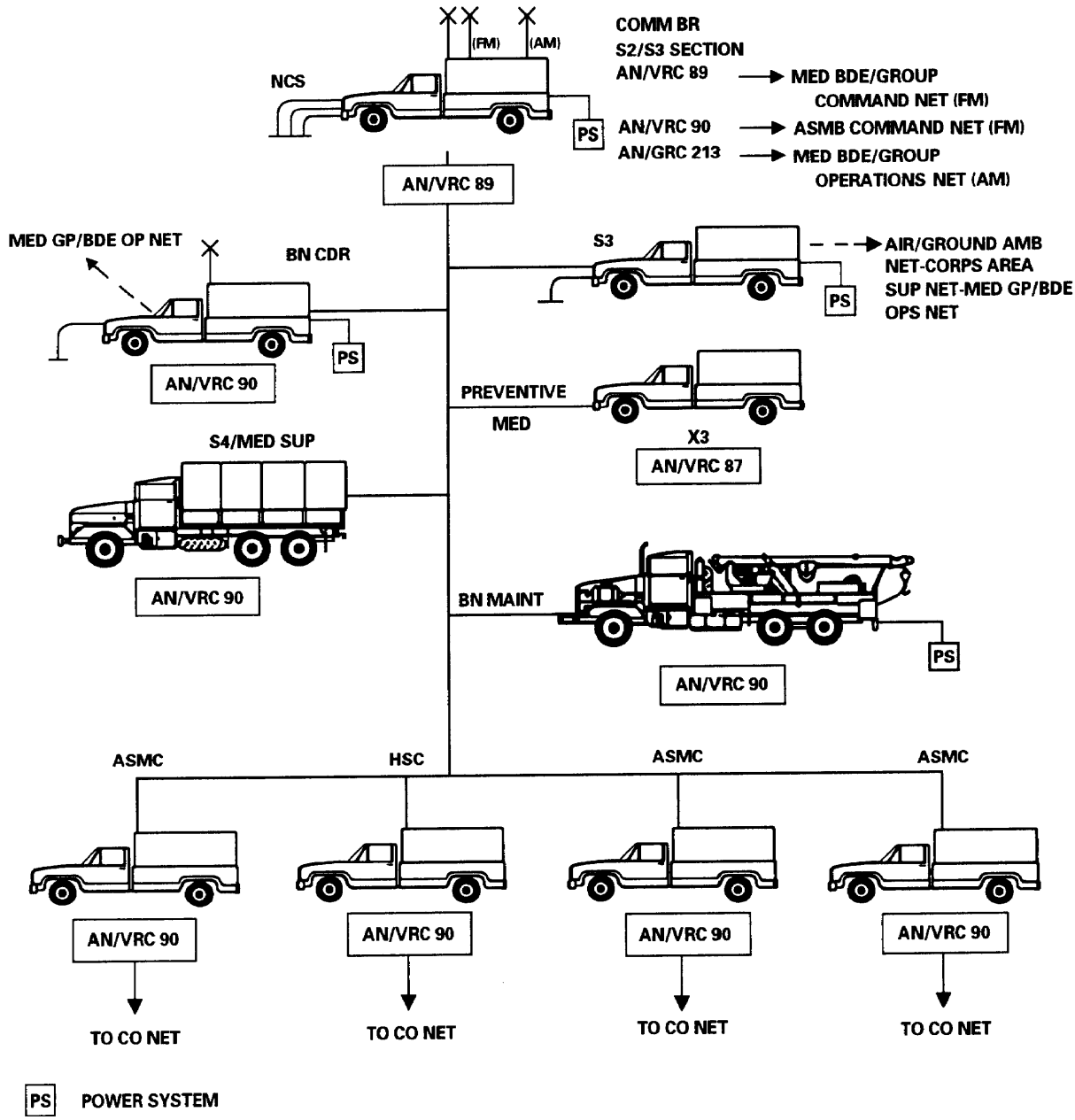


Figure 2-9. Area support medical battalion command net/FM radios.

- Constructing and using directional antennas.
- Using terrain features such as hills, vegetation, and buildings to mask transmissions.
- Dispersing transmitters.

In addition to the above considerations other guidelines for maintaining signal security include:

- Maintaining radio or radio listening silence, using radio only when absolutely necessary.

- Distributing codes on a need-to-know basis.
- Using only authorized call signs and brevity codes.
- Using wire and messengers whenever feasible.
- Using available secure voice/radio teletypewriter (RATT) devices.
- Maintaining net discipline and control.
- Using authentication and encryption codes specified in the current signal operation instructions (SOI).
- Keeping transmissions short (less than 20 seconds).
- Reporting all communications security (COMSEC) discrepancies to NCSs.
- Using lowest transmitter power output consistent with good communications.
- Avoiding significant surges in traffic on single-channel radio nets.

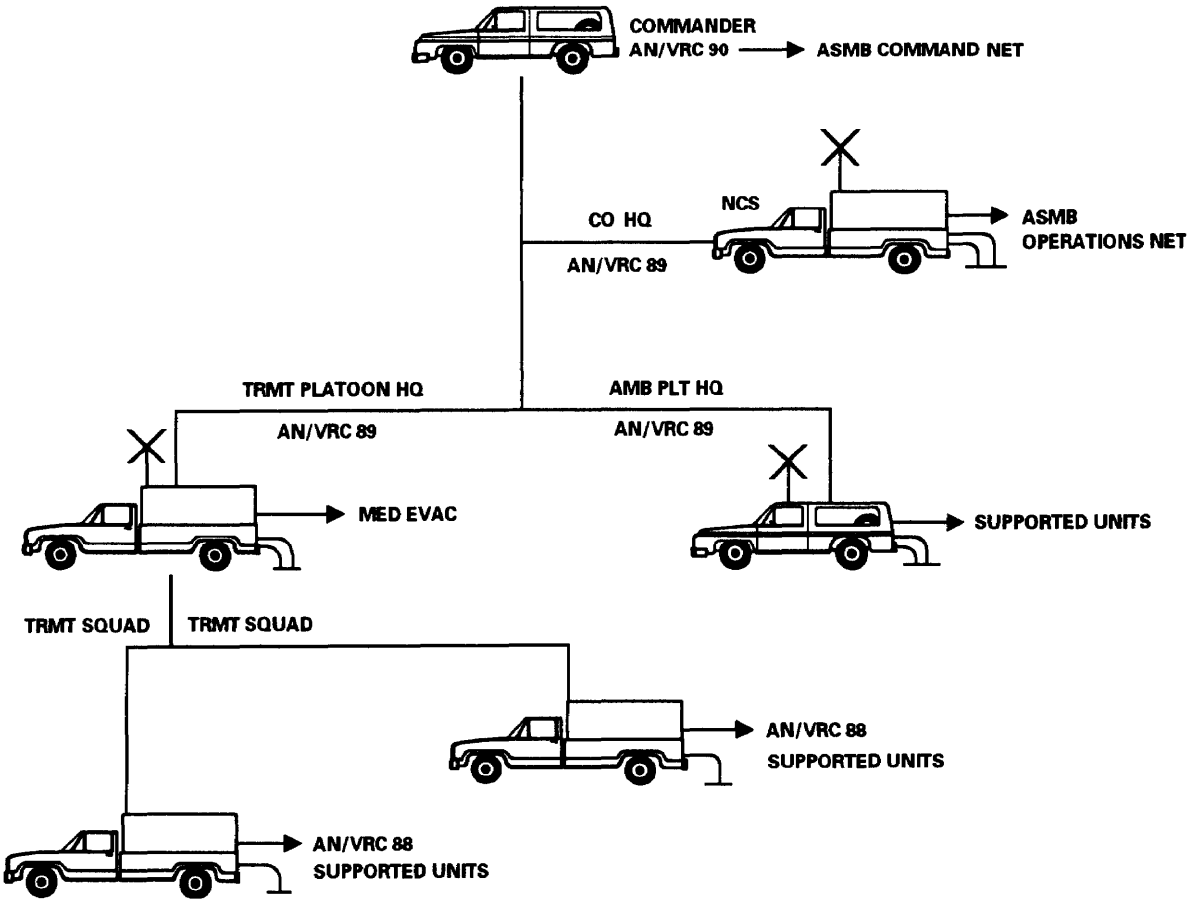


Figure 2-10. Headquarters and support and area support medical companies' command net, FM.

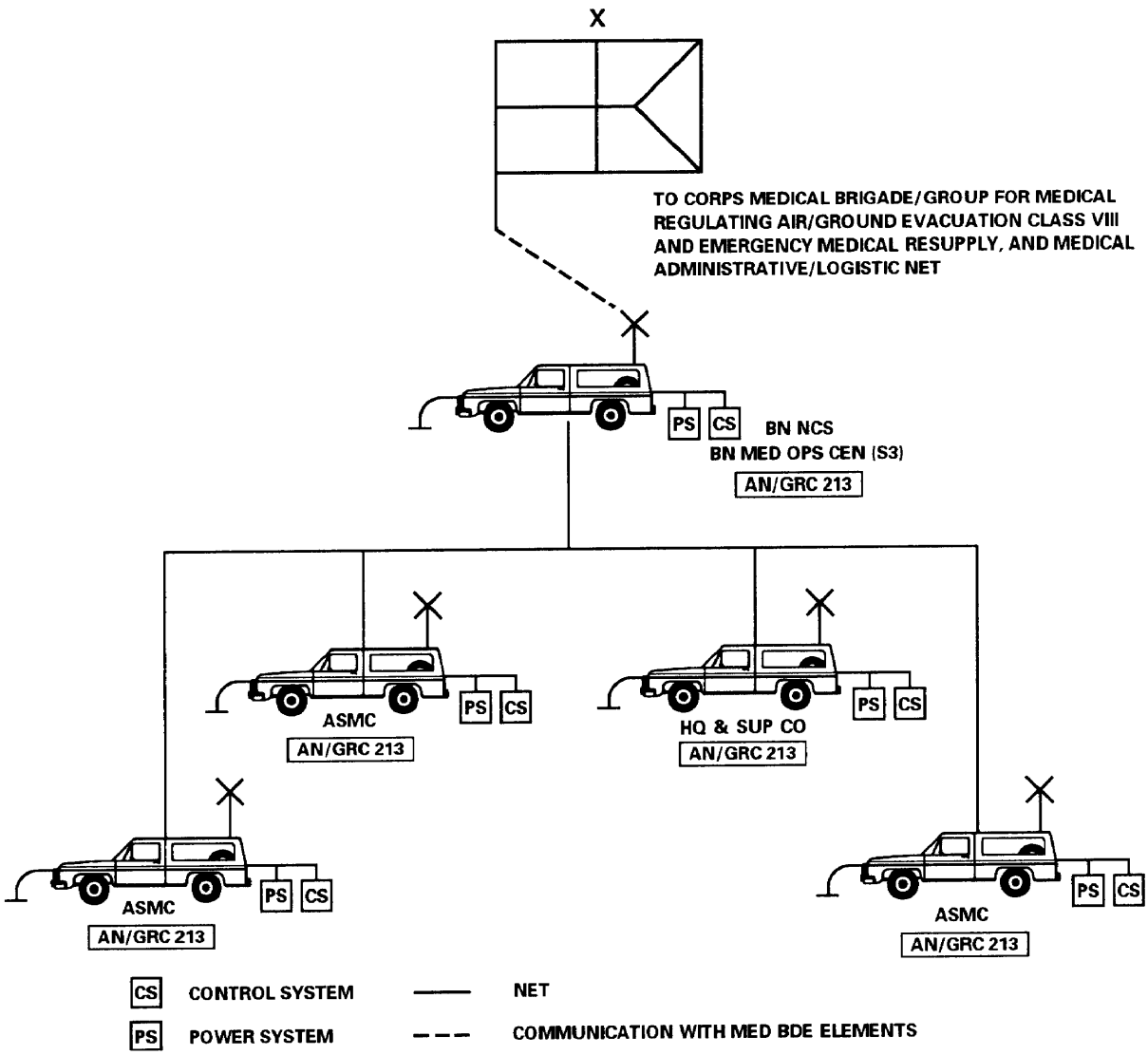


Figure 2-11. Area support medical battalion, medical operations net (AM).

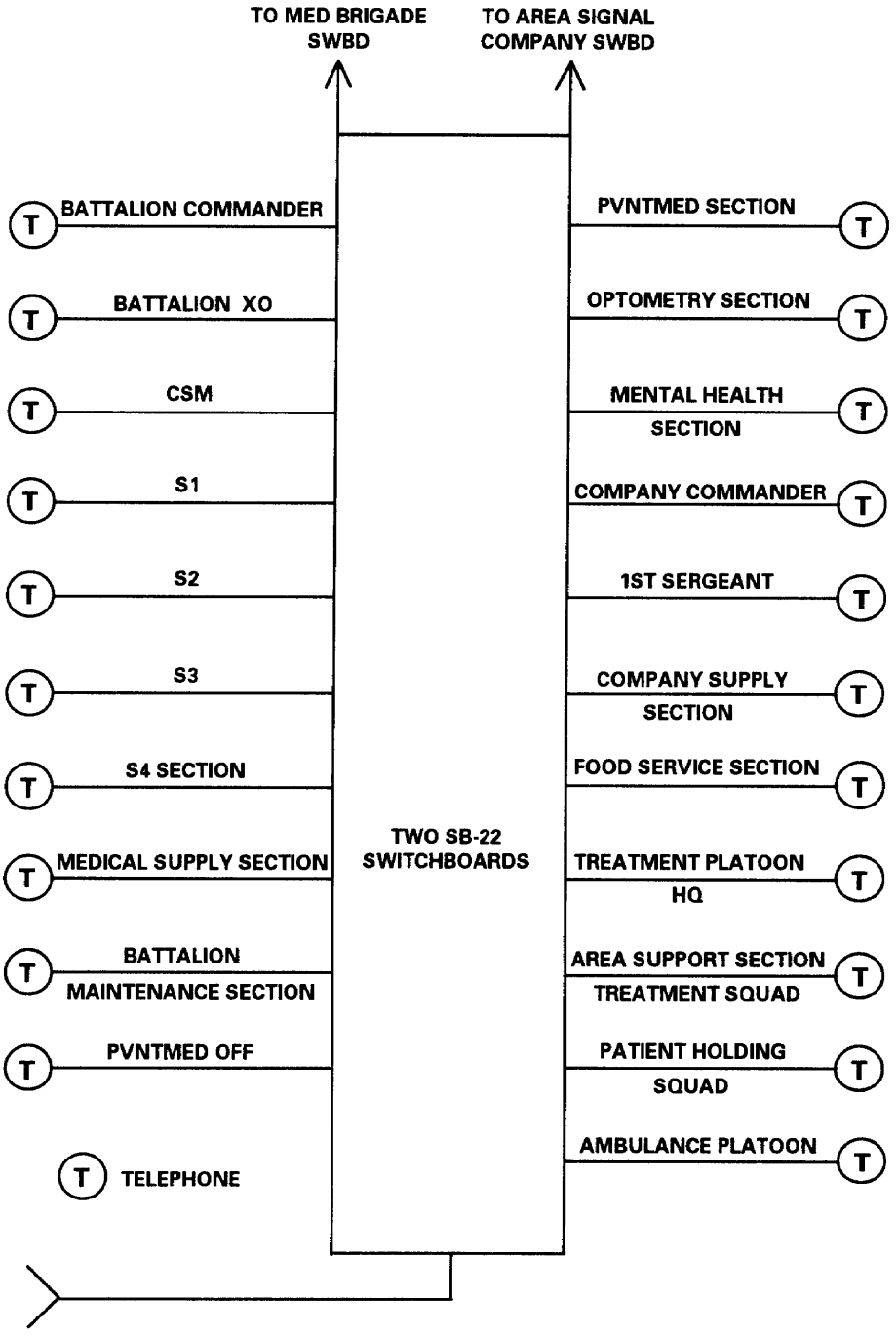


Figure 2-12. Area support medical battalion wire net.

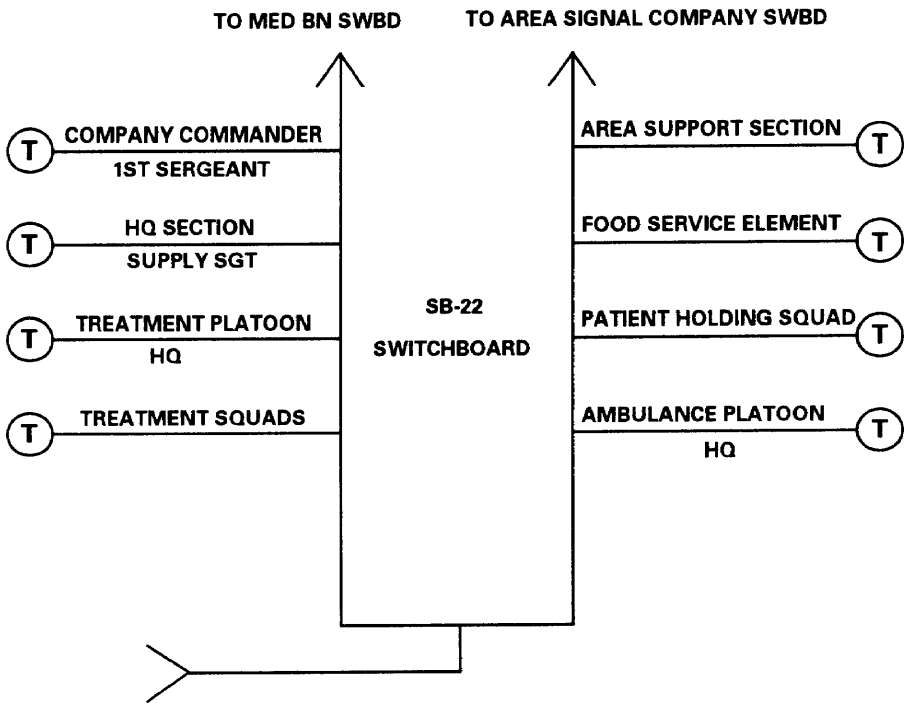


Figure 2-13. Area support medical company wire net.

Section III. BATTALION HEADQUARTERS ELEMENT

2-8. Organization and Functions

The battalion headquarters is a major functional element organized under the HSC (refer to Figure 2-2). For mutual administrative and logistical support, it is collocated with the support company element. The battalion headquarters is comprised of the following subelements:

- Command section.
- Adjutant section.
- Intelligence officer/operations and training officer section.
- Supply officer/medical supply section.
- Preventive medicine section.
- Optometry section.
- Mental health section.
- Battalion maintenance section.

The headquarters also provides C2 for subordinate units, general staff functions for the ASMB, and general HSS for all combat, CS, and CSS units/elements located within the ASMB's AO. It provides administrative and logistical support for the

battalion and plans for its employment. This headquarters also provides C2 or OPCON for attached HSS elements.

NOTE

In order to avoid degrading the battalion's support to its organic units, provisions must be made for additional logistics (including medical resupply) to support attached HSS elements.

2-9. Command Section

The battalion's command section (Figure 2-14) consists of the battalion commander and his immediate staff. These personnel supervise functions of the organizational elements of the battalion headquarters.

COMMAND SECTION

Battalion Commander
Battalion Executive Officer (XO)
Battalion S1
Battalion S2/S3
Battalion S4
Command Sergeant Major
Vehicle Driver

Figure 2-14. Area support medical battalion command section.

a. Battalion Commander. The battalion commander (Lieutenant Colonel [LTC], Medical Corps [MC], area of concentration [AOC] 60A00) is responsible for the C2 and coordination of HSS (Echelon I and Echelon II) within his AO. He provides daily reports to higher headquarters. He plans, directs, and supervises ASMB activities. He also prescribes policy, procedures, and standards for the completion of the mission.

b. Battalion Executive Officer. The *XO* (Major [MAJ], Medical Service Corps [MS], AOC 70H67) is the principal assistant to the battalion commander. He supervises the battalion staff in the execution of his staff responsibilities and ensures coordination between the staff elements. He coordinates assigned missions with subordinate unit commanders. Under the commander's directions, he formulates staff operating policies. He oversees the maintenance of the master policy files. The XO supervises CP operations and is also the battalion's materiel readiness officer.

c. Battalion S1. The battalion S1 (Captain [CPT], MS, AOC 70F67) is the battalion adjutant. He advises the commander on administrative and personnel matters. He has staff responsibility for battalion administrative/personnel matters and exercises supervision over the battalion personnel and administration center (PAC). He develops and issues instructions for submission of records and reports. The S1 also authenticates and supervises the preparation and distribution of directives, policy letters, and instructions.

d. Battalion S2/S3. The battalion S2/S3 (MAJ, MS, AOC 70H67) is the plans, operations, intelligence, and training officer. This officer advises and assists the battalion commander in the following areas:

- Planning HSS operations.
- Conducting HSS operations.
- Ensuring security requirements are met (operations and communications).
- Ensuring nuclear, biological, and chemical (NBC) intelligence/defense information is disseminated to all subordinate units.

- Maintaining communications according to TSOP and SOI.

- Planning and evaluating training activities of the battalion.

He also authenticates and supervises the preparation and distribution of orders.

e. Battalion S4. The battalion S4 (supply officer) (CPT, MS, AOC 70K67) has staff responsibilities for battalion logistics support. He directs the logistics activities of the battalion and advises and assists the battalion commander in all matters pertaining to logistics. He is responsible for directing Class VIII and blood resupply for the battalion. He also coordinates with the S3 in planning and implementing damage control measures. The duties and functions of the S4 are discussed in detail in FM 10-14-2.

f. Command Sergeant Major. The command sergeant major (CSM) (E-9, military occupational specialty [MOS] 00Z50) is the battalion commander's principal enlisted assistant. He maintains liaison between the commander and first sergeants of subordinate units. The CSM advises and assists NCOs in accomplishing their assigned mission. He also assists the commander in the inspection of subordinate units.

g. Vehicle Driver/Medical Specialist. The vehicle driver/medical specialist (E-3, MOS 91B10) is the commander's principal driver and radio operator. He operates and maintains the commander's vehicle and the AN/VRC 90. He also performs EMT duties when required.

2-10. Battalion S1 Section

The S1 section (Figure 2-15), under the direction of the battalion S1, assists the commander and staff in administrative and personnel matters. The activities of this section include the supervision of correspondence, personnel liaison, mail distribution, and dissemination of command information.

S1 SECTION

Battalion S1*
Personnel Records Supervisor
Personnel Staff NCO
Personnel and Administrative Specialists
Legal Specialist
Clerk-Typist

*Located in the Command Section

Figure 2-15. Area support medical battalion S1 section.

a. Personnel Records Supervisor. The personnel supervisor (E-7, MOS 75Z40) supervises the PAC. He advises the commander, adjutant, and other staff members on personnel administrative activities. He also assists in supervising general areas of administration, to include–

- Correspondence.
- Reports.
- Mail and distribution activities.
- Files.
- Publications.
- Classified materials.
- Orders.
- Directives.
- Printing and reproduction activities.

b. Personnel Staff NCO. The personnel staff NCO (E-6, MOS 75B30) advises, assists, and

informs the commander, the staff, and other NCOs and soldiers on personnel matters. He reviews and consolidates reports, statistics, and personnel actions submitted to higher headquarters. He advises the commander on personnel strength, shortages, and overages.

c. Personnel and Administrative Specialist. There are three personnel and administrative specialists (E-5, E-4, E-3, MOS 75B20 and MOS 75B10) who perform personnel and administrative functions in support of the battalion.

d. Legal Specialist. The legal specialist (E-4, MOS 71D10) assists in preparing and processing legal documents, These documents include general, special, and summary courts-martial records, claims investigations, line-of-duty investigations, and reclassification board proceedings.

e. Clerk-Typist. The clerk-typist (E-4, 71L10) performs administrative, clerical, and typing duties for the S1 section.

2-11. Battalion S2/S3

The battalion S2/S3 section (Figure 2-16) serves as the main operations and planning element for the battalion. This section coordinates task-organizing of battalion elements and other units assigned to the battalion to provide HSS for the battalion's AO. It coordinates patient evacuation from MTFs to other corps/COMMZ treatment facilities. This section's responsibilities include–

- Formulating HSS OPLANs.
- Developing/issuing OPORDs.
- Overseeing communication and movement of battalion units.
- Coordinating rear area security and damage control activities.
- Planning and coordinating training for subordinate units.
- Forwarding any information of potential tactical or technical intelligence value.
- Planning for Echelon I and Echelon II HSS operations in the battalion AO.
- Coordinating support arrangements with units in the AO unless delegated to the ASMCs or other staff sections.

S2/S3 SECTION
Battalion S2/S3*

Plans and Operations Branch	Communications Branch
Medical Operations Officer (Assistant S2/S3)	Battalion Communications Chief
Battalion Operations Sergeant	Signal Support Systems Specialist/Team Chief
Plans Sergeant	Signal Support Systems Specialist (2)
Intelligence and Security Sergeant	
Nuclear, Biological, and Chemical NCO	
Patient Administration Specialist (2)	

* Located in the command section

Figure 2-16. Organization of the area support medical battalion S2/S3 section.

a. Plans and Operations Branch. The plans and operations branch under the direction of the battalion S2/S3 is responsible for–

- Planning and coordinating intelligence and security matters.
- Processing, interpreting, and disseminating information pertaining to the effects of METT-T on the battalion's mission.

- Forwarding any information of potential tactical or technical intelligence value.

- Developing plans, policies, programs, and procedures pertaining to the ASMB's operations and functions, to include task-organizing the battalion.

- Planning, supervising, and inspecting the tactical and technical training of subordinate units.

- Planning and coordinating the augmentation or reconstitution of ASMB units. This includes establishing the priority for replacements.

- Coordinating and providing current operational information to subordinate medical elements.

- Planning, coordinating, and supervising the battalion's support of CMO and supporting special operations forces (SOF).

- Coordinating the evacuation of patients from battalion MTFs to corps/COMMZ hospitals.

- Planning and supervising defense against NBC attack, air attack, and unconventional warfare operations.

- Preparing the rear operations defense plan for the battalion HSCsS immediate AO (base cluster).

- Coordinating with the area veterinary support for subsistence inspections, monitoring and decontamination of NBC hazards on rations, veterinary care of government-owned animals in the area, and zoonotic disease control programs.

NOTE

This branch supervises the execution of the rear operations defense plan under the direction of the battalion XO.

(1) *Medical operations officer.* The medical operations officer (CPT, MS, AOC 70H67) (assistant S2/S3) directs and coordinates functions pertaining to HSS operations. These functions involve planning, organizing, coordinating, and analyzing all aspects of operations, intelligence, and training requirements. He monitors HSS operations for compliance with OPORDs/OPLANs and notifies the S2/S3 when changes are required.

(2) *Battalion operations sergeant.* The battalion operations sergeant (E-8, MOS 91B50) provides technical assistance to the operations officer. He determines requirements and assess the operation status of battalion elements.

(3) *Plans sergeant.* The plans sergeant (E-7, MOS 91B40) assists the assistant S3 and battalion operations sergeant in preparing HSS plans, operations, and training requirements. He reviews, designs, and maintains the battalion HSS OPLAN.

(4) *Intelligence and security sergeant.* The intelligence and security sergeant (E-7, MOS 91B40) is the principal assistant to the battalion S2/S3 on intelligence matters. This includes operations security (OPSEC) and physical security of battalion areas and facilities. He reviews and coordinates medical intelligence requirements for the battalion.

(5) *Nuclear, biological, and chemical NCO.* The NBC NCO (E-7, MOS 54B40) assists and advises the battalion S2/S3 in all matters pertaining to NBC operations. He assists in planning NBC defensive operations, training, and decontamination for the battalion. He advises the

S2/S3 on NBC preparedness. He collects, interprets, analyzes, and disseminates NBC information and data throughout the battalion. He performs inspections and training duties for company NBC operations.

(6) *Patient administration specialists.* The patient administration specialists (E-4 and E-3, MOS 71G10) consolidate and manage patient statistics on all patients seen by treatment elements of the battalion. They are responsible for patient accountability and statistical reporting functions. They prepare the required patient statistical reports and coordinate their timely submission to higher headquarters. They also drive and maintain the vehicle assigned to the S2/S3 section.

b. Communications Branch. The communications branch develops, executes, and supervises the battalion signal communications TSOP. This branch–

- Secures, maintains, and issues the command's SOI to battalion users.
- Implements the ASMB signal communications TSOP.
- Assures communications systems interface between the battalion and the medical brigade/group and between the ASMB and its subordinate units.
- Operates the battalion switchboard and serves as NCS for the battalion's command/operations (FM voice) net and the HSS operations (AM voice) net.
- Provides for technical training to battalion users of communications-electronics (CE) equipment.

(1) *Battalion communications chief.* The battalion communications chief (E-7, MOS 31U40) serves as the signal advisor for the battalion. He is the principal advisor to the commander and the battalion S2/S3 on CE matters. He supervises the installation, operation, and unit maintenance of radio and wire communications systems, FM radio sets, and air/ground radio sets. He coordinates with the supporting signal element, medical brigade/group, and major commands within the AO to ensure proper integration of communications and CE equipment. The chief supervises all functions of the communications branch to include advising on site selection for the battalion CP.

(2) *Signal support systems specialist/team chief.* This NCO (E-5, MOS 31U20) assists the battalion communications chief in maintaining the operation of the battalion headquarters radio and wire communications system. This senior CE operator supervises the activities of CE personnel. He trains ASMC personnel in tactical communications procedures to include OPSEC and SOI.

(3) *Signal support systems specialists/switchboard operators.* The signal support systems specialists (E-4 and E-3 MOS 31U10) install, operate, and perform preventive maintenance checks and services (PMCS) and unit-level maintenance on field wire communications systems, telephones, field wire switchboards, small switching systems, FM radios, and associated COMSEC equipment and accessories. They operate the unit switchboard and perform PMCS on assigned vehicles and power generators.

2-12. Battalion S4/Medical Supply Section

The S4/medical supply section is comprised of two separate functional elements which are shown in Figure 2-17. This section provides Class VIII and blood resupply as well as general supply support to the battalion. This section is responsible for

planning, coordinating, and supervising unit-level supply and service functions for the battalion. The S4 section is also responsible for–

- Determining logistics requirements, maintaining the property book, and providing general supply support to assigned and attached units.

- Requesting and issuing general classes of supplies and equipment for units of the battalion according to priorities recommended by the battalion S2/S3.

- Assisting in preparing plans for area damage control.

Supply requests for Class VIII supplies are forwarded to the S4 section from the ASMCs and other medical units which are supported by the battalion. Each medical element of the battalion maintains 3 days of supplies. In a mature theater Class VIII resupply of the ASMB in the corps is provided by the medical logistics (MEDLOG) battalion, forward. In the COMMZ, Class VIII resupply of the ASMB is provided by the MEDLOG battalion, rear.

S4/MEDICAL SUPPLY SECTION
Battalion S4 Officer*

S4 Element	Medical Supply Element
Supply NCO	Health Service Materiel Officer
Supply Specialist (2)	Medical Supply NCO
	Medical Supply Specialist/Stock Issue
	Medical Supply Specialist/Stock Control
	Pharmacy NCO
	Medical Equipment Repairers

*Located in the command section.

Figure 2-17. Organization of the area support medical battalion S4 section.

a. S4 Element. The S4 element is responsible for planning, coordinating, and supervising unit-level supply and service functions of the battalion.

(1) *Supply NCO.* The supply NCO (E-5, MOS 92Y20) assists the S4 with the accomplishment of his duties. He supervises duties involving request, receipt, storage, issue, accounting for, and preservation of individual and organizational property and expendable supplies and equipment.

(2) *Supply specialist.* Two supply specialists (E-4 and E-3, MOS 92Y10) perform duties involving request, receipt, storage, issue, accounting for, and preservation of individual and organizational property and expendable supplies and equipment.

b. Medical Supply Element. The medical supply element is organized to provide Class VIII supply and unit-level medical equipment maintenance for the battalion and attached or supported units. The functions of the medical supply element include development and maintenance of prescribed loads of contingency medical supplies, management of medical quality control program, and supervision of unit (organizational) medical maintenance support. This element provides routine and emergency Class VIII resupply to include blood (Group O packed red blood cells) to all Echelon II elements operating within the battalion AO. Class VIII resupply request procedures may be formal or informal, depending on the tactical situation. Requests may come by message; by land lines; or through existing FM administrative/logistic or command nets. The S4/medical element operates the supply point distribution system. Supported ASMCs are responsible for picking up requested supplies. When ASMCs are unable to pick up requested supplies, the medical supply element coordinates through the battalion S2/S3 for delivery. When ASMCs are established closer to the MEDLOG battalion than

their own ASMB supply section, they request Class VIII resupply directly from the MEDLOG battalion.

(1) *Health services materiel officer.* The health services materiel officer (HSMO) (Lieutenant [LT], AOC 70K67) plans, coordinates, controls, and manages a variety of functional areas pertaining to technical materiel, equipment, and services used in support of the health care delivery system.

(a) The HSMO executes the health service logistics plans. He exercises his responsibilities by–

- Developing and maintaining prescribed loads of contingency medical supplies and medical repair parts for battalion medical elements.
- Coordinating with the supported elements to determine requirements for Class VIII resupply.
- Maintaining prescribed loads of contingency medical supplies. These loads should be based upon transportation and storage constraints, as well as characteristic of the AO.
- Managing the battalion's health service logistics quality control program.
- Supervising the unit-level medical equipment maintenance program.
- Monitoring the ASMB's medical assemblage management program.
- Coordinating logistical planning for preconfigured Class VIII packages.
- Managing the battalion's blood program.

(b) The reconstitution duties of the HSMO include–

- Reconciling the shortages in each ASMC and treatment platoon as reported by the commander or the battalion headquarters elements of those supported units with organic medical elements.
- Coordinating with the S4 and ASMB commander to obtain the number of medical MESS required to field an operationally ready MTF.
- Coordinating with the MEDLOG battalion to monitor the status and number of MESS due in.
- Coordinating with the corps movement control center to move supplies from the MEDLOG battalion. (The HSMO directs quick fixes using available assets and controlled exchanges for medical equipment to maximize the capabilities of MTFs.)
- Alerting the appropriate company when MESS are arriving.
- Allocating replacement personnel and MESS to the unit based on the commander's priorities. (The HSMO coordinates through the battalion S2/S3 with the medical brigade/group to identify transportation assets to transport medical assemblages to the units being reconstituted.)
- Preparing the critical items listing and consolidating the critical shortages by ASMC.

(2) *Medical supply noncommissioned officer.* The medical supply NCO (E-6, MOS

76J30) serves as the noncommissioned officer in charge (NCOIC) for the S4/medical supply section. His supervisory duties include–

- Requisitioning medical supplies and equipment.
- Conducting receipt management.
- Conducting inventory management.
- Storing and preserving Class VIII supplies.
- Issuing Class VIII supplies and equipment.
- Conducting salvage operation for medical items.
- Overseeing destruction stock control (routine destruction of medical supplies where effective dates have been surpassed).
- Ensuring quality control procedures are followed.
- Overseeing repair parts management.
- Inspecting supplies and property.
- Packing and shipping reedical materiels.
- Maintaining stock levels.
- Segregating and accounting for Class VIII materiel and equipment.

(3) *Medical supply specialist.* There are two medical supply specialists (E-4 and E-3, MOS 76J10), and they assist the medical supply NCO. Their duties include–

- Requisitioning Class VIII supplies and equipment.
- Accounting for receipts.
- Conducting inventories.
- Storing and preserving Class VIII supplies.
- Issuing Class VIII supplies and equipment.
- Assisting with Class VIII salvage activities.
- Performing destruction stock control (routine destruction of medical supplies where effective dates have been surpassed) as directed.
- Performing quality control procedures.
- Inspecting Class VIII supplies and materiels for deficiencies.
- Packing and shipping reedical materiels.
- Segregating and accounting for Class VIII materiels and equipment.

(4) *Pharmacy NCO.* The pharmacy NCO (E-5, MOS 91Q20) performs quality control of pharmaceuticals. He supervises controlled substances and pharmaceutical stockage levels, inventories, and records. He provides limited technical advice to medical treatment personnel within the battalion.

(5) *Medical equipment repairers.* There are two medical equipment repairers (E-5

and E-4, MOS 35G20 and 35G10). These personnel provide unit-level medical maintenance for the ASMB. They exercise their responsibilities by–

- Scheduling and performing PMCS.
- Electrical safety inspections and tests.
- Calibration, verification, and certification services.
- Performing unscheduled maintenance functions with emphasis upon the replacement of assemblies, modules, and printed circuit boards.
- Operating a medical equipment repair parts program to include Class VIII as well as other commodity class parts.
- Maintaining a technical library of operator and maintenance technical manuals (TMs) and/or associated manufacturers' manuals.
- Conducting inspections for new or transferred equipment.
- Maintaining documentation of maintenance functions according to the provisions of Technical Bulletin (TB) 38-750-2 or DA standard automated system.
- Collecting and reporting data for readiness reportable medical equipment in accordance with AR 700-138.
- Notifying the CZ/COMMZ MEDLOG battalion of requirements for maintenance support services, repairable exchange, or replacement from operational readiness float (ORF) assets.

2-13. Battalion Maintenance Section

The battalion maintenance section (Figure 2-18) functions under the staff supervision of the battalion S4. This section provides unit-level maintenance for wheeled vehicles assigned to the HSC. Consolidated task-organized contact teams provide the maintenance for the ASMCs assigned to the battalion. This section also provides power generator unit-level maintenance for the HSC. It is typically organized into the following three functional work areas:

- Management element.
- Motor vehicle repair element.
- Power generator repair element.

This section establishes the battalion motor pool using standard motor pool operational procedures in accordance with FM 43-5.

BATTALION MAINTENANCE SECTION
Section Headquarters

Battalion Motor Officer
Battalion Maintenance Sergeant
Shop Clerk
Prescribed Load List Clerk

Motor Vehicle Repair Shop*	Power Generator Repair
Senior Mechanic (1)	Power Generation Equipment Repairer
Light Wheeled Vehicle Mechanic (13)	
Recovery Vehicle Operator (1)	

*2-contact team capability

Figure 2-18. Organization of the area support medical battalion maintenance section.

a. Battalion Motor Officer.

(1) The battalion motor officer (unit maintenance technician light), warrant officer [WO], AOC 915A0) plans, directs, and supervises activities of the battalion maintenance section, less medical maintenance. His duties also include–

- Supervising, planning, and evaluating the battalion maintenance program.
- Keeping the battalion commander and staff informed of the maintenance situation and the operational status of equipment.
- Analyzing the maintenance situation.
- Directing battalion maintenance operations and coordinating support for subordinate units as required.
- Monitoring calibration requirements and arranging for calibration support.
- Keeping the battalion materiel readiness officer (XO) informed of the operational readiness status of vehicles and power generation equipment.
- Monitoring prescribed load list (PLL) operations, the Army Oil Analysis Program (AOAP), and the warranty program.
- Supervising maintenance services and the training and licensing of vehicle drivers and equipment operators. (This includes PMCS training on all vehicles and power-generation equipment.)
- Directing and coordinating organizational maintenance throughout the battalion.

(2) In coordination with the battalion S3, he–

- Implements maintenance-related training and safety programs for operators and supervisors of battalion vehicles and power generating equipment.
- Inspects battalion units to ensure maximum use of equipment and vehicles assets.
- Trains subordinates.
- Schedules semiannual services for subordinate units.

b. Battalion Maintenance Sergeant. The battalion maintenance sergeant (E-7, MOS 63B40) functions as the battalion maintenance supervisor. He supervises the maintenance on wheeled vehicles, power generators, materiel-handling equipment, recovery operations, and upkeep of hand and power tools. He assists the motor officer in the accomplishment of his duties and is responsible for–

- Organizing and supervising the section's shop and teams.
- Supervising activities of the senior vehicle mechanic, generator repairer, shop clerk, and PLL clerk.
- Monitoring the scheduling of preventive maintenance (PM) services, quality control inspections of maintenance operations, and equipment deficiencies and failures.
- Monitoring calibration requirements and the AOAP.
- Recommending new maintenance procedures to the motor officer and providing technical assistance within the battalion.

c. Shop Clerk. The shop clerk (equipment records and parts specialist, E-5, MOS 92A20) performs duties involving supply of repair parts and maintenance of equipment records. He initiates and maintains records on equipment use, operation, history, maintenance, modifications, and calibration. The shop clerk is also responsible for–

- Providing input for the materiel readiness report.
- Assisting in the scheduling of maintenance and repair services.
- Issuing such tools to motor vehicle and power generation repair personnel as required.

d. Prescribed Load List Clerk. The PLL clerk (E-3, MOS 92A10) maintains the PLL. He is responsible for requesting, receiving, recording, and storing parts and tools. In addition, he issues parts to motor vehicle and power-generation repair personnel as required.

e. Senior Vehicle Mechanic. The senior vehicle mechanic (E-6, MOS 63B30) advises, trains, and supervises junior mechanics. His responsibilities also include–

- Preparing daily work sheets and charts.
- Supervising scheduled maintenance and repair services.
- Implementing the AOAP.
- Recommending maintenance procedures.
- Supervising and performing vehicle recovery operations.
- Providing technical assistance to supported units.

f. Light Wheeled Vehicle Mechanic. There are a total of fourteen light wheeled vehicle mechanics (E-5[4], E-4[4], E-3[6], MOSs 63B20 and 63B10) who are under the supervision of the senior mechanic. These personnel perform organizational PMCS and repairs on gasoline and diesel-fueled, light-wheeled vehicles. Light wheeled vehicles include prime movers designated as 5 tons or less and their trailers and associated items. Duties of the light wheeled vehicle mechanic include–

- Diagnosing malfunctions of light wheeled vehicles and associated items.
- Troubleshooting engine and equipment problems using TMs and test, measurement, and diagnostic equipment (TMDE), as required.
- Applying applicable safety precautions.
- Performing scheduled maintenance and repairs on vehicles and equipment, assisted by the vehicle operator or ambulance crew.
- Operating recovery vehicle and equipment; performing recovery operations.
- Performing PM on equipment assigned to the maintenance section.
- Maintaining and accounting for tools and equipment issued to him.

g. Power Generator Repairer. The power generator repairer (E-4, MOS 52D10) performs unit or DS/general support (GS) maintenance functions. This includes overhaul, but not rebuilding, of power-generation equipment up through 200 kilowatt (kw) capacity. He performs services and scheduled maintenance and repairs on tactical-utility and precise power generation

equipment. The major functions/tasks of the repairer include–

- Applying applicable safety precautions.
- Inspecting equipment, determining category of maintenance and extent of repairs, and recording results.
- Using TMs and TDME to troubleshoot and perform repairs on power-generation equipment and to overhaul components and assemblages as required.
- Classifying unserviceable components and equipment for disposition.
- Performing PMCSs on shop equipment.
- Maintaining and accounting for tools issued.

2-14. Preventive Medicine Section

The PVNTMED section is primarily responsible for supervising the command PVNTMED program as described in AR 40-5. This section ensures PVNTMED measures are implemented to protect corps/COMMZ personnel against food-, water-, and arthropodborne diseases, as well as environmental injuries (for example, heat and cold injuries). The section is staffed to provide advice and consultation in the areas of environmental sanitation, epidemiology, sanitary engineering, and pest management. Assigned personnel conduct evaluations to identify actual and potential health hazards, recommend corrective measures, and assist in training personnel in disease prevention programs. The PVNTMED section is staffed as shown in Figure 2-19. This section is also responsible for training unit field sanitation teams (see FM 21-10-1). The staffing of this section allows for personnel to be split into teams to conduct evaluations within their assigned AO and/or to be task-organized to provide DS to designated corps/COMMZ units, as required. Specific functions of the PVNTMED section include, but are not limited to, the following:

- Assisting the commander in preparing staff estimates by identifying the medical threat.
- Assisting the battalion S2/S3 in determining requirements for medical intelligence assessments, particularly with respect to disease prevalence.
- Conducting surveillance of corps/COMMZ 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 corps/COMMZ units in the training of PVNTMED measures against heat and cold injuries, as well as food-, water-, and arthropodborne diseases.
- Coordinating with veterinary services units for conducting and implementing food safety and quality assurance surveillance and assisting in foodborne and zoonotic disease surveillance and control.
- Monitoring the supported units' immunization program.
- Monitoring and approving the health-related aspects of water and ice sources, to include production, distribution, and consumption.
- Monitoring disease and injury incidence to optimize early recognition of disease trends and to initiate preemptive disease suppression measures.

- Conducting epidemiological investigations of disease outbreak and recommending PVNTMED measures to minimize effects.

- Monitoring the levels of 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 corps/COMMZ operations, and recommending preventive measures to minimize heat or 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.

- Providing PVNTMED support for enemy prisoner(s) of war (EPW) compounds located in the AO.

- Monitoring disposal practices/facilities for all classes of waste in the ASMB's AO.

PREVENTIVE MEDICINE SECTION

Preventive Medicine Officer
Sanitary Engineer/Environmental Science Officer
Preventive Medicine Sergeant (2)
Preventive Medicine Specialist (5)

Figure 2-19. Organization of the area support medical battalion preventive medicine section.

a. Preventive Medicine Officer. The PVNTMED officer (MAJ, AOC 60C00) is responsible for the implementation of the command PVNTMED program. He determines the status of and conditions influencing the health of units located in the ASMB's AO. He formulates and recommends measures for health improvements. Based on command guidance and corps/COMMZ requirements, he plans, directs, and prioritizes the PVNTMED sections's activities. He serves as the principal advisor on medical threats that will be encountered by corps/COMMZ units and recommends PVNTMED measures to minimize these threats in the AO.

b. Sanitary Engineer Officer. The sanitary engineer officer (CPT, MS, AOC 72E67/ environmental science officer, AOC 72D67) serves as the principal assistant to the PVNTMED officer in developing and implementing the command PVNTMED program. He serves as the principal consultant within the battalion's AO for the health-related area to include–

- Aspects of food service sanitation.

- Pest management.

- Water production, distribution, and storage.

- Waste disposal practices (see Appendix B).

- Environmental injury within the battalion's AO.

c. Preventive Medicine Sergeants. There are two PVNTMED sergeants (E-6 and E-5, MOS 91S30 and 91S20). The E-6 also serves as the NCOIC of the section. The PVNTMED sergeants assist the PVNTMED and the sanitary engineer/ environmental science officers in the accomplishment of their duties. They supervise the activities of PVNTMED specialists and manage the technical and administrative functions of the section. They

coordinate utilization of assigned/attached PVNTMED specialists. They assist with PVNTMED inspections, surveys, and control operations. They also coordinate support for PVNTMED teams deployed in support of specific units or operations.

d. Preventive Medicine Specialists. There are five PVNTMED specialists (E-4 and E-3, MOS 91S10) assigned to the section. The PVNTMED specialists perform environmental health surveys, inspections, and limited laboratory procedures. They monitor the health-related aspects of water production and distribution within the AO. They conduct investigations pertaining to—

- Food-, water-, and arthropod-borne diseases.
- Zoonotic diseases.
- Other communicable diseases.

Preventive medicine specialists assist in the training of unit field sanitation teams in the applied aspects of environmental sanitation and the (limited) control of animal reservoirs and disease vectors. These individuals also operate the PVNTMED section's FM radios and vehicles and perform operator maintenance.

e. Preventive Medicine Detachments. The PVNTMED detachments, either the sanitation detachment or the entomology detachment, provide additional support to the ASMB's PVNTMED section as required. These detachments are assigned to the medical brigade or medical group in the corps and COMMZ and are normally attached to an ASMB or other medical unit.

2-15. Optometry Section

The optometry section provides—

- Optometry services, including routine vision evaluation and refractions.

★ • Evaluation and management of ocular injuries and diseases.

- Spectacle frame assembly using presurfaced single-vision lenses.
- Spectacle repair services for units within the ASMB's AO.

The optometry section is staffed as shown in Figure 2-20.

OPTOMETRY SECTION

Optometrist (2)
Optical Laboratory Specialist
Eye Specialist

Figure 2-20. Area medical support battalion optometry section.

a. Optometrists. Two optometrists (CPT, MS, AOC 67F00) independently conduct examinations of the eyes using optometric procedures, instruments, and pharmaceuticals, as required. They are responsible for—

- Performing eye examinations and prescribing corrective lenses.

★ • Managing ocular diseases and injuries according to medical protocols (established by the medical group or medical brigade), and referring patients to other health care providers as appropriate.

- Planning and directing the activities of the optometry section.

★ • Examining, evaluating, and referring laser-induced injuries for further ophthalmologic care as appropriate.

- Providing clinical statistical input to the battalion headquarters as appropriate.

- Advising commanders on all matters relating to vision, to include protective eyewear (ballistic and laser protection).

★ *b. Optical Laboratory Specialist.* The optical laboratory specialist (E-5, MOS 42E20) assembles spectacles utilizing presurfaced single-vision lenses; surfaces multivision lenses; and repairs and fabricates spectacles. He may perform routine diagnostic tests and assist in the management of patients. He is responsible for—

- Fabricating eyewear.
- Ordering, receiving, and maintaining optical supplies and equipment.
- Coordinating and sending prescriptions which require capabilities beyond that of the ASMB to the supporting MEDLOG battalion.
- Maintaining complete files on prescriptions shipped to patients as required.
- Inspecting lenses for compliance with American National Standards Institute (ANSI) standards.
- Selecting and assembling prescribed frame components, mounting lenses, and shipping completed spectacles to customers.
- Packing, unpacking, loading, and unloading equipment and assisting in setting up unit equipment and shelters.

★ *c. Eye Specialist.* The eye specialist (E-4, MOS 91Y10) conducts routine diagnostic tests and assists in the management of optometry patients. He is responsible for—

- Determining purpose of patient visit and recording oculovisual complaints.
- Applying and removing dressings as required.
- Performing minor repairs and adjustments to spectacles.
- Measuring power and prism in spectacle lenses.
- Measuring interpupillar distances, bridge size, and temple length to aid in fitting spectacles.
- Requisitioning, storing, and maintaining ophthalmic equipment and instruments.
- Packing, unpacking, loading, and unloading equipment and assisting in setting up unit equipment and shelters.

2-16. Mental Health Section

The mental health (MH) section is the medical element with primary responsibility for assisting the command in controlling combat stress. Combat stress is controlled through sound prevention programs and maximizing the RTD rate with battle fatigue (BF) casualties being treated within or near their unit areas. Under the direction of the ASMB psychiatrist, the MH section provides MH services throughout the ASMB's AO. The MH section is collocated with the HSC clearing station. This section has staff responsibility for establishing policy and guidance for the prevention, diagnosis, management, and RTD of BF casualties. It has technical responsibility for the diagnosis, treatment, and disposition of NP disorders and disease cases and for the psychological aspect of surety programs. The staff of this section provides education to unit leaders, medical personnel, and troops. They monitor unit morale, cohesion, and mental fitness. Other responsibilities of the MH section staff include—

- Providing command consultation and making recommendations for corrective actions.

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- Evaluating soldiers for treatment or referral.

- Coordinating support activities of the CSC company elements when attached.

- Providing limited direct patient care and triage of all NP patients.

- Providing selective short-term treatment of RTD soldiers with stress reactions or BF.

The staffing of the MH section allows this section to be split into teams which can operate independently of the HSC to provide DS to units in the AO. When the corps tactically deploys, the MH section collocates with the HSC clearing station. Depending on the size of the ASMB's AO and the distances between the HSC and the ASMCs, MH section personnel may be positioned with each ASMC. These personnel provide MH consultation services and serve as the CSC coordinator for each of the ASMC's AO. The CSC coordinator establishes unit preventive training programs which assist unit members in preventing or reducing the harmful effects of excessive stress. The MH section officer supports the MH section personnel deployed to ASMCs by visiting each ASMC on a regular basis. The MH officers provide technical supervision for ASMCs and supervise MH personnel collocated with them. They ensure quality assurance over all counseling and command consultation activities. Severe BF or NP cases which cannot be managed at the ASMCs clearing stations are evacuated for further evaluation. If possible and if the distances are not too great, these cases are sent to the HSC for evaluation by the ASMB MH section, or MH personnel deploy to the unit to see these cases. When it is not feasible for the psychiatrist or other MH personnel to evaluate the severe NP or BF cases, these cases are evacuated to the supporting CSH in the corps. In the COMMZ severe NP patients are evacuated to the FH or GH for evaluation.

a. Mental Health Support. The ASMB S3 and MH section monitor and prioritize MH support missions according to the medical brigade/group SOP. Coordination for MH personnel augmentation is accomplished through the ASMB S3 and the medical brigade/group headquarters.

b. Mental Health Section Staff. The ASMB MH section is staffed as shown in Figure 2-21. The consolidation of assigned MH officers in the HSC clearing station emphasizes the area-wide preventive, education, and treatment responsibilities of the section. It ensures a multidisciplinary pool of professional expertise to–

- Provide staff input to the command within the AO.

- Provide clinical evaluation and supervision of treatment for all NP and problematic BF cases at a central location.

- Maintain communications with the medical brigade/group and corps/COMMZ resources.

- Provide selected officer expertise for brief intervention where required throughout the AO.

Mental Health Section Staff

Psychiatrist
Social Work Officer
Behavioral Science Specialist (NCOIC)
Behavioral Science Specialist (E-6)
Behavioral Science Specialist (E-5) (3)
Behavioral Science Specialist (3)

Figure 2-21. Area support medical battalion MH section staff.

(1) *Psychiatrist.* The psychiatrist (MAJ, MC, AOC 60W00) examines, diagnoses, and

treats or recommends courses of treatment for personnel suffering from emotional or mental illness, situational maladjustment, combat stress, and BF. The psychiatrist is also a working physician who applies the knowledge and principles of psychiatry and medicine in the treatment of all patients. His specific functions include–

- Establishing and operating the MH section.
- Providing staff consultation for the ASMB commander and for supported commands within the AO. This includes nuclear surety, security clearances, and alcohol and drug abuse programs.
- Being responsible for the diagnosis, treatment, rehabilitation, and disposition of NP and problematic BF patients.
- Participating in the diagnosis and treatment of the wounded, ill, and injured soldiers, especially of those who can RTD quickly.
- Training of and consulting with unit leaders and medical personnel regarding identification and management of NP disorders.
- Providing therapy or referral for soldiers with psychiatric problems.
- Providing supervision and training of assigned and attached MH personnel.

(2) *Social work officer.* The social work officer (CPT, MS, AOC 73A67) performs social work functions by providing direct services, teaching, and training for the ASMB and supported units. He provides supervision and consultation to soldiers assigned to units within the ASMB's AO. The social work officer assists in the development, management, and supervision of the battalion's MH (Combat Mental Fitness) Program for the AO. His responsibilities are to apply the knowledge and principles of social work to–

- Evaluate BF soldiers.
- Coordinate and ensure the return of recovered BF/NP soldiers to duty.
- Ensure their reintegration into their original or new units.
- Identify and resolve organizational and social environmental factors which interfere with combat readiness.
- Ensure support for soldiers and their families from Army and civilian community support agencies (if possible).
- Apprise unit leaders, primary care physicians, and other clinical personnel of available social service resources.
- Provide consultation to unit commanders and to MH section personnel regarding problem cases.
- Counsel and provide therapy or referral for soldiers with psychological problems.

(3) *Senior behavioral science NCO.* The senior behavioral science NCO (E-7, MOS 91G40) is the section sergeant for the battalion MH section. This senior NCO assists the MH officers in accomplishing their duties. He provides assistance with management of both the technical and the tactical operations of the section and supervises subordinate members. His specific duties include–

- Keeping the ASMB psychiatrist informed.

- Monitoring, facilitating, and supervising the training activities of the MH section.

- Monitoring and coordinating situation reports from MH section personnel deployed within the battalion's AO.

- Coordinating additional MH support with the medical brigade/group for the battalion's AO as directed.

- Conducting classes on selected MH topics for senior NCOs within the AO.

(4) *Behavioral science NCO.* There are four behavioral science NCOs assigned to the section (E-6, MOS 91G30 [1] and E-5, MOS 91G20 [3]). The E-6 is the assistant section sergeant and assists the section sergeant with the accomplishment of his duties. Behavioral science NCOs collect and record social and psychological data and counsel personnel with personal, behavioral, or psychological problems. All these NCOs assist with the management of the MH section. These NCOs maybe deployed with the ASMCs to provide MH support. Their general duties include–

- Assisting in a wide range of psychological and social services.

- Compiling caseload data and referring patients to specific MH officers and physicians.

- Providing counseling to patients experiencing emotional or social problems.

- Assisting with group counseling and therapy sessions and leading group discussions.

(5) *Behavioral science specialist.* There are three behavioral science specialists (E-4 [2] and E-3 [1], MOS 91G10). These specialists assist MH officers in gathering social and psychological data to support patient evaluation. They provide initial screening of patients suffering emotional disorders. In addition to their duties, they operate and maintain assigned vehicles. Under the supervision of a MH health officer, their specific duties include–

- Providing supportive counseling for patients experiencing emotional or social problems.

- Assisting in the evaluation of the emotionally disturbed or mentally ill.

- Assessing a patient's mental status (level of functioning capacity) and his need for professional services.

Section IV. SUPPORT COMPANY ELEMENTS

2-17. Organization and Functions of the Support Company Elements

a. Support Company. The support company and battalion headquarters are organized under the ASMB HSC (refer to Figure 2-2). At the table of organization and equipment (TOE) authorized level of organization (ALO), the HSC is dependent upon the following:

(1) Appropriate elements of the corps or COMMZ for support to include–

- Religious.

- Legal.

- Finance.

- Laundry.

- Personnel and administrative services.
- Clothing exchange and bath services.
- Mortuary affairs.
- Echelon commander's support for securing and handling EPW patients.
- Security during tactical movement.
- Area damage control support.

(2) Corps or COMMZ medical evacuation battalions for air and ground evacuation of patients to corps, COMMZ hospitals, or other MTFs such as host-nation (HN) facilities.

b. Design. The support company is similar in design to the ASMCs. Its major functional components (Figure 2-2) include a company headquarters, a treatment platoon, and an ambulance platoon. The company provides for Echelon I and Echelon II support functions in the HSC's AO. It has the capabilities to–

- Perform triage, initial resuscitation, stabilization, and preparation for the evacuation of sick, wounded, or injured patients generated in the HSC's AO.
- Provide outpatient consultation services for patients referred from Echelon I MTFs.
- Provide emergency and sustaining dental care and limited preventive dentistry.
- Deploy treatment squads which are capable of operating independently of the HSC for limited periods of time.
- Provide limited medical laboratory, radiology services, and blood support commensurate with Echelon II treatment.
- Provide patient holding for up to 40 patients who will RTD within 72 hours.
- Provide medical evacuation (eight ground ambulances [wheeled vehicles]) assigned on an area support basis.
- Provide food service support to staff and patients of the HSC and to other medical elements dependent upon the HSC for mess support.

2-18. Support Company Headquarters

The company headquarters provides for billeting, discipline, security, training, and administration for personnel assigned to the HSC. The company headquarters is organized into a command element, a supply element, and a food service element. It provides general and medical supply, food service, and arms maintenance to organic and attached units. Technical NBC assistance, organizational maintenance support for the company's vehicles, and CE and power-generation equipment are provided by the respective functional element of the battalion headquarters. The company is typically staffed as shown in Figure 2-22. For communications, the company headquarters employs both AM and FM tactical radios and operates on the battalion's command and operation nets (see Figure 2-9 and Figure 2-11). The HSC's wire communications net is shown in Figure 2-12. This element also–

- Plans, directs, and supervises unit training and security for its unit elements and provides general supply support for all elements of the HSC.
- Plans and supervises the HSC operational area of responsibility as directed by the battalion commander.

COMPANY HEADQUARTERS		
Command Element	**Supply Element**	**Food Service Element**
Commander Executive Officer First Sergeant (1SG)	Supply Sergeant Armorer	Food Service Sergeant First Cook Cook (3)

Figure 2-22. Typical support company headquarters organization.

a. Command Element. The command element is responsible for providing billeting, security, training, administration, and discipline of assigned personnel. This element provides C2 for its assigned personnel and is typically staffed with a company commander, a health services administrative assistant/XO, and a first sergeant.

(1) *Company commander.* The company commander (MAJ, MC, AOC 62B00) plans, directs, and supervises the operations of the company. He is responsible for the command, control, and coordination of HSS within his AO. His responsibilities also include training, discipline, billeting, security, welfare, and tactical employment of the HSC. The commander may also, as the situation allows, work as a physician in the HSC clearing station. He provides daily reports to higher headquarters in accordance with established reporting procedures. He acts as the command surgeon for supported units and mentors battalion surgeons and PAs in those units with organic HSS. He advises commanders of units without organic HSS on the health and welfare of their command.

(2) *Executive officer.* The XO (CPT, MS, AOC 70B67) provides plans, directions, and coordination of administrative activities within the HSC. The XO is responsible for supervising the activities pertaining to supply, operations, and communications of the company headquarters. He is the principal assistant to the commander in all matters pertaining to the tactical employment of company assets. He ensures liaison with supported units through their S3, or if at company level, the company commander of the supported company. This officer supervises and coordinates security, planning, tactical operations, communications, OPSEC, logistics, and training functions of the company.

(3) *First sergeant.* The first sergeant (1SG) (E-8, MOS 91B5M) is the principal enlisted assistant to the commander. He is the senior NCO in the support medical company and supervises field and company operations. He plans, coordinates, supervises, and participates in activities pertaining to organization, training, and combat operations for the medical company. The 1SG maintains liaison between the commander and assigned NCOs, provides guidance to enlisted members of the company, and represents them to the commander. He is normally responsible for the following personnel and administrative functions:

- Overseeing company-level administration.
- Advising the commander of troop assignments, reassignments, promotions, and other personnel actions.
- Supervising replacement activities to include the orientation of newly assigned personnel.
- Verifying and monitoring strength and personnel accounting reports to include battle roster change reports, casualty feeder reports, and the personnel daily summary.

b. Food Service Element. The food service element is responsible for providing food service support for staff and patients of the HSC and to other medical elements dependent upon the

HSC for support. The Army is staffing and equipping units to provide cadre with the capability for one hot-cooked prepared meal per day based on METT-T. Additional meals are selected from either heat-and-serve tray packs or individual combat meals (AR 30-21).

NOTE

Food service personnel (MOS 94B) assigned to Echelon II HSS units are not trained or prepared to provide any special diets. Patients requiring advanced dietary support or special diets are evacuated to corps/COMMZ hospital where both patient rations (Medical B Rations) and personnel trained to support these special dietary needs are available. In the CZ, only hospital units are issued Medical B Rations and have the trained personnel (dietitians and hospital food service specialists) to provide the dietary support needed. Hospital food service specialists (MOS 91M10-91M40) are assigned to all field hospitals; at the MASHs, they function without direct dietitian supervision. Dietitians are assigned to CSHs in the corps area and to FHs and GHs in the COMMZ.

(1) *Food service sergeant.* The food service sergeant (E-7, MOS 94B40) manages the field kitchen operations. He is responsible for supervising and instructing unit cooks on all food service activities within the unit. The food service sergeant is responsible for performing supply duties for resupply of Class I (rations) from corps/COMMZ support battalion ration breakdown points. He ensures that all food items on hand are properly stored, maintained, prepared, served, and disposed of in accordance with FMs 10-23 and 21-10.

(2) *First cook.* The first cook (E-6, MOS 94B30) supervises the preparation of food. He is responsible for ensuring that proper procedures, temperatures, and time periods are followed during food preparation.

(3) *Cooks.* There are three cooks (E-4 [2], E-3 [1], MOS 94B10) assigned to the food service element. These cooks work under the supervision of the food service sergeant and the first cook. They prepare, cook, and serve food to the patients, unit, and attached personnel. These cooks are also responsible for the storage of food, sanitation of cooking utensils and area surrounding the food service areas, and the maintenance of kitchen and serving equipment.

c. Supply Element. The supply element provides supply (less medical) and armorer support for the HSC and attached units. This element is typically staffed with a unit supply sergeant and an armorer.

(1) *Unit supply sergeant.* The unit supply sergeant (E-6, MOS 92Y30) requests, receives, stores, safeguards, and issues supplies (less medical) and salvaged equipment authorized to the company. He maintains company supply records, supervises unit supply operations, and maintains accountability for all equipment organic to the company. He is also responsible for supervising the armorer.

(2) *Armorer.* The armorer (E-4, MOS 92Y10) maintains the weapons storage area, issues and receives small arms and ammunitions, and performs small arms unit maintenance. He assists in supply activities and operates the vehicle assigned to the supply element.

NOTE

Medical resupply is accomplished through the S4 medical supply element.

2-19. Treatment Platoon

The treatment platoon operates the corps/COMMZ clearing station. It receives, triages, treats, and determines the disposition of patients based upon their medical condition. This platoon provides professional services in the area of minor surgery, internal medicine, general medicine, and general dentistry. In addition, it provides basic diagnostic laboratory and radiological services and patient holding support. The treatment platoon is composed of a platoon headquarters, an area support section, and a treatment section. For communications, the platoon employs a total of six tactical radios.

a. Treatment Platoon Headquarters. The treatment platoon headquarters provides–

- Command and control for the treatment platoon.
- Communications for the platoon.
- Coordination for movement of treatment squads within the HSC's area of responsibility.
- Coordination for further patient evacuation.
- Administration and logistics functions for the platoon.

The treatment platoon element also includes two treatment squads and an area support section. Assigned to the headquarters element of the treatment platoon are the platoon leader, a health services administrative assistant, a platoon sergeant, and a patient administration specialist.

(1) *Platoon leader.* The platoon leader (MAJ, MC, AOC 62B00) is responsible for the platoon. The platoon leader is dual-hatted and serves as the physician in the treatment squad of the area support section. The platoon leader directs, coordinates, and supervises platoon operations and assumes command of the company when the company commander is absent. This officer directs the activities of the HSC clearing station. He monitors Class VIII supplies, blood usage, and inventory levels and keeps the commander informed.

(2) *Health services administrative assistant.* The health services administrative assistant (CPT, MS, 67B) is the primary assistant to the platoon leader. He is responsible for assisting with the management of tactical operations, OPSEC, communications, administration, organizational training, supply transportation, and patient evacuation. This officer may also serve as the liaison officer to supported units.

(3) *Platoon sergeant.* The platoon sergeant (E-7, MOS 91B40) assists the health services administrative assistant in the management of administration, operations, and logistical functions of the platoon. He provides guidance and training to assigned enlisted members. He may also serve as liaison to supported units.

(4) *Patient administration specialist.* The patient administration specialist (E-4, MOS 71G10) manages patient statistics on all patients seen by elements of the platoon. He is responsible for patient accountability and statistical reporting functions. He may be utilized to coordinate the transfer of patients to other MTFs. He also drives and maintains the vehicle assigned to the platoon headquarters. The patient administration specialist, along with the medical specialist in the area support section, operates the treatment platoon's FM radios.

b. Treatment Section. The treatment section contains two treatment squads which provide emergency and routine sick call treatment to soldiers assigned to units within their AO. These squads can perform their functions while

located in the company area, or they can operate independently of the HSC for limited periods of time. Each squad has the capability to split and operate as separate treatment teams (Teams A and B) for limited periods of time. While operating in these separate modes, they may operate up to four treatment stations. These squads provide sick call services, EMT, and ATM support. They can be assigned to reinforce or reconstitute similar treatment squads. Personnel assigned to the treatment section include–

- Field surgeons (2).
- Physician assistants (2).
- Emergency treatment NCOs (4).
- Medical Specialists (8).

(1) *Field Surgeon.* The field surgeon (CPT, MC, AOC 62B00) plans and supervises the activities of the treatment squad. This primary care physician examines, diagnoses, treats, or prescribes a course of treatment for the initial phase of diseases and injuries. He provides ATM for the seriously injured and wounded. He is also responsible for the care and treatment provided to patients by other members of his squad.

(2) *Physician assistant.* The PA (either a commissioned officer O2/O3, Army Specialty Corps [SP] AOC 65D00, or a WO, SP, AOC 60A00) performs general technical health care and administrative duties. The PA is ATM-qualified and works under the clinical supervision of the medical officer. He treats, within his abilities, all patients reporting to him who are sick or injured. He refers those patients who require treatment beyond his capabilities to the supervising physician. He also provides initial resuscitation (ATM) to wounded personnel and assists in the conduct of CSC training for supported units.

(3) *Emergency treatment NCO.* The emergency treatment NCO (E-6 or E-5, MOS 91B30 or 91B20) is either the treatment squad NCO or the treatment team NCO. This NCO performs triage and EMT procedures in the care and management of trauma (including contaminated) patients. He assists in the care and management of BF casualties. He performs routine patient care and routine NBC detection procedures. His duties also include–

- Supervising and training medical specialists.
- Assisting in the establishment and operations of Echelon I and Echelon II MTFs.
- Maintaining the patient accountability/casualty reporting system.
- Maintaining the MES.
- Conducting training in first aid and emergency medical procedures for assigned personnel and combat lifesavers.
- Conducting sanitation inspections of troop living areas, field food service preparation areas, waste disposal areas, and potable water distribution points and equipment (see Appendix A).

(4) *Medical specialist.* The medical specialist (E-4 or E-3, MOS 91B10) assists the emergency treatment NCO in the accomplishment of his duties. There are eight medical specialists assigned to the treatment section. They perform triage and EMT. Their specific duties include–

- Erecting and breaking down the MTF.
- Performing patient care.
- Initiating patient records (DD Form 1380).

- Ensuring patients seen or treated are recorded in the daily disposition log (DDL).

- Operating and maintaining assigned vehicles, tactical radios, and power-generation equipment.

c. Area Support Section. The area support section of the treatment platoon is composed of an area treatment squad, an area support squad, and a patient-holding squad. These squads form the corps/COMMZ clearing station (Echelon II MTF) in each of the HSCs and ASMCs. The treatment squad provides trauma care and routine sick call care to personnel assigned to units located near the HSC. The area support squad provides emergency dental services and limited laboratory, radiological services, and blood support commensurate with Echelon II treatment facilities. The patient-holding squad provides up to 40 cots for patients requiring minimal treatment. Patients held in the patient-holding cots are those who are expected to be returned to duty within 72 hours from the time they became ill, injured, or wounded. Elements of this section are not used to reinforce or reconstitute other medical units. Also, they are not normally used on the area damage control team.

(1) *Treatment squad.* The area treatment squad is the base medical treatment element of a corps/COMMZ clearing station. It provides sick call services and initial resuscitative treatment (ATM) and EMT for supported units. For communications, the squad employs FM radios and is deployed in the HSC's radio and wire communications nets. This squad is typically staffed with a field surgeon, a PA, two emergency treatment NCOs, and four medical specialists.

(a) Field surgeon. The field surgeon (MAJ, MC, AOC 62B00) is also the treatment platoon leader. He examines, diagnoses, treats, and prescribes courses of treatment for patients. He also directs clinical activities of the corps/COMMZ clearing station and serves as the clinical supervisor for the PAs.

(b) Emergency treatment NCO. Information pertaining to the duties of the two emergency treatment NCOs (E-6 and E-5, MOS 911330 and 91B20) is provided in *b* (3) above. In addition to those duties, they maintain the MES and coordinate for medical supplies and blood products.

(c) Medical specialist. Four medical specialists (E-5 [1], E-4 [1], and E-3 [2], MOS 91B20 or MOS 91B10) are assigned to this squad. They perform the same duties as described for the medical specialist in *b* (4) above. In addition to these duties, these medical specialists operate the assigned radios and maintain the vehicles assigned to the area treatment squad.

(2) *Area support squad.* The area support squad comprises the dental and diagnostic support elements of the corps/COMMZ clearing station. The dental element provides emergency dental care (to include treatment of minor maxillofacial injuries), sustaining dental care (designed to prevent or intercept potential dental emergencies), limited preventive dentistry, and consultation services. The diagnostic element is composed of a medical laboratory and has field X-ray capability. It provides for basic services commensurate with Echelon II medical treatment. The area support squad is typically staffed with a dental officer, a dental specialist, a medical laboratory specialist, and an X-ray specialist.

(a) Dental officer. The dental officer (CPT, DC, AOC 63A00) examines, treats, diagnoses, and prescribes treatment for diseases, abnormalities, and defects of the teeth and their supporting structure. This officer supervises the activities of the area support squad. He is ATM-trained and assists the patient treatment element during mass casualty situations.

(b) Dental specialist. The dental specialist (E-4, MOS 91E10) assists the dental officer in the prevention, examination, and treatment of diseases and injuries of the teeth and the oral region. He also performs dental X-ray procedures and operates and maintains dental power-generation equipment. He maintains equipment and levels of supply in the dental equipment set (DES).

(c) Medical laboratory specialist. The medical laboratory specialist (E-4, MOS 92B10) performs clinical laboratory and blood banking procedures to aid physicians and paraprofessionals in the diagnosis, treatment, and prevention of diseases. His specific functions include performing elementary laboratory procedures consistent with the Echelon II laboratory MES. The medical laboratory specialist is responsible for–

- Storing and issuing blood (Group O liquid red blood cells).
- Performing hematocrit procedures.
- Performing/estimating total white blood cell (WBC) count and differential white blood count (DiffWBC) procedures.
- Performing urinalysis (macroscopic and microscopic) and occult blood procedures.
- Conducting Gram's stain of clinical specimen procedures.
- Collecting and processing clinical specimens for shipment.
- Performing platelet estimates.
- Performing thick and thin smears for malaria.
- Maintaining the blood inventory status.

(d) X-ray specialist. The X-ray specialist (E-4, MOS 91P10) operates radiological equipment consistent with the Echelon II X-ray MES. He performs routine clinical X-ray procedures to aid physicians and paramedical professionals in the diagnosis and treatment of patients. Specific functions performed by the X-ray specialist include–

- Interpreting physicians' orders, applying radiation and electrical protective measures, operating and maintaining fixed and portable X-ray equipment, and taking X rays of the extremities, chest, trunk, and skull.
- Performing manual and automatic radiographic film processing (darkroom) procedures.
- Assembling X-ray film files for patients remaining within the corps, or arranging for such film to accompany those patients who are evacuated to corps hospitals.
- Assisting the NBC NCO with radiological monitor, survey, and documentation procedures.
- Serving on the radiological monitor and survey team.
- Operating and maintaining the assigned power generator.

d. Patient-Holding Squad. The patient-holding squad operates the holding ward facility of the corps/COMMZ clearing station. The holding ward is staffed and equipped to provide care for up to 40 patients. Normally, only those patients awaiting evacuation or those requiring treatment for minor illness or injuries are placed in the patient-holding area. Neuropsychiatric patients

and BF casualties who are expected to be RTD within 72 hours may also be placed in the patient-holding area. The patient-holding squad works under the direct supervision of a physician or PA. Since Echelon II facilities such as the HSC and ASMC do not have an admission capability, patients may only be held at this facility and are not counted as hospital admissions. If recovery (RTD) is not expected within 72 hours, the patients are sent to a corps/COMMZ hospital for admission. The patient-holding squad members include a wardmaster, a practical nurse, and two medical specialists.

(1) *Wardmaster.* The wardmaster (E-6, MOS 91C30) supervises ward operations and carries out doctors' orders. He supervises and performs preventive, therapeutic, and emergency procedures for sick, injured, or wounded patients placed in the patient-holding area. He provides technical guidance and trains assigned personnel. His responsibilities include planning and executing the establishment, disestablishment, movement, and operations of the patient-holding facility. The wardmaster manages the maintenance of equipment and stockage levels of supplies.

(2) *Practical nurse.* The practical nurse (E-5, MOS 91C20) assists the wardmaster in the accomplishment of his duties. He performs preventive, therapeutic, and EMT procedures. He also provides technical guidance to the assigned medical specialists.

(3) *Medical specialist.* Two medical specialists (E-4 and E-3, MOS 91B10) are assigned who perform EMT and limited nursing procedures. They also operate and maintain assigned treatment platoon vehicles.

2-20. Ambulance Platoon

The ambulance platoon performs ground evacuation and en route patient care for supported units. The ambulance platoon consists of a platoon headquarters, four ambulance squads (or eight ambulance teams), one high-mobility multipurpose wheeled vehicle (HMMWV) control vehicle, and eight HMMWV ambulances.

a. Ambulance Platoon Headquarters. The ambulance platoon headquarters section provides C2 for ambulance platoon operations. It maintains communications to direct ground ambulance evacuation of patients. It provides ground ambulance evacuation support for units receiving area support from the HSC to the company's treatment squad locations (MTF) or to the corps/COMMZ clearing station. Further evacuation to corps hospitals is the responsibility of the medical evacuation battalion's ground or air ambulances. Personnel assigned to the ambulance platoon headquarters include the platoon leader and platoon sergeant.

(1) *Platoon leader.* The ambulance platoon leader (LT, MS, AOC 70B67) directs and coordinates ground evacuation of patients within the HSC AO. He supervises the platoon and plans for its employment. He establishes and maintains contact with supported units and treatment squads of the HSC. He makes route reconnaissances and develops and issues strip maps. He coordinates and establishes ambulance exchange points (AXPs) for both air and ground ambulances.

(2) *Platoon sergeant.* The platoon sergeant (E-7, MOS 91B40) assists the platoon leader in planning the utilization of platoon assets. He assists with the administrative and logistical functions necessary for the platoon to operate. He provides direct supervision and training of assigned personnel to include operator maintenance of the organic vehicles.

b. Ambulance Squads. The ambulance squads provide ground evacuation of patients from units and organic treatment squads/teams (aid stations) within the support sector of the HSC.

The ambulance squads consist of four aid/ evacuation NCOs and twelve aid/drivers.

(1) *Aid/evacuation NCOs.* These NCOs (E-5, MOS 91B20) supervise ambulance squads and serve as ambulance squad leaders. They perform EMT, evacuate patients, and provide for their continued care en route. They also operate and maintain assigned radios.

(2) *Aid/ambulance drivers.* These medical specialists (E-4 and E-3, MOS 91B10) serve as aid/ambulance drivers. The senior E-4s are appointed as team leaders. These medical specialists provide EMT necessary to prepare patients for movement. They operate vehicles to evacuate the sick and wounded and perform PMCS on ambulances and associated equipment. The aid/ambulance drivers provide en route care during evacuation. Ambulance aid/drivers maintain supply levels for the ambulance MES. They ensure that appropriate property exchange of medical items (such as litters and blankets) is made at sending and receiving MTFs (Army only). These specialists operate and maintain assigned radios and vehicles.

CHAPTER 3

AREA SUPPORT MEDICAL COMPANY

3-1. Mission, Organization, and Functions

The ASMC has the overall mission to provide Echelon I and Echelon II HSS to units located in its AO. It is dependent on the same corps and COMMZ elements that support the HSC (see Chapter 2). The ASMC shares identical functions with the HSC but has slightly different support requirements when displaced away from the battalion. It is organized (see Figure 2-3) into a company headquarters, a treatment platoon, and an ambulance platoon. The ASMC is similar in design to the HSC and has the same capabilities (see paragraph 2-17).

3-2. Company Headquarters

The company headquarters (Figure 3-1) is organized into a command element, a supply element, a food service element, and an operations and communications element. The company headquarters provides C2 for the company and other medical units that may be attached. It also provides general and medical supply/resupply, food service, arms maintenance, NBC operations, and CE support to organic and attached elements. For communications, the company headquarters employs AM and FM tactical radios and a manual switch board (see Chapter 2). Personnel of this section supervise unit operations, general supply, medical supply, field kitchen operations, communications, and power-generation operations.

a. Command Element. The command element is responsible for providing billeting, security, training, administration, and discipline for assigned personnel. This element provides C2 of its assigned personnel, typically staffed with a company commander, an XO, and a 1SG.

(1) *Company commander.* The company commander (MAJ, MC, AOC 62B00) plans, directs, and supervises the operations and employment of the company. The ASMC commander's duties and responsibilities are consistent with those identified for the HSC commander (see paragraph 2-18).

Command Element
Company Commander
Executive Officer
First Sergeant

Food Service Element
Food Service Sergeant
First Cook
Cooks

Supply Element
Medical Supply Sergeant
Unit Supply Sergeant
Armorer

Operations and Communications Element
NBC Operations NCO
Signal Support Systems Specialist (3)

Figure 3-1. Area support medical company headquarters.

(2) *Executive officer.* The XO (CPT, MS, AOC 70B67 [field medical assistant]) is the principal assistant to the commander on all matters pertaining to the tactical employment of company assets. His duties and responsibilities are consistent with those identified for the HSC's XO (see paragraph 2-18).

(3) *First sergeant.* The 1SG (E-8, MOS 91B5M) serves as the principal enlisted assistant to the company commander. His duties and responsibilities are consistent with those identified for the HSC's 1SG (see paragraph 2-18).

b. Food Service Element. The food service element is responsible for providing food service support for staff and patients of the ASMC

and to other medical elements dependent upon the ASMC for support.

(1) *Food service sergeant.* The food service sergeant (E-6, MOS 94B30) manages the field kitchen operations. His duties and responsibilities are consistent with those identified for the HSC's food service sergeant (see paragraph 2-18).

(2) *First cook.* The first cook (E-5, MOS 94B20) supervises the preparation of food. He is responsible for ensuring that proper procedures, temperatures, and time periods are followed during food preparation.

(3) *Cooks.* There are two cooks (one E-4 and one E-3, MOS 94B10) assigned to the food service element. These cooks work under the supervision of the food service sergeant and the first cook. Their duties and responsibilities are consistent with those identified for the HSC's cooks (see paragraph 2-18).

c. Supply Element. The supply element provides general supply and armorer support for the ASMC. It also provides emergency medical resupply for the ASMC and for all supported medical elements of ground maneuver battalions operating within its AO. This element is typically staffed with a medical supply sergeant, a unit supply sergeant, and an armorer. See FMs 10-14 and 10-14-1 for definitive information on unit supply operations and property accountability.

(1) *Medical supply sergeant.* The medical supply sergeant (E-6, MOS 76J30) supervises the requisition, receipt, inventory management, storage, preservation, issue, salvage, stock control, and accounting of medical supplies and equipment.

(2) *Unit supply sergeant.* The unit supply sergeant (E-6, MOS 92Y30) requests, receives, stores, safeguards, and issues general supplies and salvages equipment authorized to the company. He maintains company supply records, supervises unit supply operations, and maintains accountability for all equipment organic to the company.

(3) *Armorer.* The armorer (E-3, MOS 92Y10) maintains the weapons storage area, issues and receives small arms and ammunitions, and performs small arms unit maintenance. He assists in general supply activities and operates the vehicle assigned to the supply element.

d. Operations and Communications Element. The operations and communications element plans, coordinates, and trains NBC defense functions. It operates the company switchboard and serves as the company NCS for the company operation net FM and AM radios (see Chapter 2, Section II). This element also performs unit-level maintenance on all CE equipment. The operations element is typically staffed with an NBC operations NCO and three signal support system specialists.

(1) *Nuclear, biological, and chemical NCO.* This NCO (E-5 MOS 54B20) plans NBC defense operations for the company. He conducts training pertaining to procedures and techniques of NBC defense. He predicts effects of weather and terrain on chemical operations. His responsibilities also include preparing radiological fallout and chemical and biological downwind hazard predictions. He prepares and evaluates NBC reports and computes radiation factors affecting personnel, equipment, and operations. This NCO is the technical advisor to the unit on matters pertaining to NBC functions. He provides expertise in the operations and maintenance of NBC equipment and supervises decontamination of unit equipment, supplies, and personnel (except patients). He coordinates with veterinary services personnel in the conduct of food safety inspections in an NBC environment.

(2) *Signal support systems specialist.* This NCO (E-5, MOS 31U20) is the

principal advisor to the commander in CE matters. He supervises the establishment of the company's radio and wire communications nets and maintains the NCS. This senior CE operator supervises the activities of CE personnel and trains ASMC personnel in tactical communications procedures to include OPSEC and SOI. He coordinates with the ASMB communications chief, supporting signal element, and major command within the AO to ensure proper integration of communications and CE equipment.

(3) *Signal support systems specialist/switchboard operator.* The two signal support systems specialists (E-4, MOS 31U10) install, operate, and perform PMCS and unit-level maintenance on field wire communications systems, telephones, field wire switchboards, small switching systems, FM radios, and associated COMSEC equipment and accessories. They operate the unit switchboard and perform PMCS on assigned vehicles and power generators.

3-3. Treatment Platoon

The ASMC's treatment platoon is organized and performs the same functions as the HSC's treatment platoon (see paragraph 2-19).

3-4. Ambulance Platoon

The ASMC's ambulance platoon is organized and functions the same as the HSC's ambulance platoon (see paragraph 2-20).

CHAPTER 4

AREA SUPPORT MEDICAL BATTALION OPERATIONS

Section I. COMMAND AND CONTROL

4-1. Principles of Command and Control

The principles of C2 are basic, but the process can be complicated. Command and control is the system used by the ASMB to direct, coordinate, and control the activities required to accomplish the HSS mission. The process is further complicated by the ASMB's area support mission which may disperse the battalion's subordinate units over a wide geographical area. Command and control involves the personnel, equipment, facilities, and procedures for gathering and analyzing data. It also involves planning what is to be done, issuing instructions for doing it, and supervising how it is done.

a. Complexity. The complexity of the HSS mission and the dynamic and volatile battlefields of today require flexibility, creativity, and initiative by subordinate commanders. Command and control must be mission oriented. Just as the medical brigade/group commander must give the ASMB commander the resources and authority to accomplish his mission, so too must the ASMB commander ensure his subordinate commanders and leaders have the assets and willingness to innovate in order to get the job done. They must be well trained in communications and the decision-making process. They must also understand their organization and Army doctrine. They must understand the circumstances and know when they have the prerogative to act.

b. Basic Guidelines. Commanders and leaders in the ASMB must–

- Understand their responsibilities.
- Be familiar with the responsibilities and capabilities of higher, lower, supported, and supporting units. They must know the units that are supporting them. They must know what their support requirements are and the levels of support each of the supporting units can provide.
- Maintain contact with higher, lower, adjacent, supported, and supporting units.
- Write clear directives, reports, orders, and studies.
- Use effective oral communications.
- Understand the information system related to CSS and HSS.
- Ensure radio and data transmission nets are used effectively.
- Execute the plan as directed.
- Provide capability in meaningful terms to the medical brigade/group commander.
- Stay personally involved in and apprised of HSS and the tactical situation and/or threat.
- Enforce the law of land warfare with respect to civilians, civil affairs, EPW, CMO, and Geneva Conventions requirements governing HSS operations (FMs 8-10 and 27-10).
- Understand their obligation to the soldiers under their command.

4-2. Health Service Support Estimates

The ASMB staff prepares HSS estimates on their areas of expertise to assist the ASMB commander

in decision making. An estimate includes significant facts, events, and conclusions based on current or anticipated situations and provides recommendations on how available resources can best be used. These recommendations are used by the commander to determine and select the best courses of actions. Adequate HSS plans are dependent on early and continuing estimates by the ASMB staff. Failure to develop these estimates may lead to errors and omissions in developing a course of action. See FMs 8-42, 8-55, and 101-5 for definitive information on the development of estimates.

4-3. Health Service Support Planning

The ASMB commander is responsible for the development of the HSS plan for the ASMB. He is assisted with the development of HSS plans for the AO by his battalion staff elements. Health service support estimates developed by the ASMB staff are also provided to the medical brigade/group for use in developing the HSS estimates for the COSCOM or COMMZ. All factors must be considered during the initial development stages of the HSS plan. The HSS plan is updated as required to meet tactical or HSS operational requirements. Field Manuals 8-55 and 8-42 provide an in-depth discussion of the planning process and considerations for HSS operations. The ASMB commander should consider the following factors as he develops and reviews the ASMB's HSS plan or provides input to the medical brigade's/group's HSS plan:

- Mission.
- Threat.
- Medical brigade/group commander's estimates, guidance, and intent.
- Operational conditions.
- Operational constraints.
- Terrain.
- Military population supported to include allied and HN.
- Personnel status (ASMB headquarters and subordinate elements).
- Equipment status of the ASMB.
- Supply status (Class VIII and nonmedical).
- Host-nation support.
- Command, control, communications, computers, and intelligence.
- Training status.
- Current health status of supported units.
- Casualty estimates.
- Medical evacuation and medical regulating requirements.
- Medical evacuation capabilities.
- Hospitalization.
- Combat stress control requirements.
- Laboratory support.
- Veterinary support.
- Preventive medicine requirements.
- Corps/COMMZ assets in support of the ASMB.
- Additional support requirements.
- Special operations requirements.
- Record and report requirements.

- Phases of operations.
- Courses of action.
- Information requirements (medical intelligence updates, maps, and essential elements of friendly information updates).
- Blood status.
- Policy and procedure updates.
- Humanitarian aid to local nationals.
- Potential EPW support requirements.

4-4. Area Support Medical Battalion Tactical Standing Operating Procedures

The ASMB commander is responsible for the development of the HSS TSOPs for ASMB operations. The purpose of a TSOP is to establish routine protocols. The procedures in the TSOP should not be dependent upon the METT-T factors. If a specific decision is required each time, it should not be included in the TSOP. The ASMB commander is assisted in development of the TSOPs by the ASMB headquarters staff and subordinate elements. The ASMB's HSS TSOPs are based on the medical brigade/group/corps/COMMZ HSS TSOPs and serve as the foundation for subordinate ASMCs and the HSC to develop their HSS TSOPs. The ASMB's HSS TSOPs should be clear and concise, yet provide sufficient detail of procedural requirements. Health service support TSOPs must reflect procedural guidance that supports current mission and doctrinal requirements. The ASMB's HSS TSOPs should be maintained and reviewed at least every 6 months. Health service support TSOPs are developed or revised as required. A sample TSOP is provided in Appendix A.

Section II. DEPLOYMENT

4-5. Port of Debarkation

At the port of debarkation (POD) into the TO, the battalion commander and subordinate unit commander must have the means for maintaining C2. Essential equipment and material for C2 should be transported with personnel, if possible. When the battalion is transported with its equipment and basic loads, the primary mission at the POD is to assist with off-loading and obtaining operational readiness. When personnel and equipment are transported separately, personnel are normally scheduled to arrive just prior to the arrival of their unit supplies and equipment. Upon arrival of battalion personnel at the POD, the primary mission of the battalion and its subordinate units is to receive its equipment and supplies and achieve operational readiness as quickly as possible. Plan training and other activities to occupy downtime if the equipment has not arrived. Common-task and MOS training are a good start. These tasks should be prioritized based on training weakness. Normally, when the equipment and supplies are received, they are inspected for external damage or tampering. The time spent in the receiving area is dependent on the arriving shipments and priority for off-loading. The battalion is assigned an initial off-loading area where it moves its vehicles and towed loads for transitioning from the shipping mode to the ground movement mode. Fuel is available for refueling vehicles. Once supplies and equipment are moved to the off-load area, the battalion is responsible for their security. In this area, a thorough inspection of all equipment and supplies for damage or loss is conducted. Necessary repairs are made or coordinated through supporting maintenance elements. Requisitions for replacement of unusable supplies or equipment damaged beyond repair are initiated through the medical brigade/group headquarters element.

Loads are reconfigured according to unit loading plans. The medical brigade/group headquarters element assists the ASMB and its subordinate units with their initial entry into the theater. As part of the initial orientation, the battalion is briefed on current operating policies and procedures. In addition, the battalion is provided information pertaining to–

- Mission update.
- Health service support issues.
- Available support (including HN).
- Supply procedures (Class I and X should include the location and hours of operations of supply points or facilities).
- Current threat update.
- Personnel restrictions.
- Security requirements.
- Preventive medicine requirements.
- Local laws and customs.
- Hospitalization support.
- Blood support.
- Personnel replacements.
- Religious support.
- Emergency warning signals.
- Uniform requirements.
- Vehicle/unit movement requirements.
- Finance support.
- Personnel support.
- Morale support.
- Rules of engagement.
- Operations orders/fragmentary orders (FRAGOs) and warnings orders.
- Supported and supporting units.
- Status of Forces Agreements.

Ideally, troops and equipment arrive at the POD at the same time. If troops arrive before their equipment, preplanned training and other activities are initiated to occupy downtime. Training requirements may include common task and MOS training. Training in these areas should be prioritized based on training weakness.

4-6. Intermediate Staging Base

The ASMB and its subordinate units will either move to an intermediate staging base (ISB) or move to their AO with supported units. If the ISB stay is prolonged, the HSC and ASMCs may establish treatment facilities and provide HSS for supported units. When HSS operations are required, additional Class VIII supplies must be requisitioned so that basic loads for battlefield contingency operations are maintained. The HSC and ASMCs must use available downtime for training. Using their mission-essential task list (METL), they will train known areas of unit weaknesses and use the time to sharpen soldier, survival, and medical skills. When the build-up phase of the theater begins as a show of force without conflict, units will be involved in training activities. These training activities may be joint, multiservice, or unit-level exercises. Health service support requirements for training will be coordinated through the medical brigade/group. The ASMB headquarters will support units in their AO. The ASMB headquarters should ensure that training time for the HSC and each ASMCs is provided.

Section III. AREA SUPPORT MEDICAL BATTALION HEADQUARTERS INTERFACE FOR HEALTH SERVICE SUPPORT OPERATIONS

4-7. Interface with the Medical Brigade/ Group Staff

In the COMMZ, the ASMB's higher headquarters is the medical brigade. In the CZ (corps area), the medical group is the higher headquarters for the ASMB. The medical brigade/group and ASMB headquarters staff members interface on a daily basis. This interface is essential to ensure synchronization of HSS operations. Based on HSS requirements, the medical brigade/group headquarters develops OPLANs/OPORDs to ensure all HSS requirements for the COMMZ/corps are identified and provided. Coordination between staff elements is focused on providing area medical support (Echelons I and II) and identifying and coordinating the associated requirements. Interface between the ASMB and brigade/group staff elements includes the following subject areas:

- Health service support operations.
- Assignment or attachment of medical brigade/group units/elements.
- Personnel status reports.
- Class VIII status and critical resupply requirements.
- Blood status.
- Patient Summary Report.
- Casualty Feeder Reports.
- Statistical data pertaining to MTF operations.
- Operations plans.
- Operations orders.
- Personnel replacements.
- Patient evacuation and mortality report.
- Logistical support.
- Class IX (spare parts) requirements.
- Medical intelligence information.
- Threat information.
- Combat stress control/MH consultation or support.
- Preventive medicine activities (surveys, monitoring, NBC data collection, and consultation or support).
- Dental services (preventive dentistry activities).
- Maintenance.
- Optometry work load.
- Air and ground ambulance evacuation support.
- Augmentation (such as a surgical team).
- Replacements and reconstitution operations.
- Civil-military operations.
- Veterinary services.
- Host-nation support.

- Communications.
- Treatment team operations.
- Area medical support missions.
- Mass casualty plan.
- Unit safety (see Appendix C).

4-8. Interface with Major Commands

The ASMB interfaces with major commands within the battalion AO, either through the medical brigade/group or through direct contact as authorized by the medical brigade/group commander. Direct contact is the preferred method because it provides faster communications and coordination. This interface pertains to HSS provided by the battalion and to support requirements for ASMB elements providing HSS to the units within the major commands. The ASMB headquarters staff and subordinate units/elements coordinate the following basic subjects areas with the supported command and supported units:

- Health service support requirements.
- Locations of supported units.
- Communications (SOIs).
- Medical evacuation (air and ground ambulance) procedures.
- Security.
- Sick call procedures.
- Return to duty and NRTD patient procedures.
- Treatment team operations (trauma and area sick call support).
- Preventive medicine support.
- Combat stress control support.
- Optometry support procedures (eyewear replacement or repair).
- Dental treatment and preventive dentistry.
- Class VIII resupply.
- Road clearances.
- Tactical updates.
- Contingency operations.
- Enemy prisoners of war operations.
- Captured medical supplies and materiel.
- Area damage control operations.
- Base cluster defense operations (when appropriate).

4-9. Interface with Supported Units

The ASMB and its subordinate elements are normally deployed to areas of major troop concentrations. The ASMB provides HSS for all units without organic medical support within its assigned AO. Area support medical companies will, in most cases, locate in the same base cluster with the senior command element in their assigned AO. The ASMB headquarters interfaces with the headquarters elements of supported units and with its subordinate elements as authorized by the supported unit commander.

a. Senior Command Elements. Interaction between the senior command elements and

the ASMB will include the basic subject areas identified in paragraph 4-8 and may also include–

- Status reports on tactical situations and conditions along main supply routes (MSRs).
- Support requirements for the ASMB and its subordinate elements.
- Security.

b. Supported Battalion or Companies. Interactions between supported battalions or company headquarters of supported units and the ASMB headquarters or its subordinate medical elements include the basic subject areas identified in paragraph 4-8 and may also include–

- Ground movement liaison within the AC).
- Reinforcement of ASMB medical assets.
- Mass casualty evacuation plan.
- Patient-collecting points.
- Ambulance exchange point operations.
- Status of medical element operating in support of corps/COMMZ elements.
- Maintenance support (if required).
- Patient-holding procedures.
- Resupply of nonmedical items to ASMB elements (if required).
- Displacement operations.

4-10. The ASMB Coordination with the HSC and its ASMCs

The ASMB staff elements coordinate on a daily basis with the HSC and ASMCs. The ASMB headquarters staff must share and consolidate all pertinent operations information and brief the ASMB commander daily on the operational status of the battalion headquarters and all subordinate elements. Subordinate unit commanders and leaders must be updated and apprised of the tactical situation, threat, and changes in HSS operational requirements within their assigned AOs. Information exchange between the battalion headquarters and the HSC is through direct contact with battalion staff and through submission of required reports. Coordination and information exchange between battalion headquarters staff elements and ASMCs are accomplished through staff visits, messages, and radio and wire communications. It also takes place when the ASMB commander meets with his staff and subordinate company commanders. Security measures are implemented to prevent breaches of security as the command, control and communications (C3) process, exchange of information, and coordination activities evolve. The coordination and exchange of information between the battalion headquarters and its subordinate elements are designed to enhance the C2 process. An informed commander or staff officer is best equipped to plan and make decisions which lead to the best courses of actions. Coordination activities and exchange of information subject areas are not limited to but should include–

- Command and control procedures.
- Blood inventory status.
- Status of area medical support operations.
- Area ambulance coverage.
- Status reports on HSS elements.

- Tactical situation and threat update.
- Communications.
- Class VIII resupply and maintenance.
- Operational support requirements.
- Civil-military operations.
- Nutrition-related health and performance issues.
- Reinforcement and reconstitution.
- Maintenance.
- Personnel replacements.
- Augmentation.
- Preventive medicine.
- Veterinary services.
- Combat stress control operations.
- Nuclear, biological, and chemical defensive operations.
- Enemy prisoners of war operations support.
- Captured medical supplies and equipment.
- Troop medical clinic operations.
- Medical evacuation.

Section IV. EMPLOYMENT OF AREA SUPPORT MEDICAL BATTALION COMMAND POST

4-11. Establishment of the Battalion Headquarters Command Post

The battalion headquarters CP must be established at the highest level of organizational and operational efficiency. Automated and manual information systems minimize the time required for administrative processing of information to–

- Ensure accurate portrayal of the tactical situation and HSS operations.
- Prevent needless verification of data.
- Make information immediately available to the commander and staff.

a. Command Post Guidelines. During the course of providing area HSS, the battalion CP receives, analyzes, coordinates, and disseminates information which is critical to the successful accomplishment of the commands HSS mission. The ASMB commander also establishes procedures which clearly identify those CP functions that must be accomplished on a routine basis to support operations and those that require command approval. The commander is kept informed at all times. The ASMB commander establishes priorities and defines the level of authority within the battalion CP. The extent of operational authority given to members of the CP is based on the ASMB commander's decision and the experience of the staff. The exact operational authority is established in the TSOPs. Staff responsibilities and relationships must be clearly delineated and stated in the TSOP. Clear, well-defined staff functions and tasks enhance the ASMB's ability to perform routine operations during periods of stress and to maintain continuous operations over an extended period of time. It may become necessary to conduct continuous operations during high-intensity situations. When this happens, two duty shifts might be

used to ensure the C2 functions. Although all personnel must be available during critical times, off-duty personnel usually maintain vehicles and equipment, provide CP security, and rest. Table 4-1 is an example of how the major battalion headquarters staff positions could be organized into two shifts.

NOTE

Leaders must develop a sleep plan that provides all personnel at least 4 hours of uninterrupted sleep per day or 5 hours of sleep if interrupted. The sleep plan should provide sufficient sleep (uninterrupted) for ambulance teams, especially drivers.

b. Site Selection. The site selected for establishment of the ASMB CP (ASMB's primary C3 facility) is based on several considerations. A key consideration in determining the location of a CP is the ability of the site to provide for good communications with higher, lower, and adjacent organizations. The CP should be located near routes which allow relatively easy access into the area. Prominent terrain features or major road junctions should be avoided to prevent the enemy from readily determining the CP location. When possible, the CP should be in built-up areas. Buildings, garages, and warehouses may be used. Basements provide added protection from enemy fires. Covering windows and using basements enhance noise and light discipline. Use of built-up areas also reduce the infrared and electromagnetic

Table 4-1. ASMB Staff Organized in Two Shifts

PERSONNEL WHO OCCUPY THE COMMAND SECTION

GRADE	TITLE
LTC	Commander
MAJ	XO
E-9	CSM

STAFF REPRESENTATIVES AS DESIGNATED BY THE COMMANDER

PERSONNEL WHO TYPICALLY STAFF THE S2/S3 (OPERATIONS CELL)

PEAK GRADE	ACTIVITY TITLE	REDUCED GRADE	ACTIVITY TITLE
MAJ	S2/S3	CPT	Medical Operations Officer
CPT	S1	E-8	Medical Operations Sergeant
CPT	S4	E-7	Intelligence NCO
E-7	NBC NCO	E-7	Personnel Records Supervisor
E-7	Operations Sergeant	E-5	Personnel Administration Specialist
E-7	Battalion Communications Chief	E-5	Signal Support System Specialist
E-5	Signal Support Systems Specialist	E-4	Signal Support Systems Specialist (2)
E-5	Personnel Administration Specialist	E-4	Personnel Administration Specialist
E-4	Patient Administration Specialist	E-3	Patient Administration Specialist
E-4	Signal Support Systems Specialist	E-3	Signal Support Systems Specialist

signatures and can, therefore, reduce the requirement to move the CP to avoid detection. When a built-up area is not available, the CP should be located on the reverse slope of a hill to provide cover and concealment from both ground and air observation and fires. The ground must be firm enough to support vehicle traffic, have good drainage, and provide enough space to disperse vehicles.

c. Mobility. The CP should travel light and be able to move often. A CP is a major source of electromagnetic and infrared energy. If the CP does not move often, its location can be fixed and targeted. The larger and more elaborate the CP setup, the less rapidly the CP will be able to move and the more C3 will suffer. The CP may displace in a single move or in echelons. When the CP displaces by echelon, an interim operational capability is established at the new location before the remainder of the CP element moves.

d. Dispersion. The commander (ASMB, HSC, or ASMC) must balance the need for security against the need for dispersion. Medical treatment elements normally set up within proximity of each other to enhance operational efficiency and limit the distance that patients must be transported between treatment areas. The remainder of the battalion/company elements disperse within their assigned perimeters as established by the battalion or company commander. Ambulances, vehicles, and trailers are not parked in a central area as in garisson. They must be dispersed at least 30 meters apart. Tentage, other than primary treatment areas, is dispersed to the maximum extent possible to limit any collateral damage from incoming munitions.

4-12. Command Post Layout

Command posts can be organized in many different ways and still accomplish their missions. The description and diagrams which follow show one way an ASMB CP can be organized and deployed. The optimum configuration of the battalion CP requires as many radios as possible to be remoted from the CP, and antennas should be placed outside the CP. The ASMB CP layout is shown in Figure 4-1. The primary cells of the battalion CP consist of the command section and the S2/S3, which forms the CP operations cell (Figure 4-2), and the S1 and S4 (Figure 4-3). Additionally, separate briefing, security, and communications tents are set up. The briefing tent (Figure 4-4) provides a workplace for the command section in the CP area. The security tent (Figure 4-5) is established to provide security and a controlled entry into the CP area. Personnel and equipment to support the security and briefing tent are drawn from the HSC and S2/S3 section. The communications tent (Figure 4-6) contains the battalion NCS, message center, and battalion switchboard.

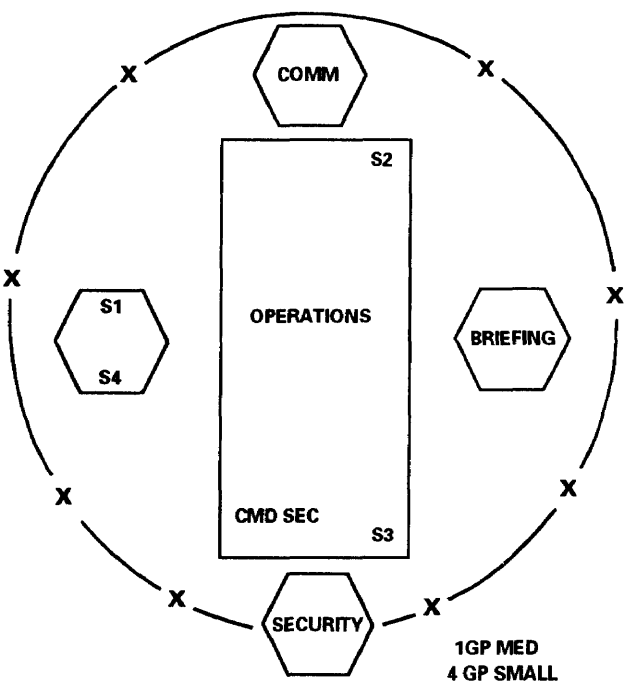


Figure 4-1. Area support medical battalion physical model.

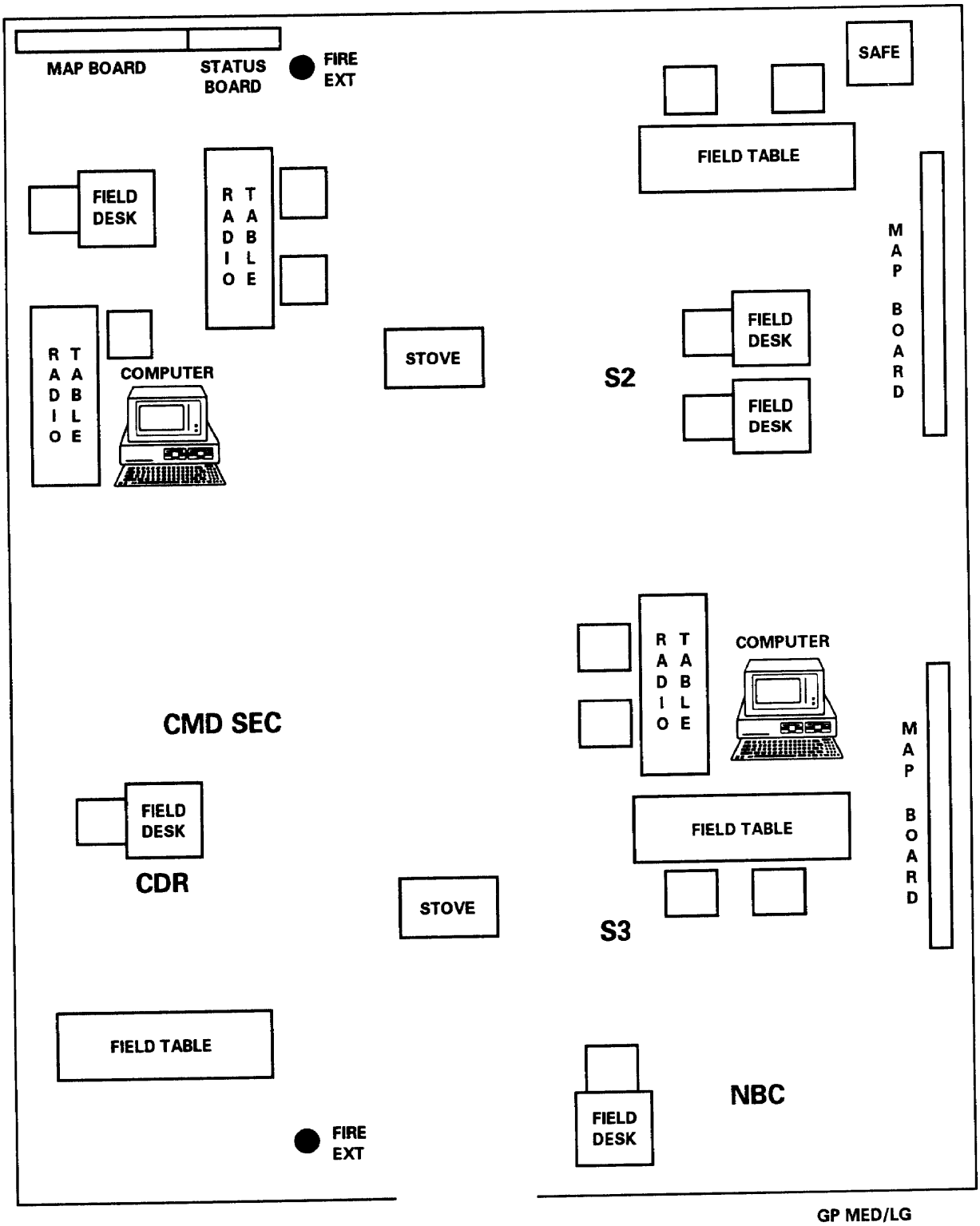


Figure 4-2. Area support medical battalion command post operations cell.

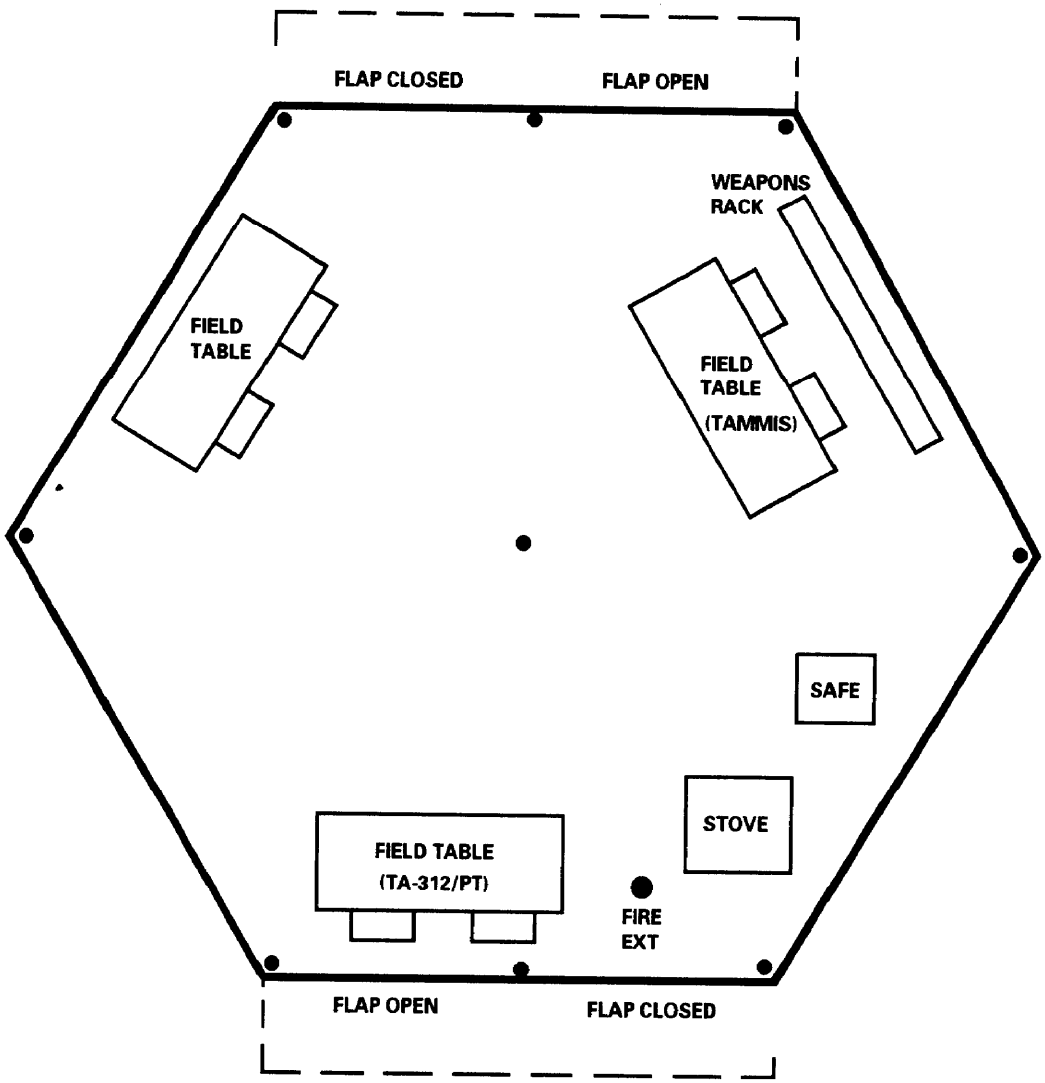


Figure 4-3. Battalion S1/S4.

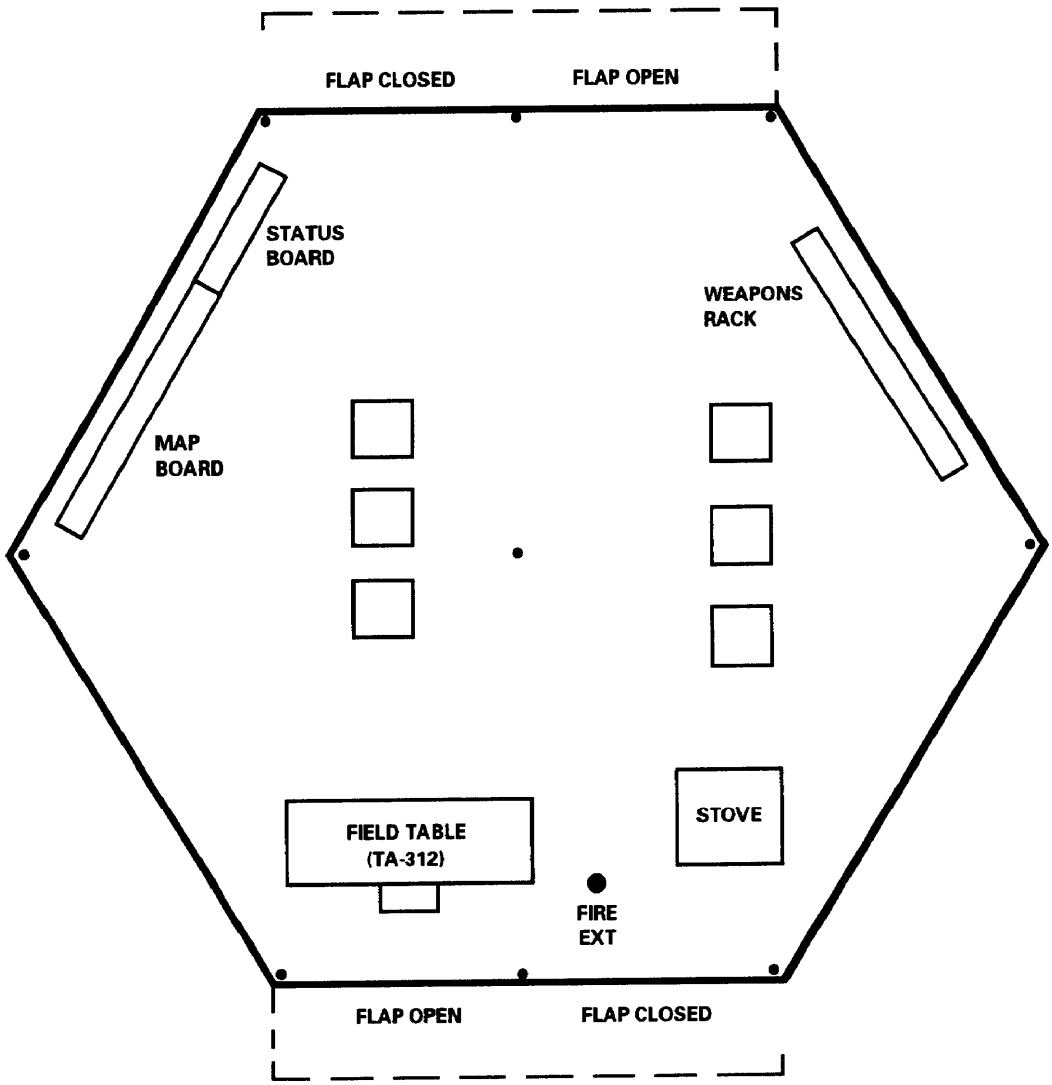


Figure 4-4. Briefing tent.

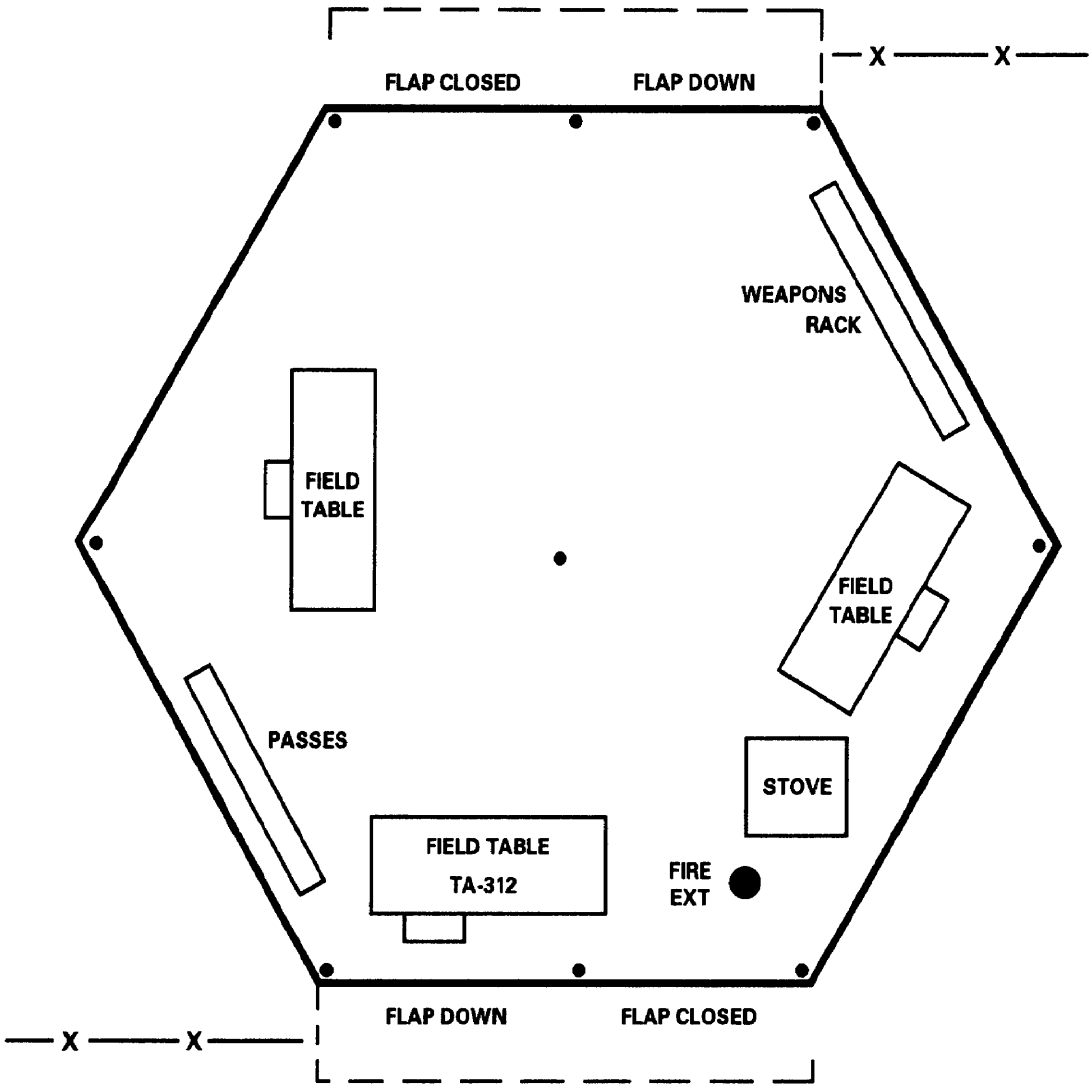


Figure 4-5. Security tent.

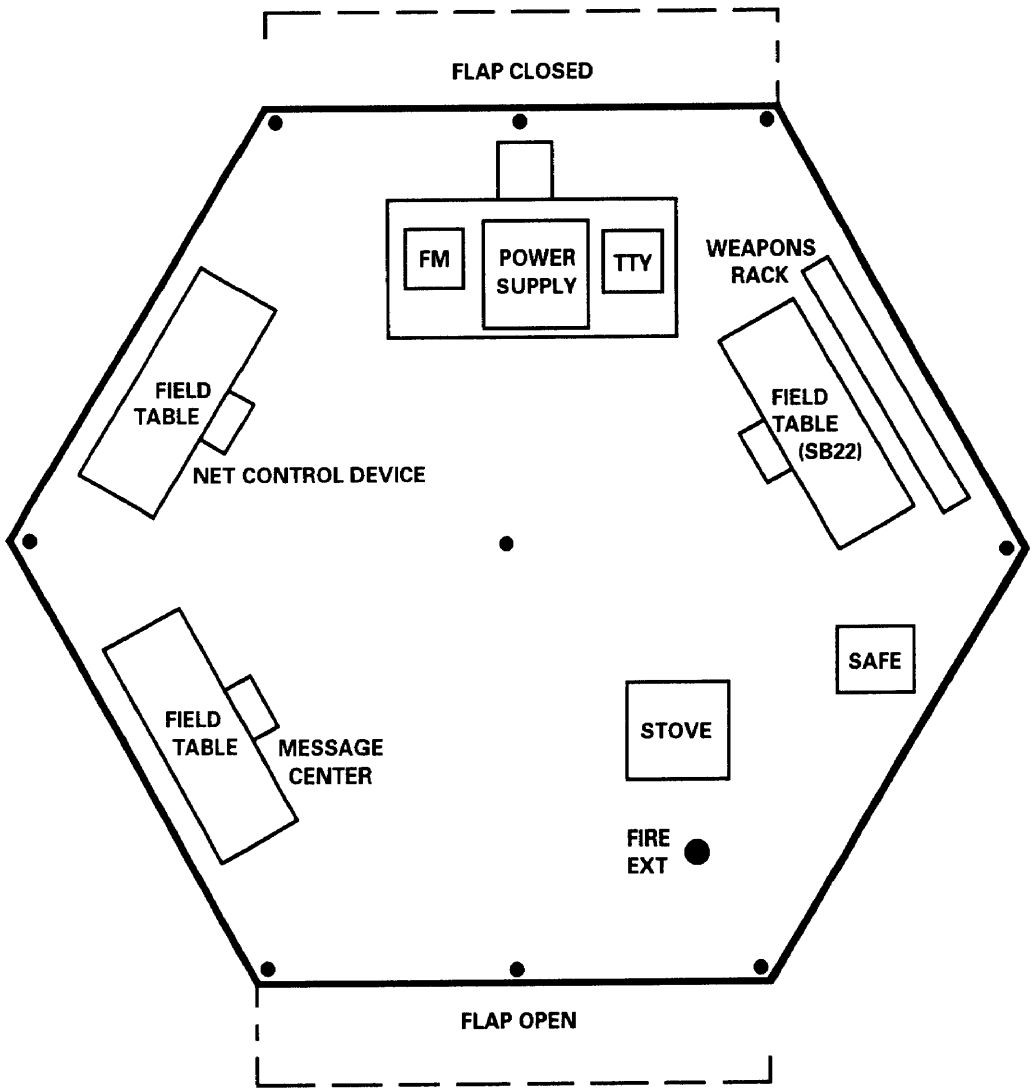


Figure 4-6. Communications tent.

Section V. EMPLOYMENT OF BATTALION HEADQUARTERS' ASSETS

4-13. Logistics/Medical Supply

The S4's job is to oversee the battalion's logistics and blood resupply operations. (Refer to Appendix A, Annex N for blood management operations.) The S4/medical supply operations facilities are established adjacent to each other and are normally placed in an area which provides for entrance, exit, and turnaround for customers and organic resupply vehicles. The site selected within the ASMB perimeter for establishment of the S4/medical supply facilities should have a hard surface which accommodates traffic into and out of the area. The area should have good drainage which does not allow standing water. The facilities should not be placed in any area which has the potential for flooding. Sites must be identified for the storage of hazardous materiel and munitions. The facilities should provide protection from weather and other environmental factors. Whether these facilities are under tents or in permanent structures, they must be spaced for easy access/retrieval of supplies.

a. S4 Supply Element. The S4 supply element facility must provide a storage area which accommodates battalion general supply support operations. All supply operating measures for controlling, locating, securing, storing, transporting, and issuing general classes of supplies are enforced. Area support medical companies deployed from the battalion receive general supply support from the battalion S4. When ASMCs are deployed and distances preclude resupply from the ASMB, the S4 coordinates their general supply support from supported units within the ASMC's AO.

b. Medical Supply Element Employment. The medical supply element initiates health service logistics support for the ASMB, attached medical units/elements, and for organic medical elements of supported units. This includes resupply of Class VIII supplies and unit-level medical equipment repair. The medical supply element operates out of medical supply sets which are prepackaged into medical chests. These chests are numbered according to the sequence that they are set up. A packing list for each chest is maintained. Pallets or canvas floors are used in the supply storage area to keep the supplies off the ground. When medical chests/supplies are stored on section vehicles, the loading plans must permit easy access for retrieving any required item without unloading the entire vehicle/trailer. The medical supply section uses the Theater Army Medical Management Information System (TAMMIS) medical supply (MEDSUP) program. This system interfaces with the MEDLOG battalion using the ATCCS computers. The medical supply element performs its mission by operating predominantly in a supply point distribution mode; however, throughput distribution will be provided on an emergency basis or as required by TSOP. While each medical unit maintains its own basic load (stock for 3 days) of medical supplies, the medical supply section normally stocks a 5- to 15-day level of selected medical supply items. The number of days of supply and any additional items maintained by the medical supply element are determined by the ASMB's mission, its location, and guidance from the medical brigade/group commander and the brigade/group medical materiel manager.

(1) During the initial employment phase, each ASMC receives a preconfigured push-package every 48 hours from the ASMB medical supply element until appropriate elements of the corps MEDLOG battalion are established.

(2) During deployment, early build-up phases, and lodgment, supported medical units/elements operate from planned, prescribed loads and from existing pre-positioned war reserve stockpiles identified in applicable logistic plans.

(3) Initial resupply efforts may consist of preconfigured medical supply packages tailored to meet specific mission requirements. Preconfigured push-packages are shipped directly to the ASMB's subordinate units until replenishment line item requisitioning is established with supporting MEDLOG battalion. While resupply by preconfigured packages is intended to provide support during the initial phase, continuation on an as-required basis maybe dictated by operational needs. Planning for such a contingency must be directly coordinated with the battalion S4 and medical materiel officer who coordinates further Class VIII resupply requirements with the supporting MEDLOG battalion. Shipment of medical materiel from the battalion medical supply element is coordinated through the medical brigade/group medical materiel management officer. Delivery of Class VIII supplies may be coordinated with the supporting transportation units, or through the use of supported unit or ASMB headquarters vehicles. In some instances, air ambulances from the medical evacuation battalion may be used to transport Class VIII supplies to requesting units.

c. Medical Supply Element Operations.

(1) *Requests received from requesting unit.*

(a) Routine. The medical supply element receives requests from supported units using the Customer Reorder List (resupply requisition format generated by TAMMIS and submitted through command channels). If requested items are available for issue, a materiel release order is printed and the stock is issued to the unit. For items not available for issue, the requests are forwarded to the next higher level of supply.

(b) Emergency. All emergency requests are immediately processed by the medical supply element and issued to the requesting unit. The HSMO has the responsibility to monitor all emergency requirements not immediately filled by his section. The battalion HSMO coordinates with the medical brigade/group HSMO for the transportation of emergency medical supplies, as required.

(2) *From source of medical supply.*

(a) Routine. The medical supply element requests all supplies in accordance with TAMMIS user's manual (MEDLOG). Supplies are either forwarded from the source of supply or are picked up at the source of supply using supply point distribution.

(b) Emergency. The medical supply element immediately forwards all emergency requests not filled to the next source of supply. The medical supply element coordinates, as required, with the medical brigade/group to meet shortfalls in the supply point distribution system by updating priorities with the MEDLOG battalion.

(c) Brigade/group health service materiel officer. The brigade/group HSMO is informed by the ASMB medical supply element of all pertinent management indicators. These indicators include–

- Number of stocked lines.
- Demand satisfaction.
- Zero balances.
- Critical item shortages.
- Nonoperational critical equipment.

(3) *Records and reports.* Records and reports are maintained as directed in the TAMMIS user's manual. (In the event of the TAMMIS failure, a backup manual system must

be implemented; see Appendix A for sample formats.)

d. Area Support Medical Maintenance. The maintenance of medical equipment is an important responsibility of the ASMB medical supply element. Medical equipment repairers are assigned to the ASMB medical supply element to support subordinate and attached units/elements. They also support organic medical elements of supported units. Medical maintenance personnel must develop a program to ensure that the ASMB's medical equipment receives appropriate maintenance and is operational. Implementation of the following programs or functions ensures the readiness of medical equipment.

(1) *Periodic services.* Services consist of PM, 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 must be in compliance with TMs and other publications. Considerations for these services include–

- Availability of equipment and manpower resources.
- Availability of TMDE.
- Other taskings.

(2) *Repairs.* Repair work orders must be completed in a timely manner to maintain a high readiness posture and prevent backlogs from occurring. A medical equipment repairer either repairs the equipment, calibrates it, orders the parts required to make repairs, or evacuates the equipment for repairs. Equipment is evacuated to the MEDLOG battalion when necessary repairs exceed the unit's TMDE or repair capability. The battalion HSMO coordinates with the MEDLOG battalion for utilization of maintenance support teams and the evacuation of equipment.

(3) *Records.* Records for medical equipment are kept according to AR 40-61 and TB 38-750-2. These should be reviewed periodically by the medical maintenance element and HSMO. Required records for medical equipment (the majority of which TAMMIS will automate) are as follows:

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

(b) DA Form 2405, Maintenance Request Register.

(c) DA Form 2408-9, Equipment Control Record.

(d) DA Form 2408-14, Uncorrected Fault Record.

(e) DA Form 2409, Equipment Maintenance Log.

(f) DA Form 5504, Maintenance Request.

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

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

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

(4) *Repair parts.* Mandatory parts lists (MPL) and PLLs need to be monitored routinely. An MPL to support medical equipment is published annually in Supply Bulletin (SB) 8-75-S4. It should be noted that 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.

4-14. Preventive Medicine Section Employment

Employment of PVNTMED elements begins prior to deployment to minimize DNBI casualties. Lessons learned from past conflicts have shown that more soldiers have been rendered noneffective from DNBIs than from injuries received as a direct result of combat. Often the victor in battle has been the force with the healthiest troops. Consequently, PVNTMED operations are characterized by preemptive actions, increased soldier and commander involvement, and priority to combat units. To accomplish this, the ASMB PVNTMED section may deploy teams to support specific areas of troop concentrations within the ASMB's AO (for example, deployed in DS of brigade- or battalion-sized units) as required. Such teams are organized as directed by the ASMB commander and PVNTMED officer based on the particular threat.

a. Predeployment Actions. Preventive medicine activities begin prior to deployment to minimize DNBIs.

(1) Actions taken include–

- Ensuring command awareness of potential medical threats and implementation of appropriate PVNTMED measures.

- Monitoring the command's immunization status (see AR 40-562).

- Monitoring the status of individual and small unit PVNTMED measures (see FMs 8-250, 21-10, and 21-10-1).

- Monitoring PVNTMED measures against heat and cold injuries and food-, water-, and arthropodborne diseases (see FMs 8-33, 8-250, and 10-52, TM 5-632, TB Meds 81, 507, 530, and 577, and United States Army Environmental Hygiene Agency [USAEHA] Technical Guide [TG] 174).

- Ensuring training and use in personal protective measures (PPM).

- Monitoring the use of prophylaxis such as antimalarial tablets.

- Ensuring an adequate supply of both topical and clothing arthropod repellents.

(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 disease.

- 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 corrected before the first case of enteric disease appears.

(3) It should be anticipated–

- That sanitation breakdowns will occur while troops are still in debarkation assembly areas.

- That arthropods will begin transmitting disease as soon as forces enter the AO.

Lack of or delay in implementing preemptive actions can significantly impact on the deployment forces' ability to accomplish its assigned mission. Refer to FMs 8-250, 21-10, and 21-10-1 for additional information.

NOTE

A successful command PVNTMED program reduces the number of DNBIs which affect the combat effectiveness of units within the operational area of the command.

b. Preventive Medicine Operations. The PVNTMED section sets up near the ASMB CP. Predeployment activities are concluded or integrated into the PVNTMED support operations. Preventive medicine support operations are prioritized based on the mission, medical threat, assessment of data collected (through monitoring, inspecting, and reporting observations), taskings from higher headquarters, or requests for PVMTMED support. The ASMB commander, based on input from the PVNTMED officer and S2/S3, determines the priorities for PVNTMED support. Preventive medicine section operations and activities may include–

- Assisting the ASMB commander and staff to prepare the HSS estimates by identifying the medical threat.
- Assisting the ASMB commander in determining disease prevalence in the AO.
- Conducting surveillance of supported 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 supported units by providing training in PVNTMED measures against heat and cold injuries and occupational hazards, as well as food-, water-, and arthropodborne diseases.
- Monitoring field food service operations to prevent foodborne diseases and illnesses.
- Monitoring the command immunization program.
- Monitoring the health-related aspects of water and ice production, distribution, and consumption.
- Monitoring disease and injury incidence to optimize early recognition of disease trends and initiation of preemptive disease suppression measures.
- Conducting epidemiological investigations of disease outbreaks and recommending PVNTMED measures to minimize effects.
- Monitoring the level of resupply of disease prevention and related supplies and equipment, including water disinfectants, insect repellents, and pesticides, for the supported AO.
- Conducting limited entomological investigations and control measures.
- Monitoring the animal bite program to prevent the transmission of rabies to soldiers.
- Monitoring environmental and meteorological conditions to assess their health-related impact on supported unit 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.

c. *Supported Units.* Supported units can request PVNTMED support through command channels or request support from the medical brigade/group, ASMB, or ASMCs. When requests are received by the ASMCs, the ASMB headquarters is notified of the requests. The S3 and PVNTMED officers coordinate missions for either requested or preemptive actions.

NOTE

To avoid health and environmental problems historically encountered by deploying troops, it is imperative that PVNTMED assets be deployed in advance of the main body/forces.

4-15. Mental Health Section Employment

The employment concept for MH support is dependent on the effectiveness of the battalion's Mental Health (Combat Mental Fitness) Program and on the assignment and proper distribution of MH personnel. It is essential that medical commanders promote training to include field experience and cross-training of critical clinical skills. For MH personnel to fill their roles in combat, they must be thoroughly familiar with the units they support and be known and trusted by those units' leaders and organic medical personnel.

a. Area Support Medical Battalion Mental Health Support. The MH support of the ASMB is provided by the ASMB MH section. The ASMB psychiatrist, the social work officer, and six behavioral science specialists make up the ASMB MH section. When the ASMB tactically deploys, the MH section collocates with the battalion headquarters but disperses its personnel and resources to support the ASMB's entire AO. The ASMB commander prioritizes the area MH support mission based on input from the ASMB psychiatrist and the CP in accordance with medical brigade/group and ASMB HSS plans. The MH section coordinates through the ASMB commander and battalion CP when requesting MH personnel augmentation. In the corps area, the battalion CP forwards the request for MH/CSC augmentation through the medical brigade/group to the CSC company. In the COMMZ, the request is sent to the medical brigade. The battalion CP coordinates with the ASMB psychiatrist and the ASMCs for deployment of MH section assets to support their AO. The battalion. CP should consider requesting MH/CSC augmentation for HSS within the AO when–

- Combat stress-related casualties are beyond the treatment capabilities of MH section's resources.
- A battalion or company-sized unit is withdrawn from a forward area back into the AO for rest and reconstitution.
- Enemy forces have used NBC weapons.
- Other high stress factors as identified in FM 8-51 are present.

The ASMB psychiatrist may use the following options to reinforce MH support within the supported AO:

(1) Send one junior behavioral science specialist to the patient-holding squad of the ASMC to reinforce the CSC coordinator previously deployed from the MH section.

(2) Place the social work officer with the ASMC. This allows the CSC coordinator to relocate to other areas as necessary. This officer can go unaccompanied to other locations within the supported AO. The CSC coordinator identifies and coordinates the requirements for such actions.

(3) Use one MH officer and one behavioral science specialist as a mobile team. They use a vehicle from the MH section for

movement to each location. The mobile team has the flexibility to move and provide CSC support at successive locations.

(4) Augment the MH section with a CSC squad from the supporting CSC company. Mental health augmentation should be considered (or planned) for all scenarios in which increases in BF and NP casualties are anticipated.

b. Area Mental Health Support Operations. Upon deployment of the ASMB to its AO, area MH support operations begin. The psychiatrist and one or two junior behavioral science specialists routinely locate near and work with the HSC clearing station. The social work officer or senior behavioral science specialist may also locate with the HSC clearing station, or with the battalion headquarters.

(1) The social work officer and the NCOIC, as directed by the battalion psychiatrist, coordinate MH section activities with the battalion CP. Coordination activities include areas such as traveling to ASMCs and supported units and obtaining status updates of ASMCs and supported units. The social work officer and the NCOIC actively support the CSC coordinators in their unit-based preventive MH and training programs and exercise technical supervision and quality assurance over all their counseling and command consultation activities.

(2) One behavioral science NCO from the MH section is allocated to each ASMC where he routinely serves as the MH section's CSC coordinator for the supported AO. The CSC coordinator provides MH/CSC advice to the ASMC commanders and treatment teams in assessment and triage. He trains the patient-holding squad personnel in management of BF casualties who must be held for restoration and treatment and in stress intervention techniques for other DNBI patients. He visits units throughout the AO to facilitate treatment of BF soldiers in the units and the reintegration of recovered BF casualties into their original or new units. He provides command consultation and conducts training for leaders in stress control principles and techniques. In order to foster a good working relationship with supported units, he deploys on tactical training exercises with supported untis. The mission objective for the CSC coordinator is to minimize BF and NP casualties by training unit leaders and medical personnel in active prevention programs. He treats combat stress related casualties (when they occur) as close to their units as possible.

c. Disposition of Battle Fatigue and Neuropsychiatric Cases. In the corps area, ASMCs refer BF and NP cases who cannot be managed at the ASMC clearing stations to the psychiatrist at the HSC clearing station as soon as the tactical situation permits. As an alternative, the soldier may be transported to a closer hospital for evaluation by that MTF's psychiatrist. The preferred method of transport for those BF and NP cases that are manageable without the use of medication or restraints is by a nonambulance ground vehicle (see FM 8-51). If physical restraints and/or medications are required during evacuation, the preferred method of transport is by ground ambulance. An air ambulance should be used only if no other means of transportation is available. Physical restraints are used only during transport, and medications are given only if needed for reasons of safety. The CSC coordinator should be advised of all such evacuations unless he is temporarily unavailable and the situation is urgent. When time and distance factors preclude the evacuation of BF and NP cases to the HSC, these cases may be evacuated to the nearest hospital for evaluation and treatment as necessary. Consultation with the ASMB psychiatrist via telephone or radio would be appropriate prior to evacuation. Direct evacuation from the ASMC clearing stations is accomplished without consultation when the BF or NP patient also has a life- or limb-threatening medical or surgical condition, or a life-threatening NP condition (for example, a suicide attempt)

which cannot be stabilized at the ASMC clearing station. This decision is made by the attending physician but, ideally, the CSC coordinator should be advised. Cases with true NP disorders, or BF casualties who do not respond to brief restoration treatment, are evacuated to the supporting corps/ COMMZ hospital or to the CSC medical company.

4-16. Optometry Section Employment

The optometry section deploys with the battalion headquarters. It normally establishes operations near the HSC. Patients seen by this section are normally referred from units and MTFs within the ASMB's AO. The section can form two teams with the capability of projecting optometry services into areas of large troop concentrations. All eyewear fabrications or repairs beyond the scope of the ASMB optical section are sent to the supporting MEDLOG battalion.

4-17. Battalion Maintenance Section Employment

The battalion maintenance section functions under the staff supervision of the battalion S4. This section establishes the battalion motor pool using standard motor pool operations procedures and provides unit-level (organizational) maintenance and repair services for the HSC and all ASMCs of the battalion. (For standard motor pool operations, see FM 43-5.) The maintenance section deploys and establishes maintenance operations with the battalion headquarters. The maintenance section establishes in an area of the perimeter away from the traffic pattern. Vehicles should not pass through the maintenance area when entering and leaving the unit area. Maintenance vehicles are dispersed (50 meters apart), camouflaged (as required), and parked facing the exit. The petroleum, oil, and lubricants (POL) point is located at least 50 meters from the working and sleeping areas. Fire points and security alarms are placed at appropriate locations in accordance with the TSOP.

a. Maintenance Operations. Battalion maintenance operations are supervised by the battalion motor officer and battalion motor sergeant. The battalion maintenance program is implemented according to the TSOP. The motor officer coordinates daily with the S4 on current and planned maintenance. The motor officer dispatches maintenance teams (MTs) based upon requests from supported ASMCs and/or command decisions to attach MTs to ASMCs. The motor officer establishes a maintenance control system that follows guidelines established by the Army Maintenance Management System. Maintenance repairs and services are scheduled based on requirements and appropriate TMs by the battalion motor officer. This schedule identifies the priorities for completion of maintenance repairs based on the maintenance support mission and the commander's guidance. Maintenance repair work schedules are developed by the maintenance officer in coordination with the motor sergeant. Together, they ensure the maintenance work flow is managed through an effective production control process. The motor officer and motor sergeant allocate work assignments and ensure efficient use of maintenance personnel, tools, repair parts, and equipment. The motor officer monitors battalion PMCS activities and ensures that operators, equipment, tools, POL, supplies, and repair parts are on hand for scheduled PMCS. The motor officer monitors the status of maintenance activities by maintaining a work status board or chart. The routine maintenance requirements status board should include–

- Actual work in progress.
- Planned work load.
- Work backlogged.
- Reasons for stoppage.
- Status of required supplies/ parts.

- Calendar date of current planned actions.
- Realistic production schedules.

The motor officer ensures the maintenance request register is maintained according to TM 38-750-1. As a minimum, the following information is entered on the maintenance request register:

- Type of equipment requiring support.
- Serial number/other identification.
- Date request was received.
- Job order number.

The motor officer is responsible for all battalion maintenance activities except for medical maintenance which is performed by medical equipment repairers assigned to the medical supply element of the S4. See paragraph 4-13 *(d)* for medical maintenance procedures. These nonmedical maintenance activities include, but are not limited to–

- Processing maintenance management records according the Army Maintenance Management System (see TM 38-750-1).
- Maintaining the PLL repair parts.
- Requesting replacement parts.
- Maintaining and accounting for all tools and tool kits.
- Establishing control procedures for common tools.
- Monitoring the battalion calibration program.
- Maintaining TMs pertaining to the equipment authorized and posting changes to publications when received.
- Conducting the quality control program according to FM 43-5 and TM 38-750-1.
- Establishing dispatch procedures according to FM 43-5 and the TSOP.
- Monitoring the equipment maintenance status and briefing the S4 daily.
- Coordinating with the DS maintenance battalion for maintenance and recovery operations beyond ASMB's capabilities.
- Monitoring battle damage assessment repairs (BDAR) reports of maintenance elements for critical equipment problems which impact on mission accomplishment.
- Monitoring cannibalization activities to ensure compliance with the medical brigade/group and COSCOM disposition instructions.
- Initiating vehicle and equipment recovery operations.
- Coordinating evacuation of nonreparable vehicle(s) or equipment to the maintenance collection point.
- Monitoring the equipment maintenance status through staff spot checks and unit PMCS activities.
- Using PM indicators to evaluate the maintenance program.
- Preparing materiel condition status reports as directed by TMs and TSOP.

- Forwarding maintenance system status reports to the S4 and higher headquarters according to the TSOP.

- Monitoring the AOAP.

b. Battalion Petroleum, Oil, and Lubricants Functions. Maintenance section personnel oversee battalion POL point operations. The battalion motor officer and motor sergeant supervise the POL point to ensure safe and efficient fuel operations to include–

- Refueling vehicles and equipment in accordance with requirements of FM 10-69.

- Forecasting POL requirements to maintain adequate amounts.

- Ensuring all POLs are maintained, stored, and distributed properly.

- Maintaining accurate accounts of fuel usage to include amounts on hand and the fuel dispensed to each vehicle or piece of equipment.

- Establishing the basic load of POL package products for vehicles and units.

- Enforcing all safety precautions concerning fuels storage, handling, dispensing, and transporting in accordance with FM 10-69.

- Protecting fuel from contaminants.

- Testing fuel samples from stored fuel to detect contaminated fuel.

c. Shop Safety.

(1) The motor officer plans and manages the shop safety program. He is responsible for establishing and enforcing safety rules. He conducts safety inspections and maintains safety inspection files.

(2) All maintenance personnel must be actively involved in the accident prevention program. Maintenance personnel are responsible for correcting, repairing, or reporting safety hazards. Technical inspections performed by maintenance personnel should ensure that vehicles and equipment are safe to operate. Maintenance personnel are also responsible for following shop safety rules and correcting others when they violate the rules or attempt to perform any unsafe act.

CHAPTER 5

EMPLOYMENT AND OPERATIONS OF THE HEADQUARTERS AND SUPPORT AND AREA SUPPORT MEDICAL COMPANIES

Section I. EMPLOYMENT

5-1. Employment of Headquarters and Support and Area Support Medical Companies

The HSCs and ASMCs are deployed to their assigned AO. These medical companies establish corps and COMMZ clearing stations and provide Echelon I and Echelon II HSS in a wide area. When deployed in the corps and COMMZ, both the HSCs and the ASMCs are normally established within a base cluster with other corps or COMMZ units.

a. Base Cluster. The units and elements located in the base cluster vary with a number of factors. The senior commander (except medical) within a base cluster is also the base cluster commander and operates the base cluster operations center (BCOC). The base cluster commander has responsibility for base cluster security. He can direct personnel from the ASMC to assist in base cluster security as long as such security does not violate any of the provisions of the Geneva Conventions or degrade the HSS mission. The base cluster commander normally has no command or control over HSS operations. The ASMB headquarters coordinates, as authorized by the medical brigade/group commander, initial support requirements for the HSC and each of its ASMCs. This coordination is with supporting units and each of the BCOCs as ASMCs displace and establish operations. The HSC and ASMCs commanders and unit leaders also interface and coordinate with supporting units and the BCOC to ensure continuation of support. The ASMB S2/S3 and ASMCs coordinate site selection and obtain approval with the BCOCs prior to establishing the company areas. The BCOC provides guidance on security and briefs the ASMCs on base cluster operating procedures and the locations of supported units/ elements. The HSC and ASMCs should verify the locations and identify the best routes to–

- Class I point (ration breakdown).
- Water distribution point.
- Class III point.
- Class II, IV, and VII points.
- Class VI point.
- Class IX point.
- Mortuary affairs collection point.
- Enemy prisoners of war collection point.
- Hospital (when located in the base cluster and not collocated with the HSC or ASMCs).
- Supported units.
- Ammunition transfer point (ATP).

The HSC moves with the battalion headquarters to its assigned AO. The HSC participates in the initial reconnaissance of the new area and assists with site selection for establishment of the battalion headquarters and HSC. Area support medical companies deploy to their separate geographical locations (area of responsibility) within the battalion's AO. The ASMB headquarters coordinates convoy clearances and security for the movement

of ASMCs to their AOs with the movement control center responsible for that AO. Prior to deployment to their areas of support, the ASMCs conduct reconnaissance of their designated areas and select the best location within their areas for establishment of the company.

b. Site Selection. Site selection is an important factor impacting on the accomplishment of the HSC and ASMC's missions. Improper site selection can result in inefficiency and possible danger to unit personnel and patients. For example, if there is insufficient space available for ambulances to turnaround, congestion and traffic jams around the MTF can result; or, if the area selected does not have proper drainage, heavy rains may cause flooding in the unit and treatment areas. The MTFs established by the companies should not be placed near hazardous materials (such as POL and ammunition) or storage areas and motor pools. The selected site is cleared of mines, booby traps, and NBC hazards. The selected site is not located near potential areas of filth such as a garbage dump, landfill, or other waste disposal site. The site is at least 1 mile from breeding sites of flies and mosquitoes and 1 mile from native habitation when possible.

c. Additional Site Selection Factors. Additional factors to consider when selecting the site for establishing the HSC and ASMCs include–

(1) *Commander's plan and mission.* The specifics of the OPLAN, the manner in which it will be executed, and the units's assigned mission can affect the selection of a specific site. The requirements for an area which is only to be used for a short period of time can differ significantly from an area which is expected to be used on an extended basis. For example, if the medical unit's mission requires that it relocate several times a day, complete treatment and holding areas will not be established; only essential services, shelters, and equipment will be used. On the other hand, if it is anticipated that the unit will be located at one site for an extended period of time, buildings or preestablished shelters, if available, maybe used.

(2) *Routes of evacuation and accessibility.* Ground ambulance is the principle means of medical evacuation for wounded/injured patient. The MTF must be situated so that it is accessible from a number of different directions and or areas. It should be situated near and be accessible to main road networks and air corridors, but not placed near lucrative targets of opportunity. The site should not be so secluded that incoming ambulances have difficulties in locating the MTF.

(3) *Expected areas of patient density.* To ensure the timely delivery of HSS, the clearing station must be located in the general vicinity proximate to the supported units. Without proximity to the areas of patient density, the evacuation routes will be unnecessarily long resulting in delays in both treatment and evacuation. The longer the distance is that must be traveled, the longer it takes for the patient to reach the next echelon of care. Further, this time delay reduces the number of ambulances available for medical evacuation support.

(4) *Hardstand, drainage, obstacles, and space.*

- The site should provide good drainage during inclement weather. Care must be taken to ensure that the site selected is not in or near a dry river or stream bed, has drainage that slopes away from the MTF location and not through the operational area, and that there are not any areas where water can pool.

- The ground, in the selected area, should be of a hard composition that is not likely to become marshy or excessively muddy during inclement weather or temperature changes. This is particularly true in extreme cold weather operations where the ground is frozen at night and begins to thaw and become marshy during daylight

hours. Further, the area must be able to withstand a heavy traffic flow of incoming and departing ambulances in various types of weather.

- The area selected should be free of major obstacles that will adversely impact on the unit layout (such as disrupting the traffic pattern), cause difficulties in erecting shelters (overly rocky soil), or require extensive preparation of the area before the MTF can be established.

- The space to establish the treatment and administrative areas of the unit is dependent upon the mission and expected duration of the operation and whether NBC operations are anticipated. The site should provide adequate space for establishment of all unit elements including possible augmentation. It must be adequate in size to accommodate dispersion of unit assets according to the TSOP. The land space required for the battalion headquarters and the support company is approximately 6 acres. The ASMCs require approximately 4 acres exclusive of the helipad and motor pool parking requirements.

(5) *Communications.* While considering all factors of site selection, remember that terrain can impede the communications systems.

(6) *Likely enemy targets.* The site must not be too closely located to likely enemy targets (in some cases such as MSRs, the facility should be located in the vicinity of the MSR for accessibility but not directly on it). These include–

- Ammunition storage facilities.
- Petroleum, oils, and lubricants points.
- Motor pools.
- Main supply routes.
- Bridges.
- River crossing points.
- Strategic towns and cities.
- Industrial complexes or factories.

(7) *Cover and concealment.* The area should provide maximum cover and concealment without hampering mission accomplishment or communications capability. Overhead cover is desirable for protection from biological and chemical contamination in the event of an attack.

(8) *Landing sites.* The site selected must have sufficient space available to serve as a landing site for incoming and outgoing air ambulances. Sufficient space must be allocated for establishing a landing site for contaminated aircraft downwind of the unit and treatment areas. Additional site selection considerations for a landing site are contained in FM 8-10-4 and FM 8-10-6.

(9) *Perimeter security.* The site selected should be easily defendable and maximize the use of available terrain features and defilade for cover and concealment. The extent of perimeter security requirements is dependent upon whether the unit is included in a base cluster or is solely responsible for its own security. A discussion on perimeter security and the Geneva Conventions is contained in FM 8-10.

(10) *Flow of traffic (patient and vehicles).* In establishing the traffic patterns within the unit area, three significant areas must be addressed:

- The selected site must permit the establishment of the treatment and administrative areas in such a manner as to maximize the smooth flow of patients through the triage, diagnostic, and holding areas. Using overlapping internal traffic patterns should be minimized.

- The external traffic pattern must afford a smooth flow of vehicle traffic through the unit area. There must be sufficient space allocated for ambulance turnaround once the patient has been delivered to the triage area. Intersections accommodating cross-traffic should be avoided as they present the potential for traffic jams and accidents.

- A route from the landing site to the triage area must be established which minimizes the distance the patient must be carried and which affords easy access to the treatment area.

(11) *Equipment.* Certain pieces of equipment require strategic placement within the company area. In selecting the site, the placement of this type of equipment must be considered. For example, trailer-mounted 10 kw generators must be placed in such a manner as to enhance their safe operation and to reduce their heat signature and noise level, yet be close enough to unit and treatment areas that the limited amount of cable can reach. It is preferable to maximize the use of natural terrain features within the site to provide a portion of this shielding rather than having to rely sole on the use of sandbags.

(12) *Decontamination area.* The site should be large enough to provide an area for patient decontamination. The specific site selected to establish the decontamination station must be downwind of the unit and treatment areas (see FM 8-10-7).

(13) *Geneva Conventions adherence.* The Geneva Conventions afford a medical unit a certain degree of protection from attack. The extent to which the combatants and irregular forces on the battlefield are adhering to the provisions of the Geneva Conventions has a bearing on site selection in that it may dictate the degree of required security for the unit.

This Paragraph Implements NATO STANAG 2931.

5-2. Establishment of the Company Headquarters

The company headquarters must ensure that communication is established with the units within the base cluster and ASMB headquarters. All security precautions and requirements must be met according to unit and base cluster operating procedures. Only essential equipment is setup to support the medical company operations. If the failure to camouflage endangers or compromises tactical operations, the camouflage of the MTF may be ordered by a NATO commander of at least brigade level or equivalent. Dispersion of tents and equipment is accomplished to the maximum extent possible. A controlled entry into the ASMC area is established.

NOTE

North Atlantic Treaty Organization STANAG 2931 (Edition 1) provides for camouflage of the Geneva emblem and red crescent on medical facilities where the lack of camouflage might compromise tactical operations.

The STANAG defines "medical facilities" as medical units, medical vehicles, and medical aircraft on the ground. Medical aircraft in the air must display the distinctive Geneva emblem. Camouflage of the red cross means covering it up or taking it down. The black cross on an olive background is not a recognized emblem of the Geneva Convention.

a. Command Element. The command element supervises the establishment of the company. The commander monitors all elements as the company sets up. He ensures the ASMC is established according to the unit layout and the TSOP. The company commander is assisted by the XO and the 1SG.

(1) The XO supervises and monitors the establishment of the company area for compliance with unit TSOP and BCOC guidance. The XO coordinates with supporting units/elements for short- and long-term support requirements. Both the commander and XO should interface with supported units as soon as possible. This interface includes–

- Health service support requirements (deployment of ambulance and treatment teams to remote sites in support of units within the company's AO).
- Sick call operations.
- Medical evacuation support and procedures.
- Dental sick call.
- Mass casualty plan.
- Nuclear, biological, and chemical patient decontamination support.
- Preventive medicine.
- Combat stress control.
- Medical threat.
- Return-to-duty policies/ procedures.
- Class VIII resupply.
- Area damage control.

NOTE

When NBC patient decontamination support is required, the supported units are responsible for providing eight nonmedical personnel to perform patient decontamination (under medical supervision). This is accomplished according to FMs 3-5, 8-10-7, and 8-285. The nonmedical personnel are identified and trained on patient decontamination procedures with medical company personnel. Additional personnel from the base cluster may be trained to transport patients by litter. All EchelonII medical companies are authorized two patient decontamination MESS. Each set is stocked with enough supplies to decontaminate 60 patients.

(2) The 1SG focuses his attention toward ensuring all unit security requirements are accomplished. The 1SG supervises the establishment of the company headquarters and the troop billeting areas. He monitors field sanitation team activities and field kitchen establishment and operations.

b. Food Service Element. The food service element establishes the field kitchen (see FM 10-23). The food service sergeant supervises the establishment of the field kitchen operations. He coordinates with and establishes an account with the Class I point (ration breakdown) and requests subsistence as prescribed by the unit TSOP. The food service element provides food service for the company, attached elements, and patients. The food service element coordinates with veterinary services on food safety and quality assurance and wholesomeness.

c. Operations Element. The operations element assists in establishing the company headquarters.

(1) The NBC NCO supervises the company NBC team by monitoring its activities and use of unit NBC-monitoring equipment. He coordinates with the BCOC and monitors the placement of early warning devices for the detection of chemical agents. He supervises and monitors

unit personnel for compliance with correct wear of mission-oriented protective posture (MOPP) clothing and equipment according to the current MOPP level and TSOP. The NBC NCO coordinates with veterinary services in cases of possible NBC contamination of food.

(2) Unit communications personnel set up communications equipment and establish the NCS for the company. They establish contact with the battalion headquarters and with supporting and supported units. They establish the ASMC net control for company assets. Communications personnel establish the internal wire communications net. They connect to the MSE area system at the wire subscriber access point operated by area support signal element.

d. Supply Element. The supply element establishes both the unit and medical supply area. They ensure all supplies are secured, properly stored, and protected from the environment. They establish the unit POL and water points. The supply element supports the company during establishment and provides additional items such as sandbags, tent pegs, and other standard equipment normally associated with establishing the company.

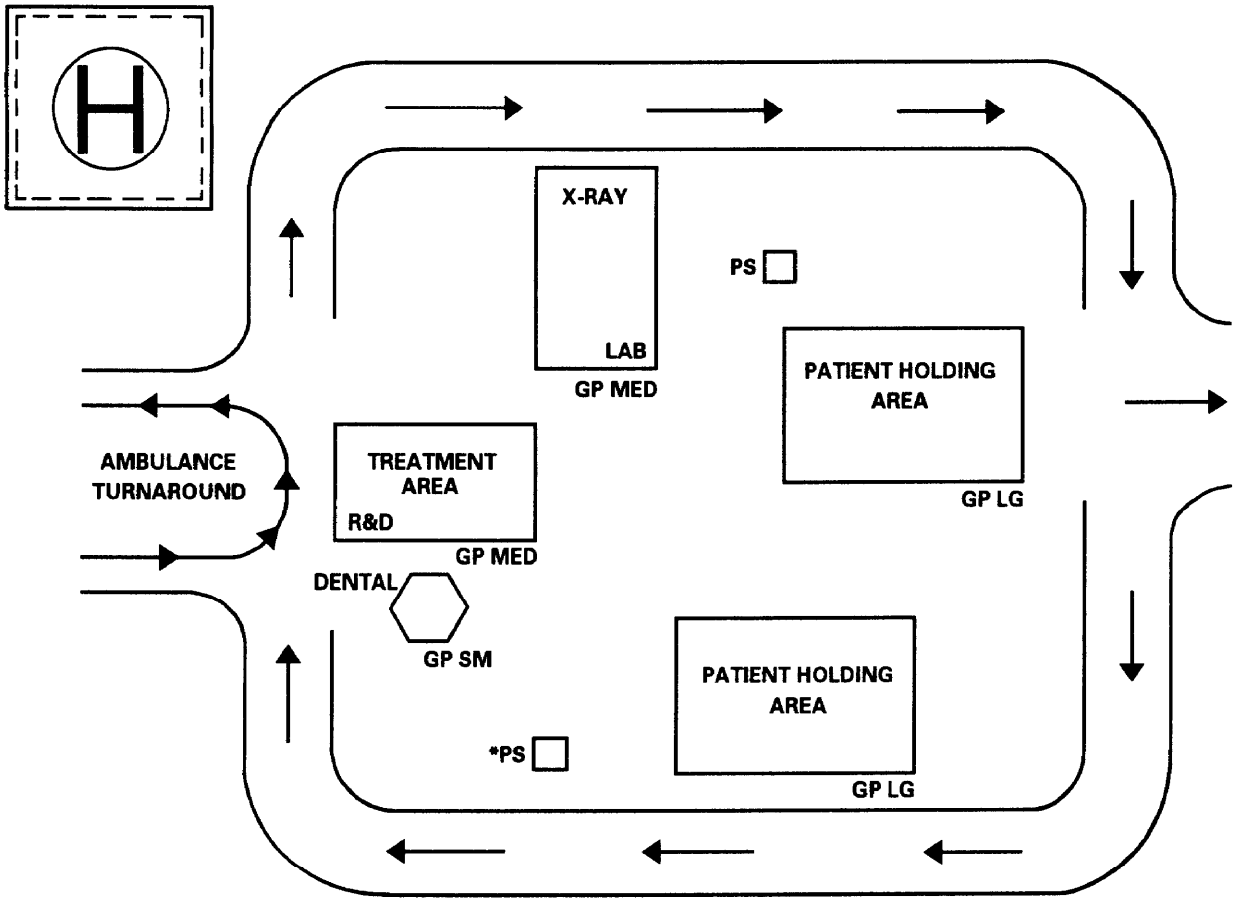
5-3. Employment of the Treatment Platoon

The treatment platoon establishes its elements using the ASMC layout. Platoon personnel setup patient treatment and holding areas. Some platoon personnel are detailed, as necessary, to assist with unit security and other unit activities associated with establishing and conducting company operations. Treatment section personnel assist the platoon with establishing the clearing section and preparing for further deployment of treatment teams according to the OPORDs/OPLANs.

a. Platoon Headquarters. The platoon headquarters element supervises establishing platoon operations. The platoon leader directs setup operations and supervises the displacement of treatment squads/teams when necessary. The field medical assistant assists the platoon leader in supervising establishment operations and coordinates the displacement of treatment squads/teams with company headquarters and supported units. He ensures all platoon elements perform PMCS on their assigned equipment and reports any uncorrectable deficiencies to the platoon leader, who reports them to the company commander. The treatment platoon sergeant is responsible for assisting the platoon leader and field medical assistant with establishing platoon operations. He ensures that the platoon treatment elements are established according to the ASMC layout and the TSOP. He supports the 1SG by providing platoon personnel to assist with security, establishment, and other operational activities of the company headquarters.

b. Area Support Section. The area support section establishes all treatment areas as directed by the treatment platoon leader. A treatment team from the treatment section is tasked with providing medical support for the company until the clearing station is established. The area support section is also tasked with clearing and marking helicopter landing areas and the ambulance turnaround point.

(1) The area treatment squad establishes and operates the clearing station in both the corps and COMMZ. The clearing station is established according to the unit layout and the company TSOP. Combat stress control and PVNTMED personnel attached from the battalion normally establish in the vicinity of the clearing station. When an ASMC supports special operation forces, or if it is required to operate at great distances from the battalion sustainment base, the ASMC may be augmented with a surgical detachment. The clearing station maintains its integrity at all times. A suggested layout for the clearing station is provided in Figure 5-1.



LEGEND:

LAB	LABORATORY
PS	POWER SOURCE (GENERATOR) *ONE POWER SOURCE IS ALSO USED FOR TREATMENT PLATOON HEADQUARTERS
R&D	RECEIVING AND DISPOSITION
GP LG	GENERAL PURPOSE TENT, LARGE
GP MED	GENERAL PURPOSE TENT, MEDIUM
GP SM	GENERAL PURPOSE TENT, SMALL

Figure 5-1. Suggested layout for a clearing station.

(2) The area support squad establishes its patient treatment areas according to the layout and the TSOP. The dental treatment facility is established adjacent to the clearing station. The dental officer supervises the placement of dental supplies and equipment within the dental treatment area. The laboratory element is normally established within the clearing station area (for medical laboratory capabilities within the theater, see Appendix D). Precautions for operating radiological equipment must be observed. Radiation hazard areas adjacent to the x-ray facility must be clearly marked and blocked so company personnel are prevented from crossing.

(3) The patient-holding squad sets up the patient-holding area. The patient-holding area is normally adjacent to the clearing station.

The number of cots set up is determined by the treatment platoon leader based on the commander's guidance, troop concentration, and casualty estimates. If the commander directs that only 20 cots be set up, this may dictate that only one general purpose (GP) large tent be erected. In the near vicinity of the patient-holding area, a water point (lister bag or collapsible fabric drums), a latrine, and a hand wash area should be placed for the convenience of those patients being held at this facility.

c. Treatment Section. Field surgeons direct the activities of the two treatment squads. They identify the treatment team tasked with providing medical support for the ASMC during movement and establishment operations. Personnel assigned to this section are involved in assisting with establishment of the medical platoon area and/or preparing for further deployment within the ASMC's AO to conduct aid station/dispensary-type operations.

5-4. Employment of the Headquarters and Support Company and Area Support Medical Company Ambulance Platoons

The HSC and ASMCs ambulance platoons locate with the treatment platoons for mutual support. The ambulance platoon is mobile because all of its assets may be totally dispatched at any given time. Each of its ambulance teams carry an on-board MES designed for medical emergencies and en route care. Once the ASMCs are deployed to their AO, the platoon establishes contact with supported medical elements operating in its area of support. Ambulances deploy within the area of support with treatment squads/teams of the HSC/ASMCs as they establish treatment station operations. The ambulance platoon leader and platoon sergeant should begin reconnaissance of the area of support to establish primary and alternate evacuations routes, to verify locations of supported units, and to field site ambulance teams as necessary. The platoon leader and platoon sergeant coordinate support requirements with supported units for ambulance platoons placed in DS. Ambulance platoon personnel obtain appropriate dispatch and road clearances prior to departing company or supported unit areas. The platoon leader ensures strip maps are provided to platoon personnel when required. If time and fuel permit, the platoon leader or platoon sergeant may take ambulance drivers on a dry run of the evacuation routes. The platoon leader/sergeant coordinate/establish AXP as required by the medical evacuation mission, Ambulance platoon personnel assist with establishment of the HSC/ASMCs and provide available personnel as tasked by the 1SG.

Section II. OPERATIONS

5-5. Staff Surgeons

When employed in their AO, medical and dental officers of the HSC and ASMCs serve as staff surgeons and staff dental surgeons to area commanders. They advise commanders on the health and welfare of their commands. They also provide assessment of the medical threat. The role of the staff surgeon/dental surgeon is outlined in FMs 101-5 and 8-10; an in-depth discussion is provided in FM 8-10-5.

5-6. Medical Support Requests

In the corps, HSS requests (including aeromedical evacuation, ground ambulance, emergency medical resupply, and reinforcement support) are normally transmitted through the AO command headquarters. For example, the support operations section of a corps support battalion/group may receive requests or they may go directly to the ASMB's HSC or ASMCs. Area support medical battalion ground ambulances from HSC's and

ASMCs' ambulance platoons evacuate casualties from Echelon I or from treatment stations (HSC's and ASMC's treatment teams) to corps clearing station (operated by the HSC or ASMC) or directly to corps/COMMZ hospitals according to the OPLAN. Casualties treated by the HSC or ASMCs may either be RTD or held for 72 hours. Minimally ill or injured patients who overflow the facility (exceeding the patient-holding capability) may be evacuated to corps hospitals in coordination with the medical group/brigade medical regulating officer (MRO). Requests for aeromedical evacuation from the corps/COMMZ clearing station (HSC/ASMCs) are transmitted directly to the medical evacuation battalion. These requests are monitored by the ASMB's S2/S3 staff who may intervene when necessary. Medical evacuation requests, both air and ground, may be submitted through the AO command headquarters or directly to the ASMB headquarters or any of its medical companies/treatment elements. Requests may also be transmitted directly to the supporting air ambulance element in accordance with SOIs and the TSOP.

a. Patient Treatment. Battle injured or trauma patients arriving at ASMB clearing stations are treated using EMT and ATM techniques. Disease and nonbattle injuries patients are also provided medical treatment. Both types of patients are stabilized for movement. Patients reporting with minor injuries and illnesses are treated within the capability of the attending medical and dental officers. These patients are treated and returned to duty or, when necessary, are held for continued treatment and observation for up to 72 hours or evacuated to a corps/COMMZ hospital for further treatment. Other functions of the clearing station include–

- Providing consultation and clinical laboratory and x-ray diagnostic services to support staff and unit physicians and PAs.
- Maintaining a roster for all patients seen or treated at the MTF.
- Notifying supported units of all patients from their organization that were processed through the facility (normally accomplished through the S1/G1.
- Verifying the information contained on the DD Form 1380.
- Monitoring, when necessary, for radiological contamination prior to medical treatment (refer to FMs 8-10-4 and 8-10-7).
- Decontaminating and treating chemical patients (refer to FMs 8-10-4, 8-10-7 and 8-285).

b. Individual Weapons. Individual weapons must be cleared prior to patients entering the MTF. The TSOP (see Appendix A) will be followed for those patients evacuated to this facility with their weapons. Individual weapons will not be evacuated with patients. Patients entering the patient treatment chain always retain their protective mask and helmet.

c. Class VIII Supplies. All ASMC medical treatment elements stock at least 3 days of Class VIII supplies and, as necessary, stock additional Class VIII to support operational contingencies based on OPORDs or OPLANs.

5-7. Mortuary Affairs Responsibilities

All commanders are responsible for unit mortuary affairs (MA) requirements and proper disposition of remains.

NOTE

Information provided in this paragraph is directed toward units/personnel located in the CZ. Mortuary affair responsibilities and procedures in the COMMZ are accomplished as directed by TA commander.

Selected unit personnel should be trained on unit-level MA tasks to ensure proper handling of remains and the deceased's personal effects. The nature of the HSS mission necessitates continuous interface with MA personnel. The HSC's and ASMCs' headquarters sections are responsible for coordinating disposition of remains (only medical company personnel and patients) and their persona] effects to the MA collection point. A temporary morgue area may be required at the medical companies for holding remains (patients and unit personnel only) while awaiting transportation to the MA collection point. These temporary morgue areas, if established, must be placed away from and out of sight of patient treatment and holding areas. Remains of deceased unit personnel or patients that are placed in the temporary morgue areas must have a completed (reviewed and signed by a physician) DD Form 1380 attached. (An exception to this procedure may be made during mass casualty situations. The remains may be tagged according TSOP and the DD Form 1380 completed when time permits.) Coordination for transporting remains to the MA collection point should be accomplished without delay. Mortuary affairs collection point personnel ensure that all remains have a completed DD Form 1380. When remains arrive at the MA collection point without a DD Form 1380, or if the DD Form 1380 is not signed by a physician, they will coordinate with the supporting medical company as discussed in FM 10-63. The form should be protected from the weather and body fluids whenever possible (see FMs 10-27-2, 10-63, 10-63-1, and FM 63-20 for definitive guidance). All personnel assigned to medical units must be knowledgeable as to the proper procedures for handling deceased personnel. All medical personnel should be aware of the principles governing medical disposition of deceased personnel provided in Table 5-1. These principles are not an absolute. Field commanders should have an understanding of the rationale behind them.

Table 5-1. Principles Governing Medical Disposition of Deceased Personnel

- Deceased personnel are segregated from other casualties.
- The deceased as determined by the senior medical authority are not evacuated with other casualties. A US Field Medical Card (FMC), DD Form 1380, should be initiated and attached to the remains if possible.
- All casualties requiring medical treatment are evacuated prior to transporting any deceased personnel.
- Medical evacuation resources should not be used to transport deceased personnel.
- All deceased personnel should have a FMC which is signed by a medical officer prior to their departure from MA collection point operating in forward areas.

5-8. 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 supporting personnel service company (PSC) is necessary for the maintenance of a responsive personnel replacement system and the Army Casualty System. Patient accountability and statistical reporting is designed to–

- Provide the commander with an accurate account of personnel losses due to enemy actions and related battlefield environment.
- Verify personnel replacement requirements.
- Quantify and prioritize corps medical evacuation demands.

- Assist the command surgeon in the preparation of the HSS estimates.

- Alert PVNTMED officers and the intelligence community to probable environmental health hazards (unidentified diseases) and potential enemy use of NBC agents/weapons.

(Refer to Figure 5-2 for samples distribution of those reports.) The ASMB CP consolidates patient reports that originate within the battalion and forwards pertinent data as directed by the TSOP to the medical group/brigade headquarters (see Appendix A for sample formats for patient reporting).

5-9. Guide for Geneva Conventions Compliance

As the United States is a signatory to the Geneva Conventions, all medical personnel should thoroughly understand the provisions that apply to HSS activities. Violations of these Conventions can result in the loss of the protection afforded by them. Medical personnel should inform the tactical commander of the consequences of violating the provisions of these Conventions.

a. Violation. The following acts of medical personnel or medical facilities are inconsistent with the Geneva Conventions and are considered violations:

- Using medical personnel to man or help man the perimeter of nonmedical facilities such as unit trains, logistics areas, or base clusters.

- Using medical personnel to man any offensive-type weapon or weapons systems.

- Ordering medical personnel to engage enemy forces other than in self-defense or in the defense of patients or MTFs.

- Mounting a crew-served weapon on a medical vehicle.

- Placing mines in and around medical units or facilities regardless of their type of detonation device.

- Placing booby traps in or around medical units or facilities.

- Issuing hand grenades, light antitank weapons, grenade launchers, or any weapons other than rifles and pistols to a medical unit or its personnel.

- Using the site of a medical unit as an observation post or a dump or a storage site for arms, ammunition, or fuel for combat.

b. Consequences. Possible consequences of violations described in a above are–

- Loss of protected status for the medical unit and medical personnel.

- Medical facilities attacked and destroyed by the enemy.

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

c. Other Violations. Other examples of violations of Geneva Conventions include–

- Making medical treatment decisions for the wounded and sick on any basis other than medical priority/urgency/severity of wounds.

- Allowing the interrogation of enemy wounded or sick even though medically contraindicated.

- Allowing anyone to kill, torture, mistreat, or in any way harm a wounded or sick enemy soldier.

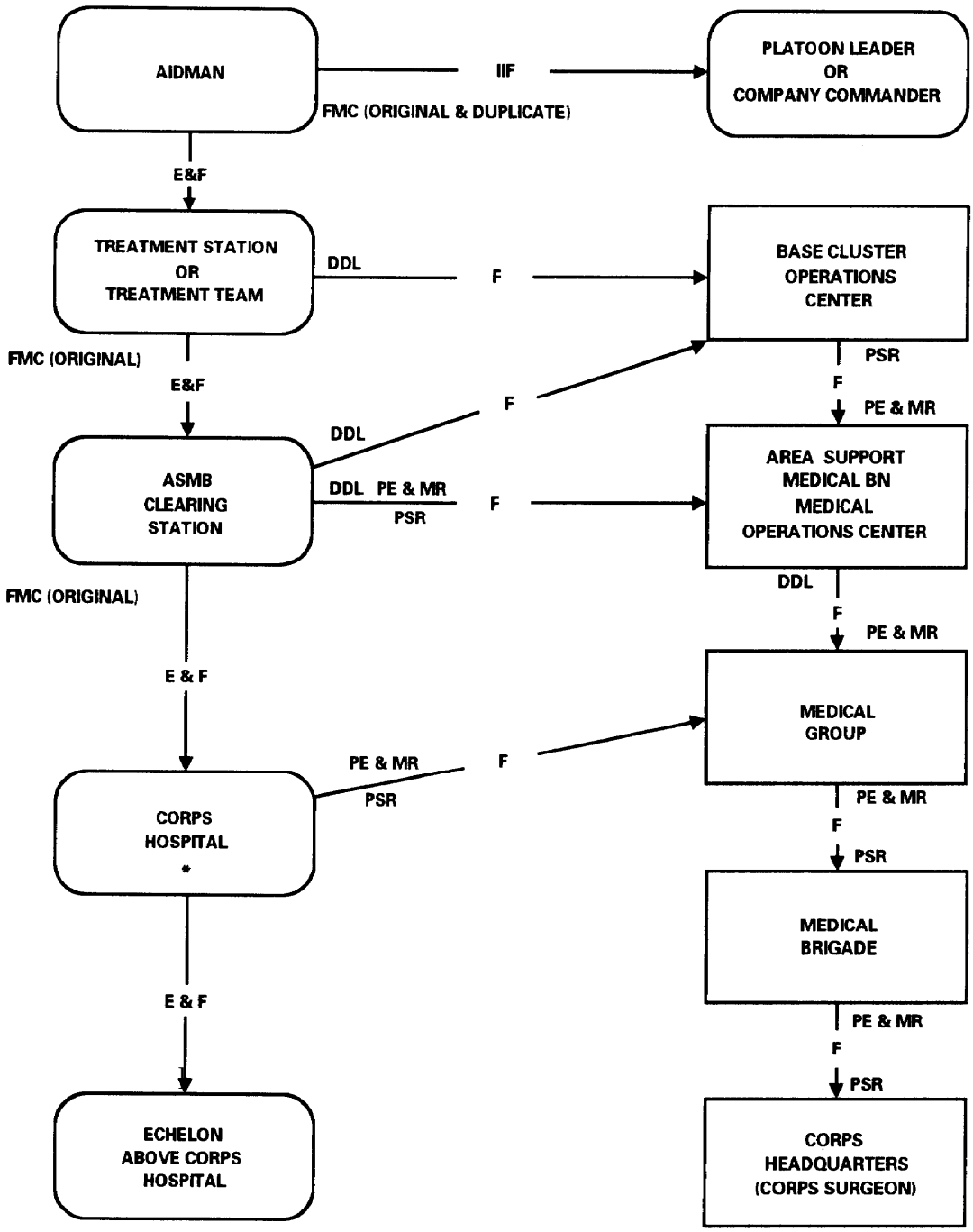


Figure 5-2. Patient accountability and status reporting for the corps area.

- Marking nonmedical unit facilities or vehicles with the distinctive Geneva emblem (red cross on a white background) or any other unlawful use of the Geneva emblem.

- Using medical vehicles marked with distinctive Geneva emblem (red cross on a white background) for transporting nonmedical troops and equipment/supplies or using full-tracked armored medical vehicles (M577 or M 113) as a tactical operations center.

d. Possible Consequences. Possible consequences of violations described in *c* above are–

- Criminal prosecution for war crimes.

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

- Decreased HSS capabilities.

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 use of smoke). Definitive information pertaining to the Geneva Conventions is found in FMs 8-10 and 27-10.

APPENDIX A

SAMPLE TACTICAL STANDING OPERATING PROCEDURE FORMAT

A-1. General

This annex provides a sample TSOP for an ASMB. It should not be considered as all-inclusive. It may be supplemented with information and procedures required for operating within a specific command or environment.

A-2. Purpose of the Tactical Standing Operating Procedure

The TSOP prescribes policy, guidance, and procedures for the routine tactical operations of a specific unit. It should cover broad areas of unit operations and be sufficiently detailed to provide newly assigned personnel the guidance required for them to assume their new positions. A TSOP may be modified by the TSOPs and OPLANs/OPORDs of higher headquarters. It applies to a specific unit and all subordinate units assigned and attached. Should a TSOP not be in conformity with the TSOP of the higher headquarters, the higher headquarters' TSOP governs. The TSOP should be periodically reviewed and updated as required.

A-3. Format for the Tactical Standing Operating Procedure

a. There is not a standard format for all TSOPs; however, it is recommended that a specific unit TSOP follow the format used by its higher headquarters. The TSOP can be divided into sections (specific functional area or major operational area). The TSOP can contain one or more annexes, each may have one or more appendixes; the appendixes may each have one or more tabs. Appendixes can be used to provide detailed information on major subdivisions of the annex, and tabs can be used to provide additional information (such as report formats or area layouts) addressed in the appendix.

b. Regardless of the format used, the TSOP should follow a logical sequence in the presentation of material. It should discuss the chain of command, major functions and staff sections of the unit, operational requirements, required reports, necessary coordination with higher and subordinate elements for mission accomplishment, programs (such as command information, PVNTMED measures, and CSC), and other relevant topics.

c. Pagination of the TSOP can be accomplished by starting with page 1 and numbering the remaining pages sequentially. If the TSOP is subdivided into sections, annexes, appendixes, and tabs, a numbering system that clearly identifies the location of the page within the document will be used. Annexes are identified by letters and are listed alphabetically. Appendixes are identified by numbers and arranged sequentially within a specific annex. Tabs are identified by a letter and are listed alphabetically within a specific appendix. After numbering the initial sections using the standard numbering system (sequentially starting with page 1 through to the end of the sections), begin numbering the annexes and their subdivisions. They are numbered as the letter of the annex, the number of the appendix, the letter of the tab, and the page number. For example, page 4 of Annex D is written as "D-4"; page 2 of Appendix 3 to Annex D is written as "D-3-2"; page 5 of Tab A to Appendix 3 of Annex D is written as "D-3-A-5." This system of numbering makes the pages readily identifiable as to their place within the document.

d. In addition to using a numbering system to identify specific pages within the TSOP, a descriptive heading should be used on all pages to identify the subordinate elements of the TSOP.

(1) The first page of the TSOP should be prepared on the unit's letterhead. The remaining pages of the sections should include the unit identification in the upper right-hand corner

of the paper (for example: "XXX Area Support Medical Battalion").

(2) A sample heading for Annex Q is as follows: "Annex Q (Preventive Medicine Section) to XXX Area Support Medical Battalion."

(3) A sample heading for an appendix to Annex Q is as follows: "Appendix 4 (Pest Management) to Annex Q (Preventive Medicine Section) to XXX Area Support Medical battalion."

(4) A sample heading for a tab to Appendix 4 to Annex Q is as follows: "Tab C (Entomological Investigations) to Appendix 4 (Pest Management) to Annex Q (Preventive Medicine Section) to XXX Area Support Medical Battalion."

e. As the TSOP is developed there may be an overlap of material from one annex to another. This is due in part to similar functions that are common to two or more staff sections. Where overlaps occur, the material presented should not be contradictory. All discrepancies are resolved prior to the authentication and publication of the TSOP. The TSOP is authenticated by the ASMB commander.

A-4. Sample Tactical Standing Operating Procedure (Sections)

The information contained in this paragraph can be supplemented. It is not intended to be an all-inclusive listing. Different commands will have unique requirements that need to be included.

a. The first section of the TSOP identifies the specific unit/headquarters that developed it.

(1) *Scope.* This document establishes and prescribes procedures to be followed by the ASMB and its assigned, attached, or OPCON units/elements.

(2) *Purpose.* This document provides policy and guidance for routine tactical operations of this headquarters and its assigned, attached, or OPCON units.

(3) *Applicability.* Except when modified by TSOPs and OPLANs/OPORDS of higher headquarters, this document applies to this unit and to all units assigned, attached, or OPCON for combat operations. In cases of nonconformity, the document of the higher headquarters governs. Each subordinate element will prepare a unit TSOP, conforming to the guidance herein.

(4) *General information.* This paragraph discusses the required state of readiness of the unit; primary, secondary, and contingency missions; procedures for operating within another command's AO; and procedure for resolution of conflicts with governing regulations, policies, and procedures.

(5) *References.* This paragraph can include any pertinent regulations, policy letters, higher headquarters TSOP, or other appropriate documents.

b. The second section of the TSOP discusses the ASMB organization.

(1) *Organization.* This unit is normally organized for field operations as outlined in Annex A.

(2) *Task organization.* The task organization listed in the TSOP is the one the unit normally operates under. Specific task organizations for the campaign is contingent on the mission and will be in the OPLAN/OPORD.

(3) *Organizational charts.* Contained in Annex A.

c. The third section of the TSOP discusses ASMB functions. It supplements the

ASMB's organizational chart(s). The functions of the various ASMB sections/elements, to include personnel and some of their responsibilities, are provided in Chapter 2. "For a more detailed description of personnel duties, refer to AR 611-201, AR 611-101, and FM 101-5."

d. The fourth section of the TSOP pertains to section/element operations and is subdivided into annexes.

A-5. Sample Tactical Standing Operating Procedure (Annexes)

Annexes are used to provide detailed information on a particular function or area of responsibility. The commander determines the level of specificity required for the TSOP. Depending upon the complexity of the material to be presented, the annex may be further subdivided into appendixes and tabs. If the annex contains broad guidance or does not provide formats for required reports, paragraphs may be used, and the annex should not be further subdivided. However, as the material presented becomes more complex, prescribes formats, or contains graphic materials, the annex will require additional subdivision. Applicable references such as ARs, FMs, and TMs should be provided in each annex. The number of annexes and their subdivisions presented below are not to be considered as an all-inclusive listing. Different commands will have unique requirements; therefore, supplementation of the information presented is permitted. The following is a recommended annex format for the development of a TSOP:

- Mission.
- Organization.
- Duties/responsibilities.
- Procedures.
- References.

a. *Annex B–Area Medical Support Operations.* The ASMB commander, assisted by the XO, battalion headquarters staff/elements, HSC commander, ASMC commanders, and CSM, provides the command and control necessary to accomplish the mission. This annex is to be used as a guide by the commander and headquarters staff in administering day-to-day operations. Procedures are outlined to assist the commander and headquarters staff during daily activities. For example–

- The day-to-day operations of the ASMB will include a review of battalion activities occurring during the preceding shift. This includes a review of the battalion activity log, situations maps, charts which monitor functional areas, and briefs by battalion staff/shift leaders as required by the XO. The daily assessment of ASMB operations can also be assisted via daily reports from battalion headquarters staff elements, HSCs, and ASMC medical/dental treatment elements. These daily reports pertain to patient-holding status, number of patients seen, RTD, NRTD, number of ground ambulance missions, total dispositions, personnel status, Class VIII status, and maintenance status for both medical and nonmedical equipment. The ASMB commander, during command visits/contacts with higher headquarters, can be apprised of the tactical/operational situation.

- Regularly scheduled meetings and review of reports/programs will be used to monitor the effectiveness and efficiency of area medical support operations.

- This annex should also address the battalion hours of operation, to include the ASMB staff and personnel shift requirements.

b. Annex C–Headquarters and Support and Area Support Medical Companies. This section provides the C2 structure for all assigned or attached officers and enlisted personnel of the

ASMB. The annex outlines procedural guidance for, but is not limited to, the following:

- Unit-level administration.
- Reenlistment and extension programs.
- Billeting, to include fire safety, sanitation, and key control.
- Security, assignment, accountability, and maintenance of weapons.
- Welfare and recreational activities.
- Unit supply.
- Duty rosters.
- Physical fitness.
- Training.
- Uniform Code of Military Justice action.

c. Annex D–Command Post.

(1) *Definition.* The CP is the command element of the ASMB containing communications and personnel required to command, control, and coordinate HSS operations for area medical support.

(2) *Purpose.* The purpose of the CP is to provide a secure area where the commander and key staff can assemble to estimate the situation, assess the requirements, and react to varying problems such as area defense, NBC operations, mass casualty situations, and HSS operations.

(3) *Responsibilities.* The ASMB commander has overall supervision and control over the CP. The battalion XO has primary staff responsibility in the absence of the commander. Daily operations will be the responsibility of the S2/S3 section.

(4) *Command post operations.* The CP will operate on a 24-hour basis. It is principally staffed by each primary staff section furnishing necessary manpower as required. The CP will be contiguous to the battalion communications area. Site of the room(s) within the battalion CP should facilitate communications among the staff while allowing for the setup of maps and storage of individual weapons and chemical defense equipment. Telephone communications/mobile subscriber radio/telephone equipment connect the CP to other staff and subordinate unit elements within the battalion, higher headquarters, and other appropriate units. The battalion's combat net radio system (AM and FM) provides communications for conducting HSS operations. Access to the CP is strictly controlled by means of an access roster and/or security badge. Only essential personnel and authorized visitors are allowed to enter. All battalion headquarters sections and subordinate unit elements at a platoon level maintain a TSOP on the organization and operation of its section. All elements within the CP maintain, when appropriate, a current situational map of their specific operations. Discussion and portrayal of HSS plans for supporting tactical operations outside of the security area is prohibited.

(5) *Composition of the CP operations cell.* Personnel comprising the operations cell normally includes the commander, XO, CSM, principal staff members, and other specific staff members, as required.

(6) *Operations cell configuration.* This is a schematic representation of the physical layout of the CP operations tent. It can be included as an appendix to the annex.

(7) *Command post operations message center.* This paragraph establishes procedures

for the handling of classified messages; provides delivery and service of IMMEDIATE and FLASH messages to the appropriate staff section; delineates procedures for preparing outgoing messages; includes delivery service to the servicing message center for the transmission of outgoing messages.

(8) *Appendixes.* The addition of appendixes to this annex is permissible. They may cover topics such as–

- Schematics of the physical layout.
- Shift change procedures.
- Security requirements, to include guard duties and identification badges.
- Briefing requirements.
- Overlay preparation.

(9) *Camouflage.* This appendix discusses required camouflage procedures including type and amount of required camouflage materials (such as nets and terrain features) and display of the Geneva Conventions distinctive emblem on facilities, vehicles, and other pertinent areas.

d. Annex E–Operations. This annex establishes procedures for S2/S3 operations within the ASMB and provides a basis for standardization of area medical support operations. It is essential that these procedures be standardized to ensure common understanding, facilitate control and responsiveness, and enhance mission accomplishment. Although intelligence and ASMB defense are functions of the battalion S2/S3 section, they may be addressed in separate annexes. For simplicity and coherency, these areas are discussed in Annexes F and G, respectively. Commanders may elect to consolidate the S2/S3 functions into a single annex.

(1) *Operational situation report.* Requirements for format, preparation, and submission of this report are discussed in this appendix.

(2) *Operations security.* This appendix provides the guidance and procedures for secure planning and conducting area medical support operations in a tactical environment.

(a) Responsibilities. The commander is ultimately responsible for denying information to the enemy. The S3 is responsible to the commander for the overall planning and execution of operations. The S3 has the principal staff interest in assuming the required degree of operations security and has the primary staff responsibility for coordinating the efforts of all other staff elements in this regard. The OPSEC officer is responsible for the preparation of the essential elements of friendly information (EEFI) and providing classification guidance. Additionally, the OPSEC officer identifies the priorities for OPSEC analysis, develops OPSEC countermeasures, and plans and supervises battalion security operations. The S2 coordinates with the S3 in planning OPSEC analysis of HSS operations, analyzing EEFI and classification guidance received from the S3, and providing all threat evaluation and intelligence updates, as received.

(b) Document classification. This area includes procedures for document downgrading/declassification and classification authority.

(3) *Area support medical battalion relocation.* This appendix provides the procedures for battalion headquarters and HSC relocation. The battalion S2/S3, in coordination with the S4 and HSC commander, plans and coordinates the battalion HSC movement. Considerations should include, but are not be limited to, the following:

- Patients in the HSC patient-holding squad.

- Tactical/operations situation.
- Maintenance status of vehicles.
- Convoy operations, to include clearance and security.
- Terrain analysis/site selection.

(4) *Communications-electronics.* This appendix establishes communications policies, procedures, and responsibilities for the installation, operation, and maintenance of CE equipment. Responsibilities of the ASMB CE NCO include–

- Advising the ASMB commander on CE matters.
- Determining requirements for communications support.
- Establishing radio communications.
- Establishing radio teletypewriter communications.
- Operating message/communications center service.
- Supervising message handling procedures.
- Establishing wire communications.
- Conducting switchboard operations.
- Supervising COMSEC and operations.
- Reporting security violations. This prescribes procedures for reporting any event or action which may have jeopardized COMSEC.
- Conducting daily change of shift inventory.
- Ensuring physical security of communications equipment.
- Monitoring transmission security.
- Maintaining security areas. This discusses access procedures and rosters, access approval requirements, and prohibited items.
- Ensuring the appointment of COMSEC officers and custodians. The appointment procedures, orders requirements, and duties of personnel are described.
- Enforcing safety procedures. This discusses requirements for grounding, handling, and storage of COMSEC equipment.
- Maintaining power units.

e. Annex F–Intelligence and Security. This annex pertains to intelligence requirements and procedures and operational security considerations.

(1) *Intelligence.* The *S2* has the responsibility of collecting information to assist the commander in reaching logical decisions as to the best course of action to pursue. Essential elements of information (EEI) include, but are not limited to, the location, type, and strength of the enemy threat; location of area of casualty concentration or mass casualty situation; known or suspected NBC activity; and issues which the commander considers to be EEI.

(2) *Intelligence reports.* The S2 is responsible for disseminating all applicable estimates, analyses, periodic intelligence reports, and intelligence summaries generated within the battalion or received from higher headquarters. Information on submission of reports and suspenses on intelligence products and reports should also be addressed in this appendix.

(3) *Reports.* These include Spot Reports from ambulance drivers or other sources. The Spot Report must be transmitted by the fastest means available. The format is narrative, including all points of information contained in the SALUTE (size, activity, location, unit, time, and equipment) outline. The Spot Report will include photographs, maps, or anything else that may help convey the fullest meaning of the information reported.

(4) *Counterintelligence.*

- *Camouflage.* When directed by a tactical commander at brigade level or above, all battalion elements initiate and continually strive to improve camouflage operations of positions, vehicles, and equipment. Noise and light discipline is implemented at all times.

- *Communications security.* These measures will be enforced at all times. Specific requirements and considerations should be included.

- *Signs and countersigns.* This paragraph outlines procedures for establishing signs and countersigns to be used during hours of darkness. It also includes reporting requirements and procedures if the signs/countersigns are lost or compromised.

- *Document security.* This paragraph discusses the procedures for inventorying, marking, safeguarding, and destroying classified material. Reporting requirements in the event of compromise are also included.

(5) *Captured personnel, equipment, supplies, and documents.* This appendix provides specific guidance on the handling of captured personnel, equipment, supplies, and documents. The disposition of captured medical equipment and supplies is governed by the Geneva Conventions and is protected against intentional destruction.

(6) *Security.* This appendix discusses weapons security, SOIs (communications) security, CP security, and sensitive item status report policies, guidance, or procedures.

f. Annex G–Area Support Battalion Defense. This annex describes procedures for security of the ASMB in a combat environment. Security should be a part of an integrated defense plan (base cluster commander's base defense plan). Within the theater area, the base cluster and base commanders are appointed by the area commander. These commanders have the overall responsibility for the base cluster/base defense organizations and plans. The HSCs and ASMCs are included as a part of the base cluster/base plan as established by the base cluster/base commander. This annex should address, as a minimum, the following:

- Perimeter defense.
- Defensive reaction force(s).
- Area damage control.
- Rear area security.
- Medical unit self-defense according the laws of land warfare.

g. Annex H–Administration and Personnel. This annex outlines procedures relating to administrative and personnel matters and associated activities. The theater surgeon will have assignment, reassignment, and career management authority for all AMEDD officers

and WO personnel arriving into/within the theater during mobilization and wartime. Request for personnel and administrative support will be submitted through the medical group S1 to the appropriate supporting regional personnel center.

(1) *Personnel loss estimate.* Initially, FM 101-10-1 and FM 101-10-2 will be used as a basis for the computation of gross and special personnel loss estimates. Factors and loss rate tables in the FMs may not accurately reflect current situations and should be modified as actual experience factors develop.

(2) *Emergency personnel replacements.* Requests for ASMB personnel replacements are submitted to the medical group S1 when there are unexpected losses for which no replacements are allocated.

(3) *Personnel daily summary (PDS).* This paragraph provides the procedures for filling out and submitting a daily personnel status report. The instructions will include requirements for encrypting the report prior to transmission, specific guidance on time of submission, corrections, or other administrative requirements.

(4) *Casualty reports.* This paragraph applies to all US military personnel who are serving within the ASMB's AO and become casualties in areas under US control. It is also applicable to EPW and civilian internees who become casualties while under control of US units.

- *Casualty feeder report.* This report is submitted on DA Form 1156. Instructions on the completion of the form and submission requirements are included.

- *Witness statements on individuals (DA Form 1155).* This statement needs to be completed only when the recovery of a body is not possible or cannot be identified. It should be submitted to the S1 within 24 hours of the incident. The procedure should contain information on obtaining the form, instructions for completing it, and other relevant information or procedures.

NOTE

The above section may also include other reports required by the command.

(5) *Personnel management.*

- *Replacements.* Individual replacements will not be readily available during the initial phases of operations. The administrative division will automatically initiate replacement requests for personnel who are reported on the PDS report as wounded inaction (WIA), missing in action (MIA), or killed in action (KIA).

- *Assignments and reassignments.* This paragraph will address the actions required for patients and permanent party personnel.

- *Leaves.* Ordinary and emergency leave procedures will be outlined per AR 630-5. Policies established by the theater will take precedence.

- *Personnel actions.* All personnel actions will be submitted to the battalion PAC (S1). Section chiefs and platoon leaders initiate personnel action requests through their company commander for his approval or disapproval. Actions will be handled expeditiously and meet suspense dates (tactical situation permitting).

- *Evaluation reports.* This paragraph requires pertinent information on the completion and submission of these reports.

- *Award recommendations.* This paragraph delineates the responsibilities and

guidance for the submission of recommendations for awards and for scheduling and conducting award ceremonies.

- *Promotions.* This paragraph discusses the procedures for submitting recommendations for promotion and scheduling and conducting promotion ceremonies.

- *Correspondence.* All correspondence addressed to higher headquarters will be submitted through the battalion S1. Requirements for submission, preparation, and approval are also provided.

- *Personnel records.* This paragraph discusses requirements for coordinating administrative support and the procedures for having correspondence included in the official military personnel records of assigned and attached personnel.

(6) *Personnel services.* Personnel services are those activities pertaining to soldiers as individuals. Unless prohibited by the tactical situation, the services listed below will be available to all assigned and attached units.

- *Morale and Welfare Activities.*

- *American Red Cross.*

- *Finance.* Finance units provide individual and organizational support on an area basis. Individual support includes casual payment, check cashing, currency conversion, and pay inquiries. Organizational support covers contracting support and commercial vendor operations, and reimbursement of imprest fund cashiers and Class A Agents. Before deployment, units will have officers with appointments prepared and trained for Class A Agent duties. (See FM 14-7 for detailed information.)

- *Legal services.* Information and specific guidance on administrative boards, courts-martial authority and jurisdiction, legal assistance, and general services will be provided.

- *Religious activities.* Religious activities include chaplain support, services available from different faiths, schedule of services, and hospital visitations.

- *Postal services.* This includes hours of operation and services available. Emergency destruction, EPW mail, and mail restriction policies will be outlined. Postal services should be addressed as an appendix to this annex.

- *Post exchange services.* This includes hours of operation and availability.

- *Distribution.* Pick up and delivery schedules and any command-specific issues/procedures are provided.

(7) *Mortuary affairs responsibilities.* Commanders at all levels are responsible for the recovery, identification, and evacuation of US dead. This section discusses the responsibilities and procedures for unit-level MA tasks for assigned and attached personnel.

- *Responsibilities.* This paragraph discusses ASMB requirements and the relationship with the medical brigade/group and supported units.

- *Disposition.* Specific guidance on procedures, MA collection points, transportation requirements, and the handling of remains is provided.

- *Hasty burials.* Specific requirements for conducting hasty burials, marking, and reporting of grave sites are included.

- *Personal effects.* Should a hasty burial be required, guidance on accounting

for personal effects and requirements for burial is contained in this paragraph.

- *Disposition of civilian and EPW remains.* The local civilian government is responsible for the burial of the remains of its citizens. The remains of EPW should be accomplished in separate cemeteries from US and allied personnel. If this is not possible, separate sections of the same cemetery will be used.

- *Contaminated remains.* This paragraph discusses handling and disposition requirements (to include protective clothing) and procedures for marking and reporting of burial sites of contaminated remains.

(8) *Public information.* This appendix contains procedures for obtaining approval on the public release of information to include the hometown news release programs.

(9) *Maintenance of law, order, and discipline.* This appendix will provide applicable regulations, policy, and command guidance on topics such as serious incident reports, notifications, submission format, straggler control, confinement of military prisoners, and EPW (also discussed in (10) below).

(10) *Enemy prisoners of war.* This appendix discusses the unit's responsibility for EPW captured by or surrendered to the unit. These procedures do not pertain to EPW patients captured by other units. Medical personnel do not guard, search, or interrogate EPW while in the HSS system; guards are provided by nonmedical personnel designated by the echelon commander for these duties.

NOTE

The treatment of EPW is governed by international and US law and the provisions of the Geneva Conventions. Personnel should be aware of these requirements and have ready access to the applicable regulations and policy guidance.

(11) *Records disposal procedures.* When hostile enemy action is imminent or if retention is prejudicial to the interest of the US, emergency disposal of files will be outlined. Nonemergency disposal, to include lost or destroyed files, is included.

(12) *Appendixes.* The following appendixes will be developed as part of this annex:

- Human relations/equal opportunity.
- Civilian personnel.
- Provost marshal.
- Safety.
- Postal operations.
- Command message center.

h. Annex I–Religious Support. This annex outlines the procedures for requesting and scheduling religious support for the battalion HSC and subordinate ASMCs. It outlines procedures and responsibilities of the S1 for coordinating/requesting chaplain support. Information pertaining to chaplain support and coverage will include–

- Normal and emergency chaplain duties.
- Religious services.
- Visitation.
- Death.

- Burial services.
- Reports.

i. Annex J–Nuclear, Biological, and Chemical Defense. After war gaming how the unit will operate based on METT-T, develop procedures for unit and individual defense against NBC attacks, decontamination procedures, and care of NBC casualties.

(1) The NBC NCO is the technical advisor to the ASMB commander and S3 on all matters pertaining to NBC operations. Procedures should be developed for–

- Organizing and training the required NBC teams.
- Establishing a warning and alarm system. The system includes vocal, visual, and sound.
- Training ASMB personnel on MOPP.
- Advising the ASMB commander on activation of the appropriate MOPP level based on the tactical situation, including masking and unmasking procedures.
- Maintaining records and submitting the required reports.
- Establishing policies on treatment of NBC casualties.
- Establishing collective shelters. The S3 determines the requirements for NBC collective shelters. The responsibility for establishing and maintaining NBC shelters rests with the S4.
- Publishing radiation exposure guidance. The guidance identifies what constitutes a radiological hazard, prescribes acceptable limits of potential casualty-producing doses of radiation, minimizes exposure, and protects against electromagnetic pulses.
- Relocating the unit from a contaminated area.
- Identifying and marking contaminated areas and controlling entrance and exit points.
- Continuing the mission in an NBC environment.

(2) This annex includes the following appendixes:

- Appendix l–NBC Teams.
- Appendix 2–Decontamination Procedures.
- Appendix 3–Individual and Collective Protective Plan.
- Appendix 4–Managing and Treating NBC Casualties.
- Appendix 5–NBC Reporting.
- Appendix 6–ASMB Displacement.
- Appendix 7–Radiation Exposure Guidance.
- Appendix 8–References.

j. Annex K–Food Service. This annex outlines procedures relating to field kitchen operations. The annex addresses field kitchen operations for the ASMB. The food service element and a detailed discussion of the

following specific areas should be included as appendixes:

- Organization.
- Rations.
- Hours of operations.
- Tactical feeding procedures.
- Safety.
- Sanitation.
- Ration accountability.
- Training.
- Kitchen police.
- References.

k. Annex L–Logistics. This annex will outline sources, procedures, requirements, responsibilities, and planning guidance for logistical support for an ASMB.

(1) *Logistical areas.* Specific areas which will be addressed are listed below. A discussion of these areas is provided in appendixes with the inclusion of tabs, if appropriate.

- S4 operations.
- General concepts of logistics support.
- Supply and distribution.
- Medical supply.
- General supply.
- Maintenance (less medical).
- Medical equipment maintenance.
- Field services (life susport).
- Waste disposal.
- Medical battalion (logistics) (forward).
- Transportation/mobility.
- Engineer support.

Logistics Applications of Automated Marking and Reading Symbols (LOGMARS), TACCS, ATCCS, CSSCS, and TMDE are included in the discussion when appropriate.

(2) *Transportation /movement requirements.* This appendix covers the following areas: applicability; responsibilities; policies on speed, vehicle markings, transporting flammable materials, transporting ammunition and weapons, and so on; convoy procedures; safety; and accident reporting.

(3) *Fire prevention and protection.* Guidance on the use of flammable materials, use of cigarettes, electrical wiring, appliances, safety of tents and occupants, spacing of tents, stoves and ranges, and fire-fighting equipment are presented in this appendix.

(4) *Field hygiene and sanitation.* This appendix provides uniform guidance and procedures for the performance of functions related to field hygiene and sanitation. It includes policies concerning communicable disease control, field water supply, water trailers and cans, water purification bags, food sanitation, latrines, liquid waste disposal, and garbage and rubbish disposal.

(5) *Conventional ammunition down/ upload procedures.* This appendix delineates responsibilities and provides guidance and procedures for the requisition, storage, and distribution of ammunition and weapons, reporting requirements, and safety.

(6) *Petroleum, oils, and lubricants accounting.*

(7) *Health service logistics support.* The health service logistics concept of operations, requisition and distribution procedures, accountability, and reports are provided in this appendix.

l. Annex M–Neuropsychiatric/Combat Stress Control Support. This annex prescribes policies and procedures pertaining to neuropsychiatric and CSC support provided by the ASMB MH section. Specific areas addressed are listed below. A discussion of the areas is provided in appendixes with the inclusion of tabs, if appropriate.

- Mental health section operations.
- Neuropsychiatric patient treatment and evacuation.
- Consultation services.
- Combat stress control program.
- Reconstitution support.
- Restoration.
- Reports.
- Safety.

m. Annex N–Blood Management. This annex prescribes ASMB's blood management policies and procedures.

(1) *Responsibilities.*

- The battalion commander is ultimately responsible for the battalion's blood program.
- The S4 is responsible for the overall planning and execution of the battalion blood program.
- The HSMO is responsible for monitoring the blood program at the ASMCs, for managing blood inventory levels, and for ordering blood for the battalion.
- The ASMC commander, through the treatment platoon leader, monitors blood usage and inventory levels.
- The medical laboratory specialist of each area support squad is the technical advisor to the ASMC commander and treatment platoon leader on all matters pertaining to the blood program.

(2) *Operations.* All supported ASMCs authorized to receive, store, and issue blood submit a daily blood report (BLDREP) to the medical supply element. The medical supply element consolidates all BLDREP and submit one BLDREP (daily) to the servicing blood bank platoon (MEDLOG battalion). Each ASMC maintains an inventory of between 30 to 50 units of group O packed red blood cells. Each medical supply element should maintain an additional 30 to 50 units for each ASMC supported. The blood banking platoon ships blood as requested to the medical supply elements. Supported units are responsible for picking up requested blood from the medical supply element. When ASMCs are unable to pick up requested blood, the medical supply element coordinates through the battalion S2/S3 for delivery. When ASMCs or their treatment squads are displaced from the ASMB, requests for blood resupply may be forwarded directly to the MEDLOG battalion blood bank platoon.

(3) *Procedural guidance.* Procedural guidance is provided for the following:

- Reporting/requesting blood.
- Receiving.
- Storing.
- Issuing.
- Transporting.
- Administering.
- Disposing of outdated blood.
- Recalling of blood.
- Managing TAMMIS blood (medical blood) products (or similar blood management inventory system).

n. Annex O–Dental Services. This annex outlines policies and procedures for dental treatment services provided by the ASMB. Procedures include–

- Priority of treatment.
- Dental records.
- Narcotics and drug control.
- Dental supply and maintenance operations.
- Mercury hygiene.
- Syringe and needle security.
- Handling of contaminated needles and syringes.
- Safety.
- Sterilization and infection control.

o. Annex P–Pharmacy Service. Pharmacy service is provided by ASMB treatment elements. This annex addresses the following procedures:

- Storing, safeguarding, labeling, and dispensing of pharmaceutical/drug products.
- Controlling drugs (Codes Q and R).
- Maintaining signature cards.
- Rotating drugs and medications.
- Requisitioning pharmaceutical drug products.
- Preparing reports.

p. Annex Q–Preventive Medicine Section. This annex outlines the general functions for the PVNTMED section. Procedural guidance is identified for the following:

- Unit surveillance for compliance of PVNTMED measures.
- Training assistance.
- Water monitoring.
- Epidemiological investigation.
- Entomological investigation.
- Pest management.
- Disease and injury incidence monitoring.
- Command immunization program monitoring.

- Nuclear, biological, and chemical surveys (water surveillance).
- Deployment of PVNTMED teams.
- Animal bite reports/rabies control program.

q. Annex R—Patient Holding. This annex provides administrative and operational guidance for all patient-holding elements throughout the ASMB. It provides nursing care standards, policies, and procedures that are applicable to the patient-holding element and treatment section. Areas addressed should include, but are not limited to, the following:

NOTE

Some of the subject areas are only applicable if augmented with a surgical squad.

- Nursing notes.
- Plan for nursing care.
- Method of documentation.
- Infection control.
- Admission and disposition.
- Reports.
- Supplies procedures/levels.
- Maintenance procedures for vehicles and equipment.
- Procedures for managing BF and NP patients.
- Procedures for cardiac arrest.
- Procedures for operating with surgical squad augmentation.
- Preoperative preparation of the patient.
- Postoperative care of the patient.
- Care of intravenous equipment and injection site.
- Procedure for care of patient with indwelling catheters.
- Tracheotomy care.
- Bedpan and urinal washing and disinfecting procedures.
- Infectious waste disposal.
- Handwashing requirements and procedures.
- Isolation procedures for patient care.
- Handling of contaminated needles and syringes.
- Procedures for handling deceased patients.

r. Annex S—X-Ray Equipment. This annex establishes policies and procedures for operating ASMB x-ray equipment. Suggested areas are—

- Film safety badges.
- Radiation safety.
- Radiation protection.

- Equipment records.
- Radiographic film storage/disposition.
- Filing procedures.

s. Annex T-Ground Ambulance Evacuation Support. This annex prescribes procedures for providing ground ambulance evacuation support for the supported AO. It includes policies and procedures for en route medical care. Areas to be addressed will include, but are not limited to, the following:

- Examination procedures.
- Emergency medical treatment.
- Ambulance supplies and resupply procedures.
- Property exchange.
- Ambulance exchange point operations.
- Preventive maintenance checks and services.
- Ambulance shuttle system.
- En route care.
- Movement control/road clearante.
- Dispatch procedures.
- Pre-positioned area ambulance coverage.

t. Annex U—Optometry Services. This annex outlines procedures for providing optometry support for the ASMB's supported AO. It should include, but is not limited to, the following:

- Routine eye examinations and refractions.
- ★ Management of ocular injuries and diseases.
- Spectacle frame assembly and repair.
- Storage and maintenance of ophthalmic equipment.
- Procedures for requesting eyewear fabrication from the MEDLOG battalion.
- Replacement of optical inserts.
- ★ Procedures for managing and reporting laser injuries.

u. Annex V. Laboratory Support. This annex outlines laboratory procedures provided by ASMB treatment platoons. The operational guidance should include, but is not limited to, the following:

- Handling and disposing of contaminated needles and syringes.
- Disposing of medical waste.
- Ensuring safety.
- Collecting blood specimen.
- Collecting urine specimen.
- Disposing of infectious waste.
- Maintaining laboratory equipment.

- Recording and reporting laboratory results.

v. Annex W–Routine Medical Treatment and Advanced Trauma Management. This annex outlines the procedures for clearing stations and all medical treatment elements assigned or attached to the ASMB to provide routine medical treatment and ATM. Routine medical treatment is defined as treatment provided for nonlife-, limb-, or sight-threatening conditions. Emergency medical treatment and ATM procedures are implemented when life-, limb-, or sight-threatening conditions exist. Procedures for either EMT or ATM include receiving patients, assessing their conditions, providing emergency treatment, and stabilizing and preparing the patient for medical evacuation. Procedures for operating all ASMB medical treatment elements include–

- Verification of personnel qualification.
- Twenty-hour physician/EMT NCO coverage plan.
- Daily Disposition Log.
- Patient Evacuation and Mortality Report.
- Triage.
- Scope of practice of MOS 91B personnel.
- Routine patient care management.
- Emergency patient care management.
- Care of HN military and dependents (as required).
- Care of HN contract civilian and other HN medical care requirements.
- Patient holding.
- Mass casualty operations.
- Medical treatment for chemical and biological agent casualties.
- Medical evacuation of patients (ground and air ambulances).
- Utilization of litter teams.
- Medical resupply and maintenance.

w. Annex X–Mass Casualty. This annex outlines procedures to enable the ASMB to respond effectively to a variety of emergency external and internal disaster situations. In any situation, the ASMB must be prepared to receive, triage, treat, and evacuate large numbers of casualties within a short period of time. The development of this plan is the responsibility of the S3 section or as directed by the battalion commander. Procedures include–

- Planning and training requirements.
- Medical cadre duty positions.
- Nonmedical personnel positions and duties, including litter teams and perimeter guard crowd control, and information personnel.
- Location of treatments areas to include triage, delayed care, immediate care, minimal care, and expectant care areas.
- Support requirements beyond ASMB's capability.
- Evacuation.

- Return to duty.
- Records and reports.
- Medical evacuation.
- Use of nonmedical transportation assets.

x. Annex Y–Individual Weapons and Equipment. Individual weapons must be cleared prior to patients *or* staff entering the MTF. Munitions such as hand grenades, light antitank weapons, or M79 rounds are to be taken into the MTF. Patients entering the patient treatment chain always retain their protective mask and helmet. No weapons, ammunition, or other equipment such as night vision devices, CE equipment, maps, SOIs, or other classified material are to be evacuated with the patient. These items are turned into the unit supply element and secured. The patients' unit must be notified that items of equipment are being held at the supporting MTF. It is the responsibility of the patients' unit S4 or company headquarters to pick up any equipment belonging to members of their unit.

y. Appendix A–Sample Formats for Reports, Tracking Charts, Coordination, and Maintaining Current Operations Charts and Maps. These sample formats are provided as examples for operations and logistical reports, tracking charts, and current operations charts and maps. These formats may be modified or changed based on command requirements. Some of the formats are provided as backup to computer-generated reports while others are primary report formats. It is important that the TSOP provide a standard format for the subject areas identified and that all subordinate elements follow the formats. The reporting formats throughout the battalion are intended to provide the commander and higher headquarters a clear picture of the battalion's current overall status. The commander uses the consolidated information contained in these reports for planning and making key decisions. If standard formats are not used, information collected may not be consistent with the operational and logistical information required by the commander and higher headquarters.

SAMPLE FORMAT 1

TEAM MOVEMENT REPORT

Purpose: To track the status and location of teams (PM, combat stress, ambulance, and treatment teams).

Line 1: Unit.
Line 2: Current location.
Line 3: Departure date-time group (DTG).
Line 4: Destination and route.
Line 5: Arrival DTG.
Lines 2-4 are reported prior to departure from any site and Line 5 is reported upon arrival.

arrival.

SAMPLE FORMAT 2

NONMISSION-CAPABLE EQUIPMENT REPORT (ALPHA REPORT)

Purpose: To track the status of vehicles or key equipment in the battalion.

Line 1: Unit.
Line 2: DTG of report.
Line 3: Type of vehicles or equipment (nomenclature).
Line 4: Bumper number of vehicle or unit for all other equipment.
Line 5: Location.
Line 6: Fault or problem.

The "A" report is sent when a piece of equipment becomes nonmission-capable.

SAMPLE FORMAT 3

MISSION-CAPABLE EQUIPMENT REPORT (BRAVO REPORT)

Line 1: Unit.
Line 2: DTG of report.
Line 3: Type of vehicle or equipment (nomenclature).
Line 4: Bumper number of vehicle or unit for all other equipment.

The “B” report is sent when the equipment becomes mission-capable.

SAMPLE FORMAT 4

CASUALTY REPORT

Purpose: For use by the ASMCs and S1 for strength accounting.

Line 1: Unit.
Line 2: DTG.
Line 3: WIA by battle roster number.
Line 4: KIA by battle roster number.
Line 5: DNBI by battle roster number.
Line 6: EPW and MIA by battle roster number and should identify status of the casualty.

SAMPLE FORMAT 5

MEDICAL EVACUATION MISSION WORK SHEET AND AFTER-ACTION REPORT

Purpose: To provide a work sheet for recording essential information pertaining to evacuation missions and to provide an after-action report pertaining to the mission when completed.

SAMPLE FORMAT 5 (CONTINUED)

MEDICAL EVACUATION WORK SHEET/AFTER-ACTION RECORD

DTG RECEIVED	CALL SIGN	AIR/GROUND	UNIT MISSION/MISSION NUMBER

ITEM	CLEAR/DECRYPTED	ENCRYPTED	BREVITY CODE	ACTUAL INFORMATION
1 LOCATION OF PICKUP SITE				
2 FREQUENCY/ CALL SIGN SUFFIX AT PICKUP SITE				
3 NUMBER OF PATIENTS BY PRECEDENCE			A—URGENT B—URGENT-SURG C—PRIORITY D—ROUTINE E—CONVENIENCE	
4 SPECIAL EQUIPMENT			A—NONE B—HOIST C—EXTRACTION EQUIPMENT D—VENTILATOR	
5 NUMBER OF PATIENTS BY TYPE			L + # OF PNT—LITTER A+ # OF PNT—AMBULATORY (SITTING)	
6 SECURITY OF PICKUP SITE*			N—NO ENEMY TROOPS P—POSSIBLE ENEMY TROOPS (CAUTION) E—ENEMY TROOPS IN AREA (CAUTION) X—ENEMY TROOPS IN AREA (ARMED ESCORT REQUIRED)	
7 METHOD OF MARKING PICKUP SITE			A—PANELS B—PYROTECHNIC SIGNAL C—SMOKE SIGNAL D—NONE E—OTHER	
8 PATIENT NATIONALITY AND STATUS			A—US MILITARY B—US CIVILIAN C—NON-US MILITARY D—NON-US CIVILIAN E—EPW	
9 NBC CONTAMINATION*			N—NUCLEAR B—BIOLOGICAL C—CHEMICAL	

NEAREST AXP	DESTINATION MTF	DEST FREQ/CALL SIGN	ETE

NOTES:
(EXPLAIN DELAYS)
(LIST MSRs OR AIR CORRIDORS)
(LIST EXCHANGE REQUIREMENTS)
*WARTIME

SAMPLE FORMAT 5 (CONTINUED)

DTG REQUEST RECEIVED BY EVACUATION UNIT	DTG REQUEST RECEIVED BY EVACUATION CREW	EVAC VEHICLE/AIRCRAFT DESIGNATION (BUMPER NUMBER/AIRCRAFT NUMBER)
DTG ARRIVED AT PICKUP SITE	DTG DEPARTED PICKUP SITE	EVACUATION ORGANIZATION
DTG ARRIVED AT MTF 1	DESIGNATION OF MTF 1	LOCATION OF MTF 1
DTG ARRIVED AT MTF 2	DESIGNATION OF MTF 2	LOCATION OF MTF 2
DTG ARRIVED AT MTF 3	DESIGNATION OF MTF 3	LOCATION OF MTF 3
DTG ARRIVED AT MTF 4	DESIGNATION OF MTF 4	LOCATION OF MTF 4

PATIENT DATA

NAME	RANK	SSN/ID NO	UNIT	MTF EVACUATION

MISSION NARRATIVE: CHRONOLOGICALLY COVER AS MUCH INFORMATION AS IS AVAILABLE.

EVACUATION CREW: INDIVIDUAL IN CHARGE:	SIGNATURE OF INDIVIDUAL IN CHARGE:
PILOT/DRIVER:	
MEDIC:	
CREW CHIEF:	

CONTINUATION OF INFORMATION:

SAMPLE FORMAT 6

PERSONNEL DAILY SUMMARY

Purpose: To provide daily update on the personnel status of the unit.

PERSONNEL DAILY SUMMARY **DTG** _____

UNIT	STAT	REQ	ASGD	PDY	KIA	WIA	MIA	NON CBT LOSS	TOTAL LOSSES	GAINS	CRNT PDY
TOTAL											

NOTES:

LEGEND:

ASGD	ASSIGNED	MIA	MISSING IN ACTION
CBT	COMBAT	PDY	PRESENT FOR DUTY
CRNT	CURRENT PDY	REQ	REQUIRED
DTG	DATE-TIME GROUP	STAT	STATUS
KIA	KILLED IN ACTION	WIA	WOUNDED IN ACTION

SAMPLE FORMAT 7

DAILY DISPOSITION LOG

Purpose: Maintained by Echelon I and Echelon II MTFs. The information from this log is extracted, when required, and provided to the BCOC or to the unit requesting such information. The Daily Disposition Log is also the primary source for the information needed in the Patient Evacuation and Mortality Report (PE&MR).

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
HERRERA, C.	E4	000000000	C3, 6 INF/US	SICK/MIGRAINE/ DIS	RTD-1400Z
JONES, C.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
FLOWERS, R.C.	E8	000000000	B TRP RECON SQDN/US	BF/DNBI	CLR-1640Z
CONRAD, W.	E5	000000000	6 PANZER/GE	BURN, 3D DEGREE CHEST/ABDOMEN/WIA	CLR-1400Z
DECK, H.	02	000000000	C BTRY, 3 FA/US	PUNCTURE WOUND R-ANKLE/WIA	CLR-1400Z
HASLEY, B.	E1	000000000	B TRP RECON SQDN/US	CHEMICAL INJ SYSTEMIC/WIA	28TH FLD-1705Z
WATSON, WM. T.	E3	000000000	B TRP RECON SQDN/US	DE INJ BOTH EYES	28TH FLD-1815Z
FISHER, T.T.	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	ELEM	ELEMENT	MP	MILITARY POLICE
BF	BATTLE FATIGUE	FA	FIELD ARTILLERY	NBI	NONBATTLE INJURY
BW	BIOLOGICAL WARFARE	FRAG	FRAGMENTATION (WOUND)	R	RIGHT
CLR	CLEARING (STATION)	GE	GERMAN	RECON	RECONNAISSANCE
DE	DIRECTED ENERGY	GSW	GUN SHOT WOUND	SCTY	SECURITY
DIS	DISEASE	INF	INFANTRY	SQDN	SQUADRON
DNBI	DISEASE AND NONBATTLE INJURY (PURPLE HEART NOT AUTHORIZED)	INJ	INJURY	TRP	TROOP
		KIA	KILLED IN ACTION (PURPLE HEART AUTHORIZED)	US	UNITED STATES
				WIA	WOUNDED IN ACTION (PURPLE HEART AUTHORIZED)
DOA	DEAD ON ARRIVAL	L	LEFT		
DTG	DATE-TIME GROUP	MA	MORTUARY AFFAIRS		

SAMPLE FORMAT 8

PATIENT EVACUATION AND MORTALITY REPORT

Purpose: Prepared by Echelon III (hospital) and Echelon II MTFs and disseminated as shown in Figured 5-2. The PE&MR primarily serves as a "medical spot report." The frequency of this report is established by the command surgeon.

PATIENT EVACUATION AND MORTALITY REPORT

DATE TIME GROUP (DTG): _____

(FROM) / (TO)

ALPHA (EVACUATED)

NAME	GRADE	SSN	*UNIT/NATION	TENTATIVE DIAGNOSIS	DESTINATION DTG
WILSON, V.C.	03	000000000	A TRP RECON SQDN/US	MULTIPLE GSWs ABDOMEN AND L-THIGH	28TH FLD/ 251015Z MAR 86
NELSON, B.	05	000000000	HHC, CAB 71D/US	FUO	15TH CSH/ 251215Z MAR 86
THOMPSON, R.L.	05	000000000	HHC, 3D BN 6 INF/US	ACUTE MYO-CARDIAL INFARCTION	28TH FLD/ 251535Z MAR 86

BRAVO (EXPIRED)

NAME	GRADE	SSN	UNIT/NATION	CAUSE OF DEATH	DTG
WILLIAM, W.R.	E3	000000000	B TRP RECON SQDN/US	BURN, THERMO, 3D DEGREE 18 PERCENT	251415Z MAR 86
MAGSAYSAY, M.			EPW	FRAGMENTATION WOUND OF HEAD	251600Z MAR 86
COMRAD, 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."

SAMPLE FORMAT 9

PATIENT SUMMARY REPORT

Purpose: To provide a status of patients seen by the ASMB's subordinate ASMCs and subordinate elements (dental, optometry, mental health, or attached units). The Patient Summary Report is a weekly report compiled as of 2400 hours each Sunday. It is prepared by Echelon I through Echelon III MTFs, then submitted each Monday to those units/commands shown in Figure 5-2.

PATIENT SUMMARY REPORT

DTG: _____

(FROM)/(TO)

		WIA	NBI	DISEASE	*NP	TOTAL
	PATIENTS					
ALPHA	US	_____	_____	_____	_____	_____
BRAVO	ALLIED	_____	_____	_____	_____	_____
CHARLIE	EPW	_____	_____	_____	_____	_____
	DISPOSITION TOTAL					
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 OR STRESS-RELATED PATIENTS.

SAMPLE FORMAT 10

LOGISTICAL STATUS REPORT

Purpose: To provide daily updates on the battalion's logistical status to include Class VIII.

LOGISTICAL STATUS REPORT

UNIT _____
DTG PREPARED _____
FOR PERIOD ENDING (DTG) _____

LINE 1: RATIONS	O/H
A.	
B.	

LINE 2: MISC (TASO, SSSC, BATT, ETC.)	
A.	
B.	
C.	

LINE 3: NBC	O/H	REQUIRED
A. MOPP SUIT (SM)		
B. MOPP SUIT (MED)		
C. MOPP SUIT (LG)		
D. MOPP SUIT (X)		
E.		
F.		
G.		
H.		
I.		
J.		
K.		
L.		
M.		
N.		
O.		

LINE 4: FUEL	O/H	REQUIRED
A. DIESEL		
B. MOGAS		

LINE 5: PACKAGE POL	REQUIRED
A. 10 WT	GAL
B. 30 WT	GAL
C. 80/90 WT	GAL
D. GAA	LBS
E. FRH	GAL
F. OHT	GAL
G. 15/40 WT	GAL
H. TURBOSHAFT OIL	GAL
I. ANTI-FRZ	GAL
J. ANTARTIC OIL	GAL
K.	
L.	

LINE 6: CL IV	O/H	REQUIRED
A. SANDBAGS		
B. BARBWIRE		
C. CONCERTINA		
D.		
E.		
F.		
G.		

LINE 7: CL V	O/H	REQUIRED
A. 5:56		
B. 9 MM		
C.		
D.		
E.		
F.		

LINE 8: CL VIII CRITICAL ITEMS	O/H	REQUIRED
A. LITTER FOLDING		
B. STERILE GLOVES		

LINE 8: CL VIII CRITICAL ITEMS	O/H	REQUIRED
C.		
D.		
E.		
F.		
G.		
H.		
I.		
J.		
K.		
L.		
M.		
N.		
O.		
P.		
Q.		
R.		
S.		
T.		
U.		
V.		
W.		
X.		
Y.		
Z.		

REMARKS:

NOTE 1: (LINES 1, 3, AND 4) RATIONS, NBC, AND FUEL O/H INCLUDE NONISSUED STOCKS ONLY.
NOTE 2: (LINE 5) CHANGE PACKAGE POL UNIT OF ISSUE AS REQUIRED.
NOTE 3: (LINE 6) CL IV O/H INCLUDES NONISSUED STOCKS ONLY.
NOTE 4: (LINE 7) CL V O/H INCLUDES NONISSUED STOCKS ONLY.
NOTE 5: (LINE 10) O/H INCLUDES ALL MISSION CAPABLE EQUIPMENT, ORGANIC OR ATTACHED, NMC COLUMN INCLUDES ALL NONMISSION CAPABLE EQUIPMENT REPAIRABLE AT UNIT OR DS LEVEL; BTL LOSS INCLUDES ALL NONREPAIRABLE BTL LOSSES SINCE LAST STATUS RPT.
NOTE 6: (LINE 11) WATER O/H INCLUDES BULK STORAGE ONLY.

NAME AND RANK OF PERSON PREPARING REPORT

SAMPLE FORMAT 10 (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.		

SAMPLE FORMAT 11

CLASS III STATUS WORK SHEET

Purpose: For use by all ASMB elements using Class III to determine Class III status.

Line 1: Unit
Line 2: DTG
Line 3: Unit
Line 4: Current status
Line 5: Last refuel
Line 6: Next refuel

SAMPLE FORMAT 12

CLASS IV STATUS WORK SHEET

Purpose: To maintain a current status on Class IV.

Line 1: Unit
Line 2: DTG
Line 3: Unit
Line 4: Sandbags
Line 5: Overhead cover
Line 6: Pickets
Line 7: 4 x 4 boards
Line 8: Concertina
Line 9: Barbed wire

SAMPLE FORMAT 13

CLASS V STATUS WORK SHEET

Purpose: To maintain a current status on Class V.

Line 1: Unit
Line 2: DTG
Line 3: Unit
Line 4: 9MM
Line 5: 5.56
Line 6: 7.62

SAMPLE FORMAT 14

BLOOD REPORT

Purpose: A required report for requesting blood support. Echelon II MTFs may request only group O whole blood. The below formats, therefore, only discuss this limited support. For additional information on the complete BLDREP submitted by Echelons III and IV MTFs, refer to FM 8-55.

Blood Management Report: Depending on the tactical situation and the command policy, the BLDREP may be transmitted by voice or written means (transmitted electronic message, telephonically, or by courier). The written message format is contained in Sample Format 14. The voice message format is contained in Sample Format 15.

MESSAGE BLOOD REPORT

FM: MEDICAL TREATMENT ELEMENT	
TO: BLOOD SUPPLIER	
INFO: AS DETERMINED BY COMMAND OPLAN	
CLAS	
OPERATIONAL DESIGNATOR	
MSGID/BLDREP/_ASMC/151215ZJUN92//	
ASOFDTG/160430ZJUN92	(Line 1)
REPUNIT/_ASMC/H//	(Lines 2 and 3)
BLDINV/20JS//	(Line 9)
BLDREQ/30JSW//	(Line 10)
BLDEXP/2JS//	(Line 11)
BLDEST/140JS//	(Line 12)
CLOSTEXT/RECEIVED 30JS/TRANSFUSED 20JS/SHIPPED O/ REFRIGERATOR NEEDS REPAIR//	(Line 13)

Report Explanation:

Line 1: The BLDREP is as of 1215Z, 15 Jun 92.
Lines 2—3: The reporting unit is the _ASMC, Code H (medical treatment element).
Line 9: The ending inventory of blood on hand is 20 units of type O red blood cells (Brevity codes): J-Red blood cells; S-Random type O.
Line 10: Quantity of blood requested: 30 units type O red blood cells within 12 hours (W).
Line 11: Quantity of blood expiring within next 7 days: 2 units type O red blood cells.
Line 12: Estimated blood requirements for the next 7 days.
Line 13: Narrative such as refrigerator needs repair or 30 units of type O red blood cells were received within the past 24 hours; 20 units of type O red blood cells were transfused; and no units were shipped.

SAMPLE FORMAT 15

VOICE TRANSMITTED BLOOD REPORT

LINE 1 151215Z
LINE 2 ASMC
LINE 3 H
LINE 9 20 JS
LINE 10 30 JS
LINE 11 2 JS
LINE 12 140 JS
LINE 13 RECEIVED 30JS, TRANSFUSED 20 JS, NO UNITS SHIPPED, REFRIGERATOR NEEDS REPAIR
LINE 14
LINE 15 (AUTHENTICATION IN ACCORDANCE WITH SOI)

Report Explanation:

Line 1: As of DTG (day, time, zone) of the blood shipment.
Line 2: Reporting unit's name or designator code.
Line 3: Reporting unit's activity brevity code letter.
Line 9: The ending inventory of blood on hand is 20 units of type O red blood cells (Brevity codes: J-Red blood cells; S-Random type O).
Line 10: Quantity of blood requested: 30 units type O red blood cells.
Line 11: Quantity of blood expired: 2 units type O red blood cells.
Line 12: Estimated blood requirements for the next 7 days.
Line 13: Narrative such as refrigerator needs repair or 30 units of type O red blood cells were received within the past 24 hours; 20 units of type O red blood cells were transfused; and no units were shipped.
Line 14: Message hour, minute, zone.
Line 15: Authentication, if required.

SAMPLE FORMAT 16

TEAM TRACKING CHART

Purpose: To maintain a current status on all teams deployed out of the ASMB/ASMC.

TEAM TRACKING CHART

TEAM/UNIT (MISSION)	LOCATION	DTG DEPART	DESTINATION AND ROUTE	DTG ARRIVE

SAMPLE FORMAT 17

COORDINATING INSTRUCTIONS

Purpose: To identify and maintain the status of coordinating instructions requirements.

COORDINATING INSTRUCTIONS

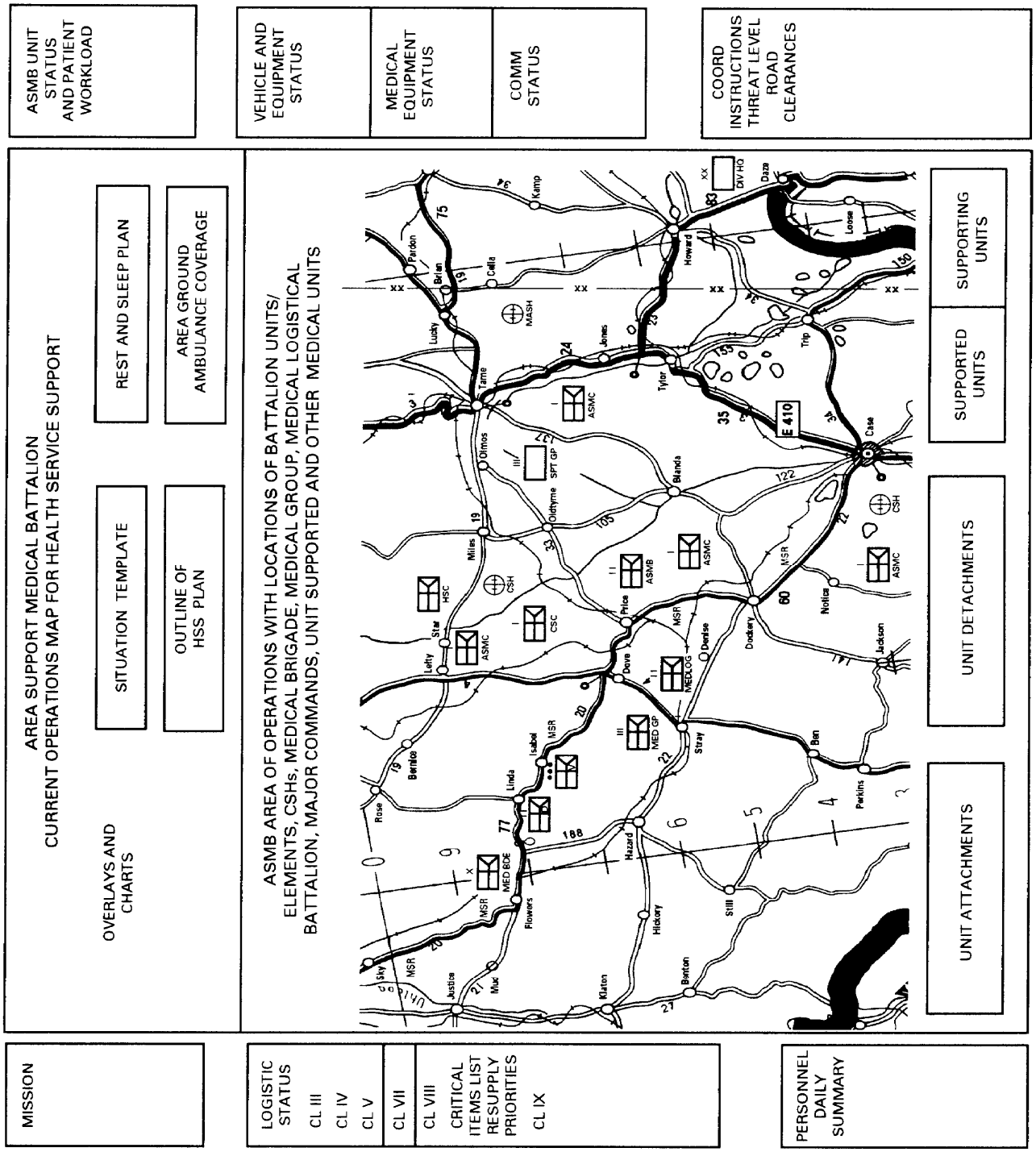
STAFF ACTIONS	THREAT LEVEL
COMMAND POST LOCATION	MOPP LEVEL
COMMANDER'S LOCATION	ASMC LOCATIONS
S3 LOCATION	LOGPAC TIME/PLACE
PRIORITY OF SUPPORT	WEATHER FORECAST

NOTES:

SAMPLE FORMAT 18

OPERATIONS MAP, CHARTS, AND OVERLAYS

Purpose: To use for conducting and synchronizing HSS operations and providing briefings as required.



APPENDIX B

FIELD WASTE

The accumulation and disposal of waste of all types is a major problem on the modern battlefield. Not only does this waste impact on military operations, but it also serves as a breeding ground for rodents and arthropods. Further the accumulation of waste contributes to environmental contamination.

Section I. OVERVIEW

B-1. General

All waste is disposed of in an environmentally acceptable manner consistent with good sanitary engineering principles and accomplishment of the unit mission. While operating outside the continental United States (OCONUS), either in training or actual contingency operations, the theater commander determines the applicability of both US and HN policies.

B-2. Responsibility for DisposaI of Waste

a. Depending on the nature and volume of the waste created, units generating the waste are responsible for its collection and disposal.

b. Certain types of waste require special handling that may be beyond the capability of the unit or facility. Further, units generating large amounts of waste, such as hospitals or MTFs, may not have the resources or equipment to properly dispose of solid waste. In these cases, supporting engineer units should be contacted to provide waste disposal support.

B-3. Categories of Waste

Waste can be subdivided into five distinct categories: general waste (including solid waste), hazardous waste, medical waste, human waste, and wastewater. Nonmedical solid waste (general and hazardous waste) is generated by all military units. Medical waste is only generated by medical elements, such as treatment, research, and laboratory.

a. General Waste. This category includes all waste not specifically classified as medical waste or hazardous waste. It includes items such as–

- Paper and plastic products (by far the most abundant solid waste generated in a field environment).
- Garbage (generated by dining facilities).
- Scrap material (wood, metal, and so forth).

b. Hazardous Waste. This includes wastes which are ignitable, corrosive, reactive, or toxic, especially POL and some chemicals, and which require special handling, transportation, disposal, and documentation. Supporting engineer and PVNTMED personnel can provide guidance and assistance in the handling and disposing of hazardous waste.

c. Medical Waste. Waste produced in a MTF (nongeneral) which contains pathogens of sufficient quantity and virulence to result in an infectious disease in a susceptible host.

d. Human Waste. This waste is comprised of feces and urine.

e. Wastewater. This includes liquid waste generated by laundry, shower, food service, and routine MTF operation.

Section II. GENERAL AND HAZARDOUS WASTE

B-4. General

General and hazardous waste are produced by all military units. The information contained in this appendix on these types of waste is minimal. The focus of this appendix is on the remaining categories of waste.

B-5. Sources of General and Hazardous Waste

a. The primary sources of general and hazardous waste are–

- Routine troop support operations.
- Maintenance and motor pool operations.
- Administrative functions.
- Dining facility operations.
- Medical treatment facilities.

b. In all of these operations or functions, a major effort must be made to reduce the amount of waste generated and thus, to lessen the burden on the disposal system.

B-6. Disposal of General and Hazardous Waste

Most general waste is buried or burned by the generating element. It can be transported in organic vehicles to a waste disposal point (sanitary landfill). It is important to remember, however, that vehicles used to transport waste must be properly cleaned and sanitized before being used for other operations. During training exercises, supporting engineer assets are responsible for the construction and operation of the landfills.

a. Putrescible waste from dining facilities, while not hazardous or infectious in and of itself, can become both a serious aesthetic problem and a breeding ground for disease-carrying rodents and arthropods. This class of solid waste must be removed and disposed of after every meal. Burial of this type of waste should be at least 30 yards (or meters) from the food service facility. Normally, one garbage pit is required per 100 soldiers per day (FM 21-10-1).

b. Used oil and other POL products are classified as hazardous waste. Disposal methods for this waste must comply with federal, state, local, and HN regulations. Military engineer and PVNTMED support elements can advise on required disposal procedures.

Section III. MEDICAL WASTE

B-7. General

A component of medical waste, infectious waste is defined as any waste generated by an MTF capable of producing infectious disease. For a waste to be infectious, it must contain (or potentially contain) pathogens of sufficient virulence to result in an infectious disease in a susceptible host.

B-8. Responsibility for Disposal of Medical Waste

a. Medical treatment facility commanders, assisted by their PVNTMED personnel, are responsible for implementing policies for medical waste management to include medical waste–

- Identification.
- Detection.
- Segregation.
- Handling.
- Storage.
- Disposal.

b. The medical company commander, a physician, is responsible for ensuring that procedures to control the spread of infectious diseases are instituted and enforced within the facility. Infectious control procedures are established to preclude the spread of infection within the MTF and to prevent the spread of infectious disease outside the facility.

B-9. Types of Medical Waste

All medical waste may be subject to an infectious nature. There are six types of medical waste requiring specific handling and disposal techniques.

a. Isolation Waste. This waste is generated by patients who are isolated to protect others from highly communicable disease. It includes–

(1) All discarded materials contaminated with blood, excretions, exudates, or secretions.

(2) Other than the initial triage, treatment, and further evacuation of these patients, the medical company does not generate a significant amount of this type of medical waste.

b. Microbiological Waste. This waste comes from cultures and stocks of infectious agents from medical laboratory elements, such as specimens or discarded vaccines from treatment areas.

c. Blood and Blood Products. This waste results from the use of all blood and blood-related products including blood bags, blood tubes, and other material contaminated with blood.

d. Contaminated Sharps.

(1) This particular waste includes, but is not limited to, used–

- Hypodermic needles and syringes.
- Pipettes.
- Glass tubes.
- Broken glassware.
- Scalpel blades.

(2) In addition to the physical hazards of sharps, there is the potential for transmission of pathogenic organisms from puncture wounds. Unused sharps should be considered dangerous as the same puncture hazard exists.

e. Surgical Waste. Surgical waste is the material that has been contaminated as the result of surgical procedures. Examples of this category include–

- Soiled dressings.
- Used sponges.
- Contaminated drainage tubes.
- Soiled surgical drapes and gloves.
- Other material discarded after completion of a procedure.

f. Pathological Waste. This waste is comprised of tissue, organs, body parts, and fluids

removed during a surgical procedure. Human corpses (remains), however, are not considered pathological waste and are handled by mortuary affairs elements.

B-10. Source of Medical Waste

a. The major sources of medical waste are patient care areas. In the medical company, this includes the EMT and triage areas, dental treatment area, the 72-hour patient-holding area, and the medical laboratory element. In the event that a surgical detachment is collocated with the medical company (or the surgical squads organic to the airborne/air assault division medical companies), additional medical waste will be generated by this element.

b. The actual amount of medical waste generated by the unit is dependent on the–

- Intensity of the tactical situation.
- Number of casualties (patient work load).
- Types of medical conditions.
- Complexity of medical procedures.
- Patient-holding considerations.

B-11. Handling and Transporting Medical Waste

a. Proper handling is the key to an effective waste program. Segregation of infectious waste from general waste at its source is a must. Procedures for handling medical waste are:

- Personnel who transport and dispose of infectious waste wear a disposable mask, butyl rubber apron, and gloves.
- Infectious waste is collected in double-lined impervious containers with tight fitting lids, if available; otherwise, double plastic bags are used. The containers are clearly labeled as infectious waste. All bags are sealed after being filled to only two-thirds capacity then sealed by lapping the gathered open end and binding it with tape or a closure device. This ensures that liquid waste cannot leak. A method of segregating infectious waste from general waste is the use of distinctly colored bags (red) for infectious waste, if available (AR 40-5).
- Sharps are placed in a rugged, clearly marked, puncture resistant container.
- Blood, blood products, and semi-solid waste are placed in unbreakable capped or stoppered containers.
- Medical waste is stored in designated areas, either secured or under direct physical control.
- Infectious waste is removed from the point of generation and is disposed of at least every 24 hours.

b. The transportation of medical waste within an MTF is in rigid, leakproof containers, marked and used exclusively for its transport. Vehicles used to transport medical waste to disposal sites should not be used for the transportation of rations, clean laundry, or medical supplies. Before the vehicle is used for other purposes, it must be thoroughly cleaned and sanitized using a 5 percent chlorine solution (48 ounces of chlorine granules in 5 gallons of water).

B-12. Disposing of Medical Waste

The purpose of properly treating and disposing of medical waste is to render it nonpathogenic an make it inaccessible. Depending on the quantity

and type of waste, command policies, availability of disposal facilities and engineer support, a variety of options exist. Every effort should be made to use the safest and most complete method of disposing of these materials.

a. Training and Tactical Deployment. During training deployment in CONUS and training and tactical deployment in many OCONUS locations (such as European), the HN environmental regulations are such that disposal of medical waste via field expedient methods is not permitted. Furthermore, the quantities and types of medical waste generated during training are relatively limited due to limited amount of actual patient care. As such, the option of choice is to haul the medical waste, via military vehicle or contract services, to fixed installations (preferably large fixed MTFs) for treatment and disposal according to command policies. While this option does not provide the most ideal training, it may be the only viable option available. The requirements for segregating and handling waste are critical and remains an essential part of training.

b. Steam Sterilization. Some types of medical waste, especially in small quantities, can be rendered nonpathogenic by autoclave (steam sterilization). This technique is particularly appropriate for small amounts of waste generated in EMT areas and the laboratory element (for example, contaminated dressings, needles, syringes, cultures, culture plates, pipettes, and blood tubes). To ensure complete disinfection, the steam sterilizer must operate at a minimum of 250°F (121°C) under 15-17 pounds of pressure per square inch (psi), for 45 minutes. Two factors must be kept in mind when using the autoclave: the size of the load placed in the chamber and the exposure time. There are a number of different types of autoclaves; therefore, for detailed information on the operation of a specific autoclave, refer to the manufacture's instructions or technical manual.

c. Controlled Incinerations. Incineration is the method of choice for most types of medical waste, but it must be controlled. Burning medical waste requires incinerators specifically designed for the various types of medical waste. During OCONUS mobilization deployment, an inclined plane incinerator (Figure B-1) is a field expedient when no other option is available. For the medical company to build and use this incinerator, there should be no immediate plans to move the unit location. This field expedient incinerator is a controlled open air burning method that can be used for burning small amounts of medical waste; however, command approval must be given prior to its use. Thorough consideration must be given to all available options before deciding to implement the open air burning method. This incinerator will dispose of trash and medical waste from a hospital or a smaller-sized MTF. The combustion achieved by this incinerator and the fact that it is not affected by light rain or wind makes it an excellent improvised device. Time and skill, however, are required in building it. A sheet metal plane is inserted through telescoped oil drums from which the ends have been removed. A loading or stoking platform is built; then one end of the plane drum device is fastened to it, thus creating an inclined plane (FM 21-10-1). Agrate is positioned at the lower end of the plane, and a wood or fuel oil fire is built under the grate. After the incinerator becomes hot, drained waste material is placed on the stoking platform. As the waste dries, it is pushed down the incline in small amounts to burn. Final combustion takes place on the grate. The operator of this device must wear gloves, a butyl rubber apron, and a disposable mask.

NOTE

In all cases, ash from waste incineration must be buried.

d. Disposal by Burying. As a last resort and with command approval, medical waste can be

buried. Engineer support is required for the design and construction of the waste disposal site. The waste must be covered immediately after disposal to ensure inaccessibility. All previous options are considered before accepting burial as the final option. Close coordination with PVNTMED personnel and HN authorities is essential.

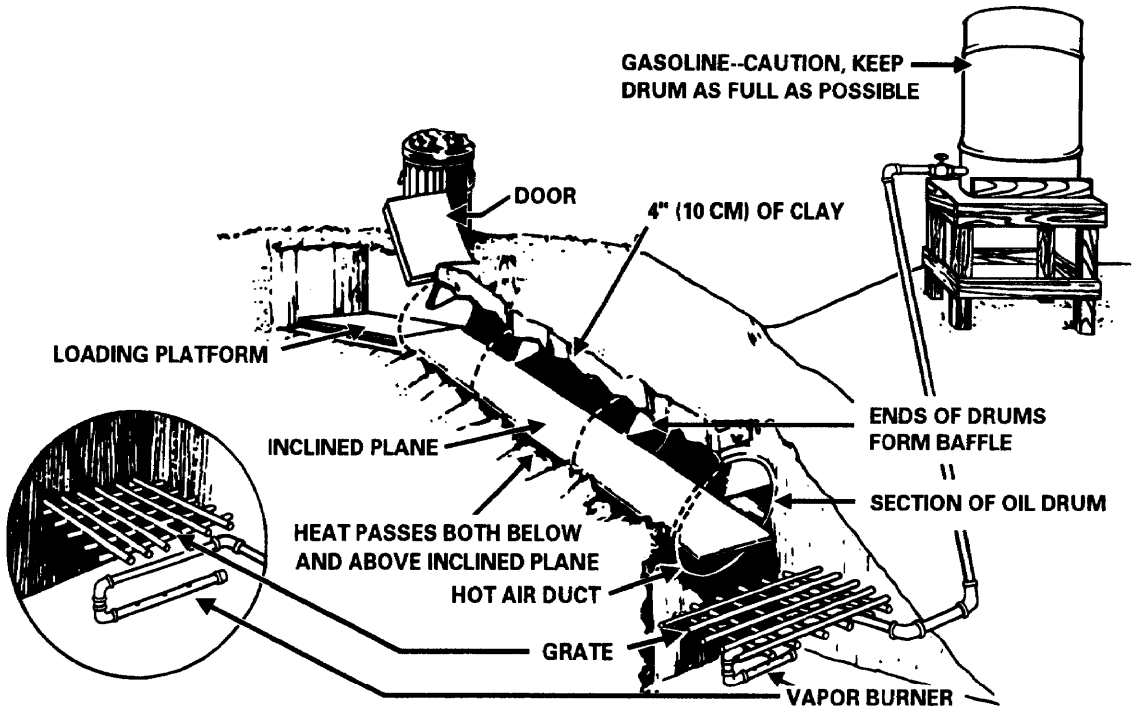


Figure B-1. Improvised inclined plane incinerator.

Section IV. HUMAN WASTE

B-13. General

Human waste (feces and urine) disposal is essential to prevent the spread of diseases caused by direct contact, contamination of water supplies, or dissemination by rodents or arthropods. It is even more critical at MTFs because patients are more susceptible to diseases transmitted through fecal contact. All human waste must be disposed of in a manner consistent with command policy and good sanitary engineering practices.

B-14. Responsibility for Disposal of Human Waste

The unit commander is responsible for providing the appropriate human waste disposal facilities. However, commanders of field MTFs may require engineer support in the construction of latrine facilities.

a. Field Medical Treatment Facilities. In some locations, construction and use of actual

field expedient waste facilities may be prohibited. In this case, one option is to obtain engineer support. The option of choice is to establish the MTF in an area with permanent or semipermanent latrine facilities already constructed and connected to an established sewage system. However, this may only be possible in some areas designated as deployment sites. In many instances, for MTFs located in the COMMZ, it may be possible to contract waste removal or latrine facilities through a HN support contract. Procedures will vary depending on the command policy and local (HN) agreements, but waste will still have to be separated into types by the unit. The use of chemical or self-contained toilets is another option instead of constructing field expedient latrines. In all types of arrangements, the unit field sanitation team and PVNTMED personnel are responsible for monitoring the achievement of field sanitation requirements (FM 21-10-1).

b. Field Expedient Facilities.

(1) *Type selection.*

(a) The type of field latrine selected for a given situation depends on a variety of factors, such as–

- Number of personnel (staff and patients).
- Duration of stay at the site.
- Geological and climatic conditions.

(b) Supporting PVNTMED personnel and the unit's field sanitation team can assist the commander in determining the appropriate type of latrines, their locations, and size.

(c) Specific guidance on selection criteria is provided in FMs 21-10 and 21-10-1.

(2) *Location.* Location of MTF latrines is a compromise between the requirement for physical separation from dining facilities, water sources, and the like, and convenience of access for staff and ambulatory patients. Multiple latrine sites may be required depending on the size of unit area and distances between patient care, administrative, and sleeping areas.

(3) *Maintenance.* Sanitation and maintenance of the MTF latrine facilities are critical to prevent disease transmission. Handwashing facilities must be placed at each latrine.

(4) *Closing and marking.* The closing and marking of latrines is accomplished according to command policy and good field sanitation practices.

B-15. Patient Facilities

As the medical company has a limited holding capability, most of patients treated and held at the MTF are ambulatory patients. However, due to the tactical situation, inclement weather, or other contingencies, litter patients may have to be held for periods greater than 72 hours. The unit TSOP should, therefore, include instructions for both types of patients.

a. Ambulatory patients will use the same latrines as the staff. The number of latrines established will be based on both the number of staff and the anticipated patient load. However, male and female latrines are required. Latrines need to be close enough to the holding areas for convenience of access while still maintaining distances from the dining facilities, water sources, and the like.

b. Nonambulatory patients require the use of bedpans and urinals. Disposal (of fecal and urine) and sanitation of bedpans and urinals for the nonambulatory patient is a major concern.

A designated area is established for bedpan cleaning and sanitizing. The sinks or handwashing facilities within the MTF should not be used for bedpan/urinal disposal or washing. An area should be established similar to that of a mess kit laundry line, using metal garbage cans and immersion heaters. One can must have warm soapy water and while the other can has clear boiling rinse water. These containers must be clearly marked for use in cleaning bedpans and urinals only.

SectionV. WASTEWATER

B-16. General

a. Water usage results in the production of wastewater which requires disposal. Depending on the source, wastewater may contain–

- Suspended solids and particulate matter.
- Grease.
- Organic material.
- Dissolved salts.
- Biological, pathological and pathogenic organisms.
- Toxic elements.

b. Just the volume of wastewater alone, without consideration of the various contaminants, can cause significant operational problems in the field environment.

B-17. Requirement for Disposal

a. All wastewater and water soluble wastes generated in a field environment must be collected and disposed of in a manner that–

- Protects water resources from contamination.
- Preserves public health while minimizing mission impairment or adversely impacting on the readiness of the force.

When operating OCONUS, units may have to comply with applicable HN laws and procedures; this is determined by the theater commander. In an actual contingency operation, the theater commander (with input from the command surgeon) determines the applicability of local environmental laws in the AO. Irrespective of laws and regulations, proper disposal of wastewater is essential to protect the health of the force by precluding contamination of water supplies and the development of rodent and arthropod breeding sites. Further, large volumes of wastewater in an AO can impact adversely on functions of US military units and may even aid an adversary in locating and identifying them.

B-18. Responsibility for Disposal

Units generating wastewater in the field are responsible for their own wastewater collection and disposal. However, large volume wastewater generators, such as some MTFs, may require some engineer support. Theater combat engineers provide support during OCONUS deployments or contingency operations. In any case, the unit commander has the final responsibility for coordinating disposal of his unit's wastewater.

B-19. Wastewater Sources and Collection

Medical treatment facilities generate a significant volume of wastewater corresponding to the volume of water consumed for the various functional areas. A conservative estimate of wastewater volume for planning purposes is that 80 percent of all water

used (other than for human consumption) will end up as wastewater. The largest volumes of wastewater are generated by support operations of MTFs such as laundry, shower, and food service operations. While this type of wastewater is not unique to MTFs, it will contribute to an enormous volume requiring collection and disposal. On the other hand, wastewater generated from direct patient care functions is unique to the MTFs and may be contaminated with blood, other body fluids, particulate matter, and potentially infectious organisms. In addition to the quantity of wastewater, an added problem is the multiplicity of sources within the MTF that contribute to the complexity of collection.

a. Field Sinks. Field sinks are the primary source of wastewater for staff handwashing, patient hygiene, instrument cleaning, and the like. This liquid waste is generated intermittently, and volume is highly variable depending on the functional area and patient work load. The sinks can operate with the drain line placed in an empty 5-gallon water can. This can must be periodically emptied into a disposal system. If wastewater collection cans are not used, the sinks must be connected to drains that lead to soakage pits or sewer systems; otherwise, the wastewater will collect at the immediate exterior of the MTF shelter. If not collected the volume of wastewater will result in an unacceptable pooling through out the MTF area.

CAUTION

Extreme care must be taken to ensure that the 5-gallon cans used for wastewater are not mistaken or confused with the 5-gallon cans used for potable water; Clear labeling and safe-distance separations between the two are critically essential.

b. Medical Treatment Facility Sources. Sources of wastewater other than sinks are limited and will generate relatively small volumes of wastewater. In most cases, this wastewater can be collected and discharged into a nearby sink. An exception may be the water used for facility and major equipment sanitation; for example, wastewater from washing litters, ambulances, and other medical materiel.

c. Field Showers.

(1) While not an actual part of the MTF, quartermaster field showers may be collocated with or near the MTF to support both patient and staff. These showers may also support personnel of other units within the area. The quartermaster personnel operating field showers are responsible for wastewater collection and disposal. In some situations, the disposal of this wastewater maybe in conjunction with that of the MTF.

(2) If quartermaster support is not available, field expedient showers must be established by the medical company (FM 21-10 and FM 21-10-1). The medical unit is responsible for the collection and disposal of this wastewater.

d. Field Laundries. The field laundry is one of the largest generators of wastewater. Field laundries may be collocated with or near MTFs to provide support and can present an inordinate wastewater disposal problem. Like the showers, quartermaster personnel operating laundries are responsible for wastewater collection and disposal. Because of the large volume of water required for laundry operations, the facility may have to be located away from an MTF and closer to a water source. In effect, this reduces or removes a portion of the wastewater disposal problem within the immediate MTF area. (Preventive medicine personnel must ensure that laundry personnel are trained in and properly implementing procedures for handling contaminated linens.)

e. *Field Kitchen.* Army field kitchens are also significant sources of wastewater. In addition to the volume, the greases and particulate matter in wastewater from a field kitchen must be dealt with in a much more deliberate manner. For instance, grease traps must be constructed to remove food particles and grease from the kitchen wastewater before disposal. Information for the construction and operation of the filter and baffle grease traps is provided in FM 21-10 and FM 21-10-1. Also, commanders may obtain technical assistance from the supporting PVNTMED element.

B-20. Disposal of Wastewater

a. Indisposing of wastewater, a number of factors should be considered. These include—

- Volume and characteristics of the waste.
- Operational considerations (duration of stay in a given location and the intensity of combat operations).
- Geological conditions (type of terrain and soil characteristics or depth of water table).
- Climatic conditions.
- Availability of engineer support.
- Accessibility of established sewage collection, treatment, and disposal systems.
- Applicability of command environmental programs.

b. In light of the above factors, there are a number of wastewater disposal alternatives that an MTF commander may select. These include–

- Connection to an established sanitary sewer system.
- Collection and holding of wastewater for engineer or HN removal to a fixed wastewater treatment facility.
- Engineer-constructed semipermanent wastewater collection and disposal system.
- Unit-constructed field expedient wastewater disposal system.

c. In many OCONUS noncombat operations, especially in the more developed countries, use of existing disposal facilities should be the method of choice. Even in some contingency operations, preplanned siting of MTFs can take advantage of preestablished connections to the existing sewer system. Assistance from supporting engineers is required to establish the necessary connections and access to the sewer system. However, grease traps or filters may still have to be used in some areas, such as the dining facility. Traps and filters are required to remove grease and particulate matter that would adversely affect the operation of the wastewater pumps.

d. If use of a HN sewer is possible, but direct connection is not readily available, an alternate approach is to consolidate and collect wastewater in containers for eventual removal to a sewage treatment plant or sanitary sewer access by supporting engineers or a HN agency. As these storage containers are not part of the MTFs TOE and the wastewater tanks trucks and pumping equipment are not standard engineer equipment, this option requires extensive prior planning and coordination.

e. All AMEDD personnel are required to know how to construct and operate field expedient waste facilities. Traditional field expedient methods of wastewater disposal consist of soakage pits, soakage trenches, and/or evaporation beds. The effectiveness of these methods depends on the geological conditions and the climate. While these

disposal devices, especially soakage pits, are constructed for small volumes of wastewater, with proper design and operation they can be effective for larger volumes. Because these methods result in final disposal, it is necessary to remove grease, particulate matter, and other such organic material that could reduce the effectiveness of the process. Guidance on designs and construction of these devices is available in FMs 21-10 and 21-10-1 and from PVNTMED personnel.

f. In arctic environments, or when geological or climatic conditions are such that soakage or evaporation is not possible, the only field expedient alternative may be to collect the wastewater in tanks or drums for removal by Army engineer or HN operators.

APPENDIX C

SAFETY

Section I. INTRODUCTION

C-1. General

Commanders and unit leaders at all levels are responsible to protect and preserve Army personnel and equipment against injury, damage, or loss. This appendix looks first at general safety applicable to all units when in a field environment, and second, at specific safety considerations for medical units. Functions of the DOD Federal Hazard Communication Training Program and the US Army Environmental Hygiene Agency are also discussed.

C-2. Safety Policy and Program

An effective safety program is essential to any unit. Leaders must stress the importance of constant vigilance to detect potential hazards and reduce or eliminate these hazards.

a. *Policy.* The safety policy of the Army is to reduce and keep to a minimum accident-related manpower (and monetary) losses, thus providing more efficient use of resources and advancing combat effectiveness.

b. *Program.* The unit safety program should be designed to cover all operations and take into consideration all conditions peculiar to the specific operation of the unit. Implementation of the program includes the establishment of a safety organization consisting of a unit safety officer responsible for the supervision and coordination of all unit safety activities and other personnel as required to assist him (see AR 385-10).

C-3. Responsibility for Accident Prevention

a. *Commander.* The unit commander is responsible for ensuring that all activities of his unit are conducted according to established safety rules for determining causes of accidents and for seeing that corrective action is taken immediately to prevent their recurrence. He must be aware of and enforce all safety regulations promulgated by higher headquarters. If a deviation from an established safety rule is necessary, it is his responsibility to request permission for the deviation. The unit commander appoints the unit safety officer (see AR 385-10).

b. *Unit Safety Officer.* The unit safety officer, with the concurrence of the commanding officer and within his guidelines, develops directives, policies, plans, and procedures for the safety program.

c. *Supervisors.* Supervision is a method of preventing accidents through continuous instruction and guidance in the development of good work habits. Supervisors are in a position to observe working conditions and the hazards to which operating personnel are exposed.

d. *Individuals.* All personnel should be made to realize that safety rules have been established for their protection. It is their responsibility to follow all instructions and to use all safeguards when using equipment, machinery, and tools.

C-4. Principles of Accident Prevention

An effective safety program depends on the proper application of accident prevention principles.

a. *Stimulation of Interest.* Emphasis on safety must be vigorous and continuous and it must originate with the unit commander. Group discussions, safety meetings, bulletin board notices, posters, and recognition of individuals for participation create interest in the safety program.

b. Fact Finding. This refers to the assembly of information bearing upon the occurrence of accidents. For each accident, the following facts should be determined:

(1) Who was injured and what was damaged.

(2) The time and place where the accident or injury occurred.

(3) The severity and cost of the accident or injury.

(4) The nature of the accident or injury.

(5) Measures that can be instituted to guard against future recurrences.

c. Corrective Action Based on Facts. Any corrective action that is adopted should be based on available and pertinent facts surrounding the accident or injury. Near accidents also should be reported with all available information so that hazards and unsafe procedures or conditions can be eliminated. Similarly, any procedure or condition which might be dangerous should be reported so that remedial action can be instituted.

d. Applicability. Practicable safety controls should be provided in all planning, training, tactical operations, professional activities, and off-duty activities.

e. Safety Education and Training. The objectives of safety education and training are to develop the individual's safety awareness so he performs his tasks with minimal risk to himself and to others.

f. Inspections. The purpose of safety inspections is to eliminate the cause of accidents through specific, methodical procedures.

C-5. Safety Plan

Many items that can be included in any safety plan are listed below, but the list is neither all-inclusive nor restrictive. Certain conditions or geographical areas may require guidance to conform with those needs. Precautions for certain medical/dental procedures or equipment are included here.

Accident Reporting. Basic to any safety plan *is* accident reporting. A definite procedure should be established that emphasizes prompt and complete reporting of all accidents or injuries (AR 385-40). The unit commander or his designated representative should investigate all accidents or injuries to determine the causes and take corrective action to prevent their recurrence. Any accident resulting in damage to equipment should be reported immediately. Continued operation of damaged equipment can result in subsequent injuries to personnel.

b. Safety Color Code Markings and Signs. Safety color codes prescribe the use of color combinations that are effective in preventing accidents and in improving production, visual perception, and housekeeping. The code defines the application of colors for such specific purposes as the uniform markings of physical hazards, showing the location of safety equipment, identifying fire fighting equipment, and designating colors to be used if local conditions warrant the use of color coding (AR 385-30).

c. Fire Prevention.

(1) A unit fire plan or fire SOP should be included in the safety program. It should contain fire prevention guidance and information on what to do if a fire occurs.

(2) NO SMOKING signs are posted wherever fire hazards exist. Smoking should be permitted only in designated safety areas. Firefighting equipment should be available, and all

personnel should be familiar with its location and operation. This equipment should be inspected frequently to determine if it is serviceable and operable. Fire drills should be conducted often enough for all personnel to be familiar with the procedures. Guard personnel should be alert to fire hazards at night. Gasoline, oil, paint, and other flammables will be stored in approved locations and in authorized containers. Oxygen and acetylene tanks must be stored separately and away from other flammables.

d. Generators. Generators in the field produce the same potential electrical hazards that are found with electricity at permanent installations and demand the same precautions. Personnel working around generators or electrical wiring will remove rings and watches. Generators should be grounded and not refueled while they are in operation. Generators used for patient treatment areas will be located to reduce, as much as possible, their noise in the operative area.

e. Housekeeping. Professional and administrative areas must be kept clean and orderly at all times. Hazards to personnel and equipment can be eliminated or controlled by enforcing high housekeeping standards.

f. Heaters. When heaters are used, they should be watched closely as potential fire hazards. Spark arrestors or flue guards on stove exhaust pipes and metal shields in stovepipe openings in tents are used when heaters are in operation. Fire guards are utilized when stoves are in use to monitor stoves for correct operations and to alert others of any potential fire hazards.

g. M2 Burner Unit. The M2 burner unit is a heat source used in cooking. These units require safety precautions and trained operators who know what to do if the burners malfunction or afire starts. Commanders may direct that operators be licensed on the burner. The burner units have one U-shaped tank that contains fuel under pressure. When the burners are used, they are closely monitored because of potential fire and safety hazards. Burners must be used in well-ventilated areas because of the build-up of carbon monoxide gas produced during use.

h. Vehicle Operation. See AR 385-55, DA PAM 738-750, and TM 938-750 for guidance on how to operate government vehicles.

i. Weapons and Ammunition. Continual command emphasis should be directed toward training each unit member the correct methods of handling weapons and ammunition. Training should begin when an individual joins the unit. Commanders should ensure that all medical/dental personnel are briefed on the handling of weapons which inadvertently accompany patients that are evacuated to the treatment facility. Weapons of unit personnel should be cleared and placed on safety until required otherwise. (Army Regulation 190-11 and FM 19-30 provide guidance on the physical security of weapons and ammunition.)

C-6. Accident Investigation and Reporting

a. Investigations. Accident investigation is necessary for accident prevention. Investigation seeks to determine the cause of accidents by finding the elements and sources from which accidents develop. Corrective measures may then be instituted.

b. Reporting. In accordance with AR 385-40, the Army accident reporting system provides for the initial reporting of accidents at unit level. This is done to notify the higher echelon of command that a mishap has occurred; to record information that will identify causes and corrective actions, indicate trends, and provide a basis for formulating future plans; and to evaluate progress in accident prevention.

Section II. DEPLOYED MEDICAL UNIT SAFETY CONSIDERATIONS

C-7. X-ray Protective Measures and Standards

a. General. Every possible safety precaution must be used when exposing radiographs. If all safety rules are strictly adhered to, medical personnel should receive virtually no radiation, and the patient's exposure will be minimal.

b. Medical Personnel Protection and Standards.

(1) *Radiation monitoring.* Army Regulation 40-14 prescribes monitoring practices for Army personnel. It requires all x-ray technicians or other personnel who are likely to take x-rays as part of their normal duties to wear a dosimeter. The unit's medical supply personnel should coordinate dosimeter support with the US Army Ionizing Radiation Dosimetry Center (USAIRDC). The dosimeter monitors the amount of whole body radiation received by the individual. The dosimeter will be worn below the shoulders and above the hips on the outside of the clothing. Results are maintained at the USAIRDC and reports are submitted quarterly.

(2) *Care and handling of dosimeter.* When not being used, dosimeters will be stored in such a manner to avoid accidental exposure.

(3) *Radiation standards.* For the personnel operating diagnostic (medical and dental) x-ray machines, the level of radiation must never exceed an accumulated whole body dose in rems of 5 rems per year and 1.25 rems in a continuous 3 month (that is, quarter) period.

(4) *Protective shielding.* Fixed medical facilities use lead shielding to protect those working in the area where diagnostic x-rays are taken. However, the potential of finding lead-lined facilities in a deployed environment is limited. Therefore, deployed units must use buildings of opportunity or field sites in tents.

(a) Buildings of opportunity.

- When using field x-ray apparatus in a building of opportunity, a major consideration is the location of a room or an isolated area where access can be easily controlled. This area should have at least one, preferably two, wall common to the building exterior. Adjoining rooms should be unoccupied.

- The x-ray apparatus should be positioned to maximize the distance from the back of the x-ray tube head to the operator. The apparatus should be positioned so that the x-ray beam will not routinely be directed toward occupied space or heavily traveled passageways.

- The operator should wear a lead apron when a protective barrier is not available.

- The unoccupied area outside the building should be cleared of personnel for at least 50 feet from the x-ray head. This exclusion area should include all potential areas toward which the x-ray beam may be directed. The 50-foot exclusion area fulfills the requirements of TB MED 521 for both the Siemens and the hand-held field x-rays.

(b) Field sites in tents. Field x-ray apparatus should be placed in a separate tent located on the outer perimeter with a clear area of a minimum of 50 feet. This area should be marked off using engineer tape and radiation hazard signs in accordance with unit SOP. Prior to operating an x-ray unit in a tent, check to ensure no one is in the exclusion area.

(5) *Patient protection.* Use all means available to reduce the patient's exposure to ionizing radiation. The following practices will be helpful:

- Take only those x-rays that are required for diagnosis and treatment.

• Avoid wrong exposures, improper exposure techniques, and faulty film processing techniques.

• Use a lead apron with a cervical collar for each exposure.

• Check the patient's medical history.

• Use the most sensitive emulsion film available.

(6) X-ray system, dental, miniature (hand-held x-ray). The hand-held x-ray unit is safe for dental personnel to hold during use if the following guidelines are followed:

• The operator must keep the radiation shielding ring flat against the skin of the patient's face.

• The operator must stand so that his body is in line with the long axis of the x-ray tube.

If these precautions are followed, the operator is exposed negligible exposure. Therefore, an operator should be able to make unlimited exposures each year, keeping the annual rate below 5 rems. Even though this system actually exposes the patient to less radiation than other dental x-ray systems, an important consideration is an exclusion area beyond the patient as discussed in paragraph C-7 *b* (4) above.

C-8. X-ray Processing

When working with the film-processing chemical, personnel will use protective eyewear, gloves, and aprons. Used x-ray fixer/developer is hazardous waste.

C-9. Hearing Conservation

a. Department of the Army Pamphlet 40-501 provides the guidance on units' hearing conservation programs.

b. Units will contact the PVNTMED activity of the area medical support activity for identification of noise-hazardous equipment, job sites, and exposed personnel. This will be accomplished by conducting noise-level surveys on field dental equipment (that is, compressors, generators, dental handpieces, field laboratory equipment, and military vehicles). These data will be used for planning and prioritizing screening tests for those individuals exposed in their work environment.

c. Personnel identified in this survey will be entered in the hearing conservation program and monitored by the medical unit for response to noise exposure and adequacy of hearing-protective devices by periodic testing of hearing levels. Audiograms will be conducted annually as a minimum.

d. Hearing protection will be issued to all unit personnel and its use will be required when operating or in proximity to generators, compressors, field laboratory equipment, and tactical vehicles, 2-½ tons and larger. Areas around this equipment should be indicated by placing NOISE HAZARDOUS AREA, HEARING PROTECTION REQUIRED signs as directed in the unit SOP.

C-10. Compressed Gas Cylinders

All compressed gas cylinders should be considered full for handling purposes. They should never be dropped or struck by any object. While cylinders are being transported in vehicles, they should be restrained to prevent them from falling. Cylinders must be protected from dampness and excessive

temperatures. Smoking should be prohibited near a cylinder. Valve protection caps must be installed on each cylinder. Oxygen cylinders must be tested for purity with an oxygen monitor. A log book must be maintained, as well as tags placed on each cylinder to indicate when tested and with the signature of tester. Oxygen cylinders must be pressure tested every 5 years with date stamped into the metal to indicate when tested. Oxygen should be stored in areas separated from flammable gases by at least 50 feet. Oxygen should be separated from acetylene gas by at least 100 feet. Gases used in dental laboratory procedures require caution in handling.

C-11. Flammable or Explosive Materials

These materials must be stored in National Fire Protection Association approved flammable storage cabinets and away from any potential source of ignition. Acids used in dental laboratory procedures will be stored in noncorrosive containers and cabinets designed to hold caustic corrosive materials.

C-12. Special Equipment

Individuals using high speed dental units and those working in the dental laboratory are required to use safety eyewear to prevent injuries to their eyes.

C-13. Scrap Amalgam

Scrap dental amalgam should be kept under silver-free or fresh x-ray fixer.

C-14. Department of Defense Federal Hazard Communication Training Program

Department of Defense Instruction 6050.5, January 25, 1978, directed the elements of DOD to develop a training program to meet the requirements of the Occupational Safety and Health Administration's (OSHA) Hazard Communication Standard (29 C.F.R.. 1910.1200). The OSHA issued this standard to ensure everyone's right to work in a safe and healthful environment. It requires that all personnel understand the hazards of the materials they work with and know how to minimize these hazards. Material safety data sheets should be maintained at each work location that list personnel trained in the hazards of their occupation. It also lists all hazardous materials along with their specific hazards.

C-15. United States Army Environmental Hygiene Agency

The USAEHA has the mission of looking out for the soldiers' welfare worldwide. The USAEHA is an excellent source for advice and assistance in areas related to environmental quality or occupational health. Any Army official safety representative (for example, unit safety officer) can request assistance from this organization. Potential areas for assistance include, but are not limited to–

- Technical assistance on monitoring the use of ionizing radiation, telephone Defense Switching Network (DSN) 584-3526.
- Tactical unit hazardous waste management on-site visits, DSN 584-3651.
- Dental safety program on-site visits, DSN 584-3040.

The USAEHA also provides document review services which may be of assistance in evaluating a unit safety program.

C-16. Infection Control

Special precautions must be taken during patient treatment procedures to avoid the transmission of infections. Infection control, to include contaminated medical waste disposal, is covered in detail in Appendix B.

APPENDIX D

MEDICAL LABORATORY CAPABILITIES

D-1. General

The medical laboratory capability at Echelon II is extremely limited. This appendix provides information on the medical laboratory capabilities of Echelons II through IV MTFs.

D-2. Capabilities

Tables D-l through D-3 discuss what laboratory procedures can be accomplished at each echelon of care.

Table D-1. Medical Laboratory Procedures, Biochemistry

Description	Area Support Squad	MASH	CSH	FH	GH
Perform blood gas analysis		X	X	X	X
Perform electrolyte levels (Na, K, Cl, CO_2)		X	X	X	X
Determine total serum protein			X	X	X
Determine serum creatinine			X	X	X
Determine serum amylase			X	X	X
Determine serum AST activity			X	X	X
Determine serum ALT activity			X	X	X
Determine CK level			X	X	X
Determine serum glucose		X	X	X	X
Determine serum urea nitrogen		X	X	X	X
Determine serum T. bilirubin			X	X	X
Determine serum calcium			X	X	X
Determine CSF glucose			X	X	X
Determine CSF protein			X	X	X
Determine urine protein				X	X
Determine urine glucose				X	X

Table D-2. Medical Laboratory Procedures, Hematology / Urinalysis

Description	Area Support Squad	MASH	CSH	FH	GH
Perform white cell count	X	X	X	X	X
Perform CBC count (WBC, Hct, Gran Ct, % Gran, Plt, Lymph/ Mono Count and %)		X	X	X	X
Determine hematocrit	X	X	X	X	X
Perform WBC differential	X	X	X	X	X
Perform prothrombin time (PT)			X	X	X
Perform partial thromboplastin time (APTT)			X	X	X
Perform CSF count and differential		X	X	X	X
Perform urinalysis (Dipstick)	X	X	X	X	X
Perform urinalysis (microscopic)	X	X	X	X	X
Perform platelet estimate	X	X	X	X	X
Perform platelet count			X	X	X
Determine fibrinogen level				X	X
Determine fibrin split products				X	X

Table D-3. Medical Laboratory Procedures, Microbiology / Serology / Blood Bank

Description	Area Support Squad	MASH	CSH	FH	GH
Perform occult blood test	X		X	X	X
Perform thick and thin smears for malaria	X		X	X	X
Perform gram stains	X	X	X	X	X
Perform rapid plasma reagin (RPR) (syphilis)			X	X	X
Perform IM test (infectious mononucelous)			X	X	X
Examine feces for ova, cysts, and parasites			X	X	X
Perform potassium hydroxide (KOH) preparations			X	X	X
Perform pregnancy tests			X	X	X
Perform urine cultures (colony counts and sensitivity)			X*	X	X
Perform wound culture and sensitivity			X*	X	X
Perform blood culture and sensitivity				X	X
Perform sputum culture and sensitivity				X	X
Perform stool culture and sensitivity				X	X
Perform CSF culture and sensitivity				X	X
Perform culture and sensitivity for gonorrhea			X*	X	X
Perform throat cultures			X*	X	X
Perform microscopic exams for acid-fast bacteria				X	X
Identify anaerobes					X
Perform blood group and type (ABO, RH)		X	X	X	X
Perform blood crossmatches			X	X	X
Thaw fresh frozen plasma		X	X	X	X
Prepare platelet concentrate			X	X	X

*Requires microbiology augmentation set.

GLOSSARY

ABBREVIATIONS, ACRONYMS, AND DEFINITIONS

ACR armored cavalry regiment

ACUS area common user system

advanced trauma management This is the resuscitative and stabilizing medical or surgical treatment provided to patients to save life or limb and to prepare them for further evacuation without jeopardizing their well-being, or prolong the state of their condition.

ALO authorized level of organization

AM amplitude modulation

amb ambulance

ambulance exchange point A point in an ambulance shuttle system where a patient is transferred from one ambulance to another en route to a medical treatment facility.

AMEDD Army Medical Department

ANSI American National Standards Institute

AO *See* area of operation.

AOAP Army Oil Analysis Program

AOC area of concentration

AR Army regulation

area of operation That portion of an area of conflict necessary for military operations. Areas of operations are geographical areas assigned to commanders for which they have responsibility and in which they have authority to conduct military operations.

AS area support

ASMB area support medical battalion

ASMC area support medical company

assign(ed) 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 of personnel for the primary function, or greater portion of the functions, of the unit or personnel. (*See also* attached; operational control; operational command; organic.)

ATCCS Army Tactical Command and Control System

ATM *See* advanced trauma management.

ATP ammunition transfer point

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 there over as he does over units and personnel organic to his command. However, the responsibility for transfer and promotion of personnel will normally be retained by the parent formation, unit, or organization. (*See also* assigned; operational control; operational command; organic.)

attn attention

AXP *See* ambulance exchange point.

BAS battalion aid station

BCOC base cluster operations center

BDAR battle damage assessment and repairs

BF battle fatigue

BLDREP blood report

bn battalion

brigade support area A designated area in which combat service support elements from division support command and corps support command provide logistics 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.

C2 *See* command and control.

C3 command, control, and communications

C4I command, control, communications, computers, and intelligence

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.

CE communications-electronics

clearing station An operating field medical facility established by a clearing company or medical company which provides emergency or resuscitative treatment for patients until evacuated and definitive treatment for patients with minor illness, wounds, or injuries.

cmd command

CMO civil-military operations

co company

combat service support The support provided to sustain combat forces, primarily in the fields of administration and logistics. It may include administrative services, chaplain service, civil affairs, food service, finance, legal service, maintenance, medical service, military police supply, transportation, and other logistical services. The basic mission of combat service support is to develop and maintain maximum combat power through the support of weapons systems.

combat stress control A coordinated program, conducted by unit mental health personnel plus echelon above division combat stress control units, for the prevention, triage, and treatment of each echelon of battle fatigue to maximize rapid return to duty and minimize misconduct combat stress reactions and post-traumatic stress disorders.

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 zone That area required by combat forces for the conduct of operations. It is the territory forward of the Army rear area boundary.

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.

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

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.

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, establishment for supply and evacuation, and other agencies required for the immediate support and maintenance of the field forces.

COMMZ *See* communications zone.

COMSEC *See* communications security.

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 assumption or intent in regard to an operation or a series of operations; includes, at a minimum, the scheme of maneuver and fire support plan. The concept of operations is embodied in campaign plans and operations plans, particularly when the plans cover a series of connected operations to be carried out simultaneously or in secession. 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

coord coordinating

COSCOM corps support command

CP *See* command post.

CPT captain

CS *See* combat support.

CSA corps support area

CSB corps support battalion

CSC *See* combat stress control.

CSG corps support group

CSH combat support hospital

CSM command sergeant major

CSS *See* combat service support.

CZ *See* combat zone.

DA Department of the Army

DC Dental Corps

DD/DOD Department of Defense

DDL daily disposition log

DES dental equipment set

diff differential

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. (*See also* general support.)

DISCOM division support command

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

division support area An area normally located in the division rear positioned near air landing facilities and along the main supply route. The division support area contains the division support command, command post, the headquarters element of the division support command battalions, and those division support command elements charged with providing backup support to combat service support elements in the brigade support area and direct support to units located in the division rear. Selected corps support command elements may located in the division support area to provide direct support backup and general support, as required.

DMOC division medical operations center

DNBI disease and nonbattle injury

DS *See* direct support.

DSA *See* division support area.

DSN Defense Switching Network

DTG date-time group

EAC *See* echelons above corps.

echelon of care This is a North Atlantic Treaty Organization term which can be used interchangeably with the term level of care.

echelons above corps Army headquarters and organizations that provide the interface between the theater commander (joint or combined) and the corps for operational matters, and between the continental United States/host nation and the deployed corps for combat service support. Operational echelons above corps may be United States only or allied headquarters, while echelons above corps for combat service support will normally be United States national organizations.

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 to a new site where, after it becomes operational, it is joined by the base element.

echelonment An arrangement of personnel and equipment into assault, combat follow up, and rear components or group.

EEFI *See* essential elements of friendly information.

EEI essential elements of information

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

EMT *See* emergency medical treatment.

EPW enemy prisoner(s) 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 activity 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 while providing en route medical care.

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.

ext extinguisher

FAX facsimile

FH field hospital

1SG first sergeant

fld field

FLOT *See* forward line of own troops.

FM field manual; frequency modulation

FMC US Field Medical Card

forward line of own troops A line that indicates the most forward position 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.

FRAGO fragmentary order

FSB forward support battalion

FSMC forward support medical company

G1 Assistant Chief of Staff (Personnel)

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

GH general hospital

GP general purpose

GS *See* general support

health service support This term is used in current doctrine to include all 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.

HHC headquarters and headquarters company

HMMWV high-mobility multipurpose wheeled vehicle

HN *See* host nation.

host nation A nation which receives the forces and/or supplies of Allied nations and/or NATO organizations to be located on, or to operate in or to transit through its territory.

host-nation support Civil and military assistance rendered by a nation to foreign forces within its territories during peacetime, times of crisis/emergencies or war based on agreements mutually concluded between nations.

HSC headquarters and support company

HSMO health services materiel officer

HSS *See* health service support.

IHFR improved high-frequency radio

ISB intermediate staging base

kw kilowatt

lg large

LOGMARS Logistic Applications of Automated Marking and Reading Symbols

LOGPAC logistics package

LT lieutenant

LTC lieutenant colonel

MA mortuary affairs

MAJ major

MASH mobile army surgical hospital

MC Medical Corps

med medical; medium

MEDCOM medical command

medical equipment set(s) Chest(s) containing medical instruments and supplies designed for specific table(s) of organization and equipment units or missions.

medical intelligence That intelligence produced from the collecting, evaluation, and analysis of information concerning the medical aspects of foreign areas which have immediate or potential impact on policies, plans, and operations.

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

MEDSUP medical supply

MES *See* medical equipment set.

METL mission-essential task list

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

MH mental health

mobility The percentage of organic equipment and personnel that can be moved in a single lift using organic vehicles. It does not include patients in the medical treatment facility.

MOPP mission-oriented protective posture

MOS military occupational specialty

MPL mandatory parts list

MRO medical regulating officer

MS Medical Service Corps

MSB main support battalion

MSE mobile subscriber equipment

MSMC main support medical company

MSR main supply route

MSRT mobile subscriber radio-telephone terminal

MT maintenance teams

MTF *See* medical treatment facility.

NATO North Atlantic Treaty Organization

NBC nuclear, biological, and chemical

NC node center

NCO noncommissioned officer

NCOIC noncommissioned officer in charge

NCS net control station

NDMS Natural Disaster Medical System

NP neuropsychiatric

NRTD nonreturn to duty

OCONUS outside the continental United States

OPCON *See* operational control.

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

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

operations security All measures taken to maintain security and achieve tactical surprise. It includes countersurveillance, physical security, signal security, and information security. It also involves the identification and elimination or control of indicators which can be exploited by hostile intelligence organizations.

operational command North Atlantic Treaty Organization: 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. Department of Defense: The term is synonymous with 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 (10 United States Code 124). (*See also* operational control.)

operational control The authority delegated to a commander to direct forces assigned so that the commander may accomplish specific missions or task 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 of logistics control. In the North Atlantic Treaty Organization, it does not include authority to assign separate employment of components of the units concerned. (*See also* assign; attach; operational command.)

OPLAN *See* operation plan.

OPORD *See* operation order.

OPSEC *See* operations security.

opt optical

order A communication written, oral or by signal that conveys instructions from a superior to a subordinate. In a broad sense, the term order and command are synonymous. However, an order implies discretion as to the details of execution whereas a command does not.

ORF operational readiness float

organic Assigned to and forming an essential part of a military organization; an element normally shown in the unit's table of organization and equipment. (*See also* assign; attach; operational control.)

OSHA Occupational Safety and Health Administration

PA physician assistant

PAC personnel administration center

patient A sick, injured, or wounded person who receives medical care or treatment from medically trained (MOS-or AOC-specific) personnel. A casualty becomes a patient when first treated by a medically trained (MOS-or ACO-specific) individual.

PDS personnel daily summary

PE&MR patient evacuation and mortality report

PLL prescribed load list

plt platoon

PM preventive maintenance

PMCS preventive maintenance checks and services

POD port of debarkation

POL petroleum, oils and lubricants

PPM Personal protective measures

PSC personnel service company

PVNTMED preventive medicine

PW/POW prisoner of war

RATT radio teletypewriter

RAU radio access units

rear area The area in the rear of the combat and forward areas. Combat echelons from the brigade through the field Army normally designate a rear area. For any particular command, that area extending rearward from the rear boundary of their next subordinate formations, or units deployed in the main battle or defense area to their own rear boundary. It is here that reserve forces of the echelon are normally located. In addition, combat support and combat service support units and activities locate in this area. (*See also* brigade support area; division support area.)

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

RMC remote multiplexer combiner

RTD return to duty

S1 Adjutant

S2 Intelligence Officer

S3 Operations and Training Officer

S4 Supply Officer

SALUTE size, activity, location, unit, time, and equipment

SB supply bulletin

SCC system control center

sec section

SINCGARS Single Channel Ground and Airborne Radio System

SOF Special Operations Forces

SOI signal operation instructions

SOP standing operating procedures

SP Army Specialty Corps

spt support

Sqd squad

Sqdn squadron

SSN social security number

STANAG Standardization Agreement

TA theater Army

TACCS Tactical Army Combat Service Support (CSS) Computer System

TAMMIS Theater Army Medical Management Information System

TB technical bulletin

TG technical guide

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

TMDE test, measurement, and diagnostic equipment.

TO *See* theater of operations.

TOE table(s) of organization and equipment

trmt treatment

TSOP tactical standing operating procedure

TTY teletypewriter

ULC unit-level computer

US United States

USAEHA United States Army Environmental Hygiene Agency

USAIRDC US Army Ionizing Radiation Dosimetry Center

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

WBC white blood cell

WO warrant officer

XO executive officer

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