FM 4-02.24 (FM 8-10-24)

AREA SUPPORT MEDICAL BATTALION

TACTICS, TECHNIQUES, AND PROCEDURES

HEADQUARTERS, DEPARTMENT OF THE ARMY

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FIELD MANUAL
NO. 4-02.24 (8-10-24)

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DEPARTMENT OF THE ARMY
Washington, DC, 28 August 2000

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). This manual sets forth tactics, techniques, and procedures (TTP) for providing area medical support in the corps and echelons above corps (EAC). It is intended to assist the commanders and staffs of the ASMB headquarters and headquarters detachment (HHD); it is also designed to be used by subordinate area support medical company (ASMC) commanders and their staffs. Information provided in this manual is based on doctrine found in FMs 8-10, 8-10-6, 8-10-26, 8-10-8, 8-55, 100-5, and 100-10.

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

The staffing and organizational structure presented in this publication reflect those established under the Medical Reengineering Initiative (MRI) and those approved by the Department of the Army (DA) in Tables of Organization and Equipment (TOE) 08456A000 and 08457A000, dated May 1997. However, staffing is subject to change to comply with manpower requirements criteria outlined in Army Regulation (AR) 71-32 and can be subsequently modified. The staffing and organizational structure for the ASMB and ASMCs, Medical Force 2000, based on the L-series TOEs, is provided at Appendix A for those ASMBs and ASMCs that have not converted to the MRI A-series TOEs.

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

As the Army Medical Department (AMEDD) transitions to the 91W military occupational specialty (MOS), positions for 91B and 91C will be replaced by 91W when new unit modification table(s) of organization and equipment (MTOE) take effect.

Users of this publication are encouraged to submit comments and recommendations to improve the publication. Comments should include the page, paragraph, and line(s) of the text where the change is recommended. The proponent for this publication is the United States (US) Army Medical Department Center and School (AMEDDC&S). Comments and recommendations should be forwarded directly to **Commander, AMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-6175**, or by using the E-mail addresses on the Doctrine Literature website at *http://dcdd.amedd.army.mil/index1.htm* (click on Doctrine Literature).

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

CHAPTER 1

COMBAT HEALTH SUPPORT FOR ARMY OPERATIONS

1-1. Army Operations Doctrine

The Army's keystone doctrinal manual, FM 100-5, expresses how the Army expects forces to operate while allowing for boldness, creativity, and initiative. It guides the conduct of campaigns, major operations, battles, and engagements, in conjunction with other Services and allied forces. Army forces accomplish missions worldwide by combining and executing offensive, defensive, stability, and support operations. Operations encompass rapid deployment, decisive application of military power, and the staying power necessary to achieve long-term success. This manual provides information on the Army's operational concept and operational guide principles. It explains how concepts, principles, functions, and operating systems combine to enable units to execute categories of operations. The capstone manual for the AMEDD, FM 8-10, explains the purpose of CHS in its support of Army operations. It is the primary guide for obtaining and providing CHS for the theater of operations (TO).

1-2. Combat Health Support Mission

The CHS 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, CHS 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 CHS plan and the synchronization of CHS. 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 CHS plan is the primary vehicle for providing the CHS operational information required to support the commander's tactical plan.

1-3. Army Medical Department Battlefield Rules

The AMEDD has developed medical battlefield rules to assist leaders, working in a complex environment, to establish priorities for providing CHS. The CHS planner and operator applies the following rules, in order of precedence, when priorities are in conflict:

- Maintain medical presence with the soldier.
- Maintain the health of the command.
- Save lives.
- Clear the battlefield.
- Provide state-of-the-art care.
- Return soldiers to duty as early as possible.

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

1-4. Principles of Combat Health 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 CHS. Only by participating in the development of the commander's operation plan (OPLAN) can the CHS planner ensure adequate CHS at the right time and place. For additional information on CHS planning, refer to FM 8-55.

b. Proximity. Proximity involves placing CHS units and personnel in the right place at the right time to provide CHS to sick, injured, or wounded soldiers. The location of CHS assets in support of combat operations is dictated by the—

- Mission, enemy, terrain, troops, time available, and civilian considerations (METT-TC) 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 CHS. Medical planners and staffs must be proactive rather than reactive and aggressively coordinate any changes to the CHS plan.

d. Mobility. Mobility must be maintained to ensure CHS assets remain close enough to support maneuvering combat forces. The mobility of medical elements should equate to the force being supported.

e. Continuity. Continuity in care and treatment is achieved by moving the patient through a progressive, phased CHS system. The CHS system is a continuum from the forward line of own troops (FLOT) rearward through the continental United States (CONUS). Medical personnel and units must provide optimum care and treatment to the sick, injured, and wounded in an uninterrupted manner. Each type of CHS 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 CHS 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. Control is achieved through planning, coordinating, and monitoring all CHS activities. Control measures include maintaining graphical updates of current routes and boundaries, movement criteria, support priorities, and tactical standing operating procedures (TSOPs). Control also ensures that the scope and quality of medical treatment meets professional standards and policies. For additional information on principles of CHS, refer to FM 8-10.

1-5. Threat

The overt threat to medical units on today's battlefield is virtually no different from that of other types of units. Deploying 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 (CW).
- Biological warfare (BW).
- 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)

Combat health support (Echelons I and II) is provided by the modular medical support system that standardizes all medical subunits within the division, corps, and 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 CHS resource managers 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 CHS 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 to evacuate patients from units on an area support basis.

NOTE

Armored ambulances require a third medic to perform en route care.

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, an A-team (which has the physician) and B-team (which has the PA). 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 may be 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 officer, a dental specialist, two x-ray specialists, and two medical laboratory specialists. 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 a medical-surgical nurse, 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 CHS 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 concentrations of troops in the CSA and COMMZ. The area support and patient-holding squads are incapable of independent operations.

f. Forward Surgical Team. The corps forward surgical team (FST) is assigned to the combat support hospital (CSH) when not operationally employed forward. Forward surgical teams are organic to the airborne and air assault divisions and are assigned to the main support medical company (MSMC) of the main support battalion (MSB) for Army of Excellence (AOE) divisions. In the Army XXI concept, the FST is also assigned to the CSHs. In the future Army XXI airborne and air assault divisions, the FST is assigned to the division support medical company (DSMC) of the division support battalion (DSB). In both AOE and Army XXI heavy division, separate brigade or ACR, the FST is deployed from the supporting corps. The mission of the FST is to provide a rapidly deployable immediate surgical capability, enabling patients to withstand further evacuation. It provides surgical support in division, separate brigades, and ACR operational areas. The requirement to project surgery forward increases as a result of the extended battlefield. This small lightweight surgical team is designed to complement and augment emergency treatment capabilities for the brigade-sized task force. The FSTs are clinically standard modules regardless of their assignment. These 20-person units are organized into four functional areas—triage-trauma management (TTM), surgery, recovery, and administration/operations. The team provides initial surgery for those critically injured patients who cannot be transported over great distances without surgical intervention and stabilization. Refer to FM 8-10-25 for definitive information on the FST.

1-7. Echelons of Medical Care

Medical care echelons describe the five levels of treatment within the military system. Each echelon has the same capabilities as the echelon before it, but adds a new treatment capability that distinguishes it from the previous echelon. The five echelons are—

- *Echelon I*—The first medical care a soldier receives is provided at this level. This care includes immediate lifesaving measures, ATM, disease prevention, combat stress control (CSC), casualty collection, and evacuation from the supported unit to the supporting medical treatment element. Echelon I elements are located throughout the combat zone (CZ) and COMMZ. These elements include the combat lifesaver, combat medic, and BAS. Some or all of these elements are found in maneuver, CS, and combat service support (CSS) units. When Echelon I medical care is not present in a unit, this support is provided to that unit by Echelon II medical units.

- *Echelon II*—This echelon duplicates Echelon I and expands services available by adding dental, laboratory, x-ray, and patient-holding capabilities. Emergency care and ATM, including beginning resuscitation procedures, are continued. (No general anesthesia is available.) If necessary, additional emergency measures are instituted; however, they do not go beyond the measures dictated by the immediate needs. Echelon II units are located in the CZ (BSA and CSA) and the COMMZ. Echelon II medical support may be provided by a clearing station, forward support medical company (FSMC), MSMC, DSMC, ASMC, or a troop medical company. Optometry is located at some Echelon II units; also, PVNTMED and mental health/CSC support are now located in some Echelon II medical units.

- *Echelon III*—This echelon of support expands the support provided at Echelon II (division level). Casualties who are unable to tolerate and survive movement over long distances will receive surgical care in hospitals as close to the division rear boundary as the tactical situation will allow. This may be provided within the division area under certain operational conditions. Echelon III care is provided by an FST or a CSH. Operational conditions may require Echelon III units to locate in offshore support facilities, third country support bases, or in the COMMZ.

- *Echelon IV*—This echelon of care is provided by a CSH, which has increased treatment capabilities that are staffed and equipped for general and specialized medical and surgical treatment. This echelon of care provides further treatment to stabilize those patients requiring evacuation to CONUS. This echelon also provides area CHS for EAC soldiers or those located within the COMMZ.

- *Echelon V* (*Continental United States Support Base Echelon of Care*)—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 National Disaster Medical System (NDMS).

1-8. Planning for Combat Health Support

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

situations change. Effective and timely planning is essential to ensure adequate and employable CHS. For definitive information on CHS planning, see FM 8-55.

a. Army Service Component Command Combat Health Support Plan. The Army CHS plan for the TO is developed by the Army Service Component Command (ASCC) surgeon/medical command (MEDCOM) commander. The ASCC surgeon is on the special staff of the ASCC commander. He is the medical staff adviser to the ASCC commander and is responsible for staff planning and coordinating and developing policies for the CHS of ASCC forces. The ASCC surgeon's section of the MEDCOM assists ASCC surgeon. The MEDCOM may be assigned to the ASCC/Army forces, or a C2 module of the MEDCOM may be assigned to the theater support command at the discretion of the ASCC.

b. Corps Combat Health Support Plan. The CHS portion of the corps OPLAN is developed by the MEDCOM and corps surgeon's section. The corps surgeon is a special staff officer located in the corps headquarters. He has a small staff section to assist in completing his mission. The corps surgeon has direct access to the corps commander on CHS matters. He keeps the commander and his staff informed concerning the health of the command and the CHS aspects of combat operations and effectiveness. As the principal medical staff officer, he advises the corps commander and his staff on all CHS matters related to personnel, intelligence, operations, logistics, and civil-military operations (CMO). The corps surgeon works with the MEDCOM for coordinating and synchronizing CHS for the corps. He provides technical supervision and guidance required to ensure that all CHS activities are accomplished for support of corps operations. The corps surgeon exercises staff supervision over CHS in the corps support command (COSCOM), divisions, and other subordinate corps units. The corps CHS plan that is developed is based on the corps commander's guidance and his intent and on information obtained through mission analysis and staff estimates. The corps surgeon makes long-range plans (96 hours and beyond) for CHS. The commanders of the MEDCOM and medical brigade convert these OPLANs into day-to-day operations to fulfill the CHS mission. The ASMB develops a CHS plan for providing area medical support; this process will be discussed in subsequent chapters of this manual.

CHAPTER 2

AREA SUPPORT MEDICAL BATTALION

Section I. ORGANIZATION AND FUNCTIONS

2-1. Area Medical Support

Area medical support in the corps and EAC/COMMZ is provided by the ASMB (Figure 2-1). This battalion provides Echelon I and Echelon II CHS and medical staff advice and assistance for all units located in its area of responsibility.

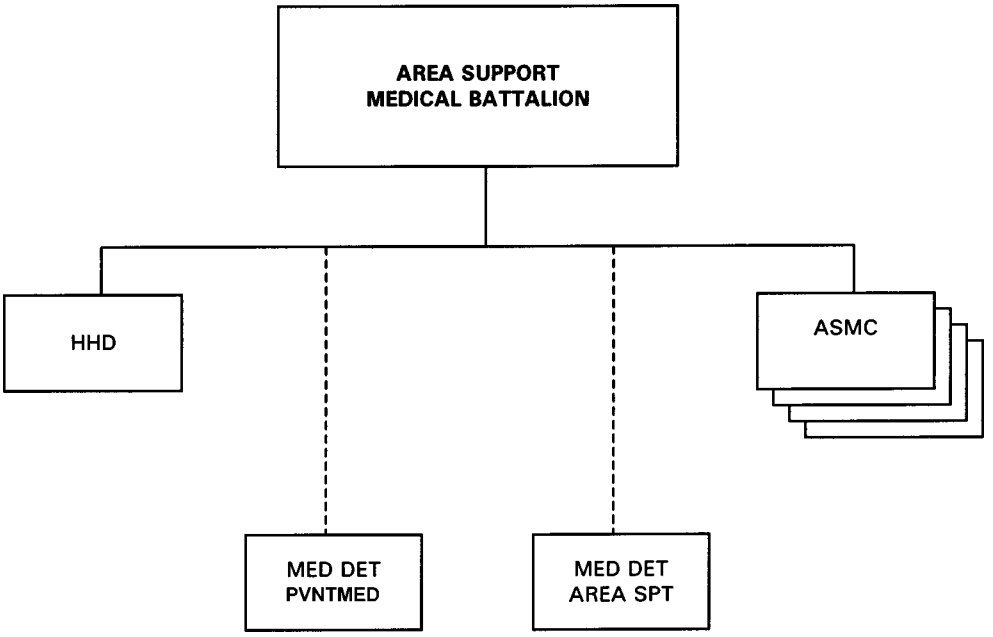


Figure 2-1. Area support medical battalion.

2-2. Organization

The ASMB is organized to provide Echelon II CHS within its assigned area of operations (AO). The ASMB also provides unit-level (Echelon I) CHS 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 HHD (Figure 2-2) and four ASMCs (Figure 2-3). It is normally assigned to a medical brigade or a MEDCOM.

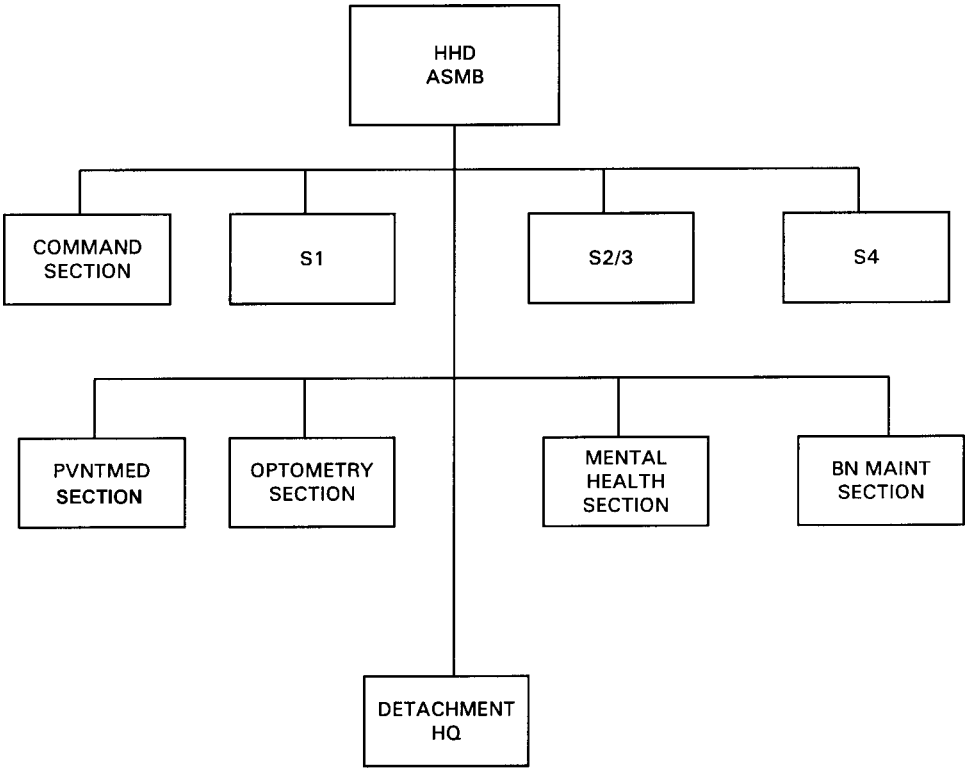


Figure 2-2. Headquarters and headquarters detachment, area support medical battalion.

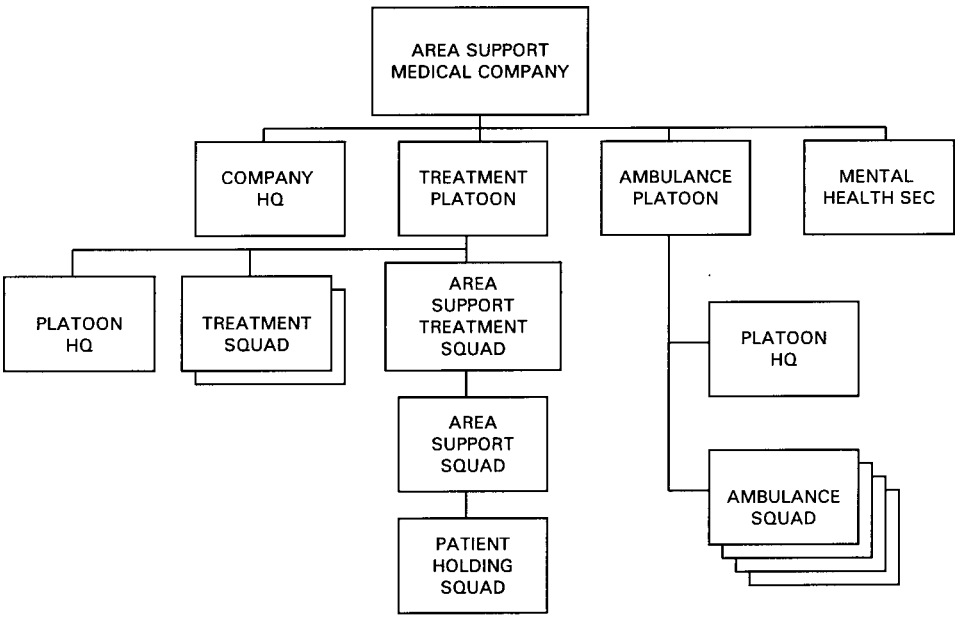


Figure 2-3. Area support medical company.

a. Employment in the Theater. In a mature theater, ASMCs are employed primarily in the corps rear and support areas of the EAC/COMMZ. They are deployed to a geographical area to provide area CHS or may be deployed to provide CHS for designated nondivisional units/troops. The ASMCs also establish clearing stations and provide Echelon I and Echelon II CHS in a wide area (normally, an area or sector of the size established and supported by a corps support group or a corps support battalion). 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 CHS. 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 HHD, ASMB provides C2 for assigned and attached units and provides Echelon I and Echelon II CHS to units located in the battalion's AO. It provides 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—

- Command and control and administrative and logistical support for up to seven subordinate units which will be a combination of the ASMCs and area support medical detachments (ASMD), TOE 08753A00. The ASMD is assigned to the medical brigade but will normally be attached to an ASMB.

- Planning and coordinating Echelon I and Echelon II CHS 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 and on health aspects affecting their unit's mission or CSS.

- Forwarding information concerning the medical aspects of CSS situations to higher headquarters.

- Allocation of medical resources (personnel and equipment) to ensure adequate medical treatment to all assigned or attached units operating in the battalion's AO in either corps or EAC.

- Mental health consultation/CSC for elements operating in the battalion's AO.

- Optometry support that includes limited eye examination, eyewear frame assembly utilizing presurfaced single-vision lens, and repair service for units assigned to the battalion's AO.

- Preventive medicine consultation and support for units assigned to the battalion's AO, to include planning and coordinating operations of attached PVNTMED detachments. This section is capable of operating as separate teams.

- Unit vehicle maintenance for assigned and attached units.

- Unit administration for assigned and attached units.

- Combat health logistics, to include Class VIII resupply, medical equipment maintenance support, and blood management.

- Food service support for staff and other medical elements dependent upon the battalion for food service.

- Operating clearing stations (Echelon II) with limited short-term holding capability and limited pharmacy, laboratory, and x-ray services.

- Providing daily sick call services on an area basis.

- Providing ground ambulance evacuation of patients.

- Providing trauma and sick call CHS (Echelon I) on an area basis to units without organic medical elements.

- Providing emergency, preventive, and general dentistry services.

- Providing limited neuropsychiatric (NP) services and management of battle fatigue (BF) and stress-related casualties.

- Providing consultation service for patients referred from unit-level medical treatment elements.

- Reinforcing or reconstituting unit-level medical elements, to include technical supervision of PAs in units with organic medical platoons 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 MEDCOM/brigade. 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 Headquarters Detachment Commander. The HHD commander exercises C2 over all elements assigned to his detachment, 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 element operating within his AO. He advises commanders of units without organic CHS 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 intent, guidance, and 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 CHS operations are dependent on the battalion headquarters' ability to communicate with its subordinate ASMCs, ASMDs corps MEDCOM/brigade, corps medical elements, supporting elements, and with the supported units. Communication assets available to the ASMB include radios (amplitude modulation [AM] and frequency modulation [FM]), satellite communications (SATCOM) systems, 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 System. 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 (FAX) throughout the corps. Additionally, it provides a direct interface to EAC, other Services, NATO, combat net radios, and commercial communications systems. The MSE system is composed of multiple communications nodes with network features that 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 radiotelephones 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 radiotelephone users communicate with other mobile and wire telephone users throughout the AO. The system control centers 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.
- Subscriber terminals (fixed).
- Wire subscriber access.
- Mobile subscriber terminal 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 radiotelephone, FAX, 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 ASMB MSE telephones into the extension switches that 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), the Army Tactical Command and Control System (ATCCS), and the transportable computer unit 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 that 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 wires. One pair is olive drab and the other pair is brown. The olive drab pair has a ridge along the side for night identification.

(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 is to provide mobile subscribers access to the MSE area network. Figure 2-8 is a typical connectivity and MSRT interface into the area system. Radio access units are deployed to maximize area coverage and MSRT concentrations. Mobile subscriber radiotelephone terminals can also operate in CPs to allow access to staff and functional personnel. Local standing operating procedures (SOPs) will determine the use of MSRTs 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 FM 11-55 for definitive information pertaining to the MSE area communications system.

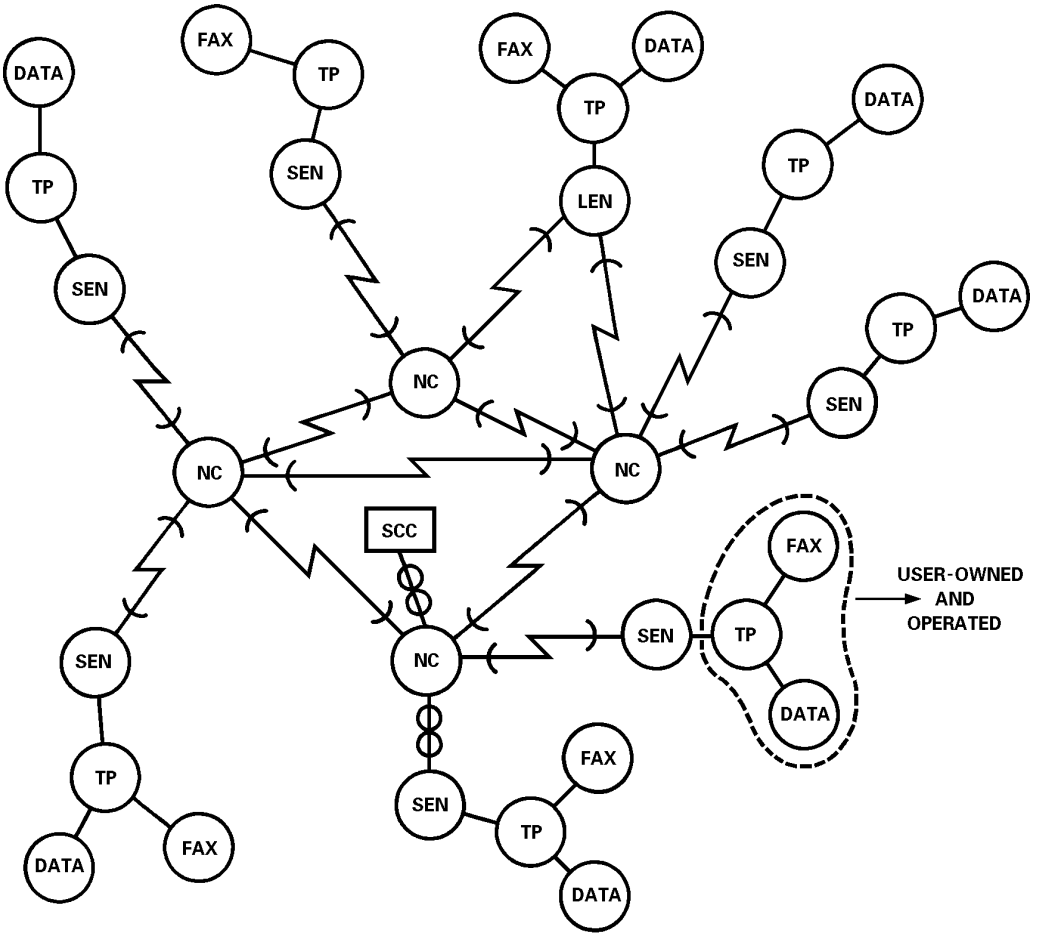


Figure 2-4. Sample of fixed subscriber terminal.

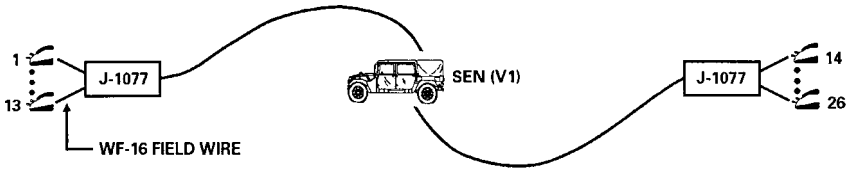


Figure 2-5. Sample small extension node switch interface (V1).

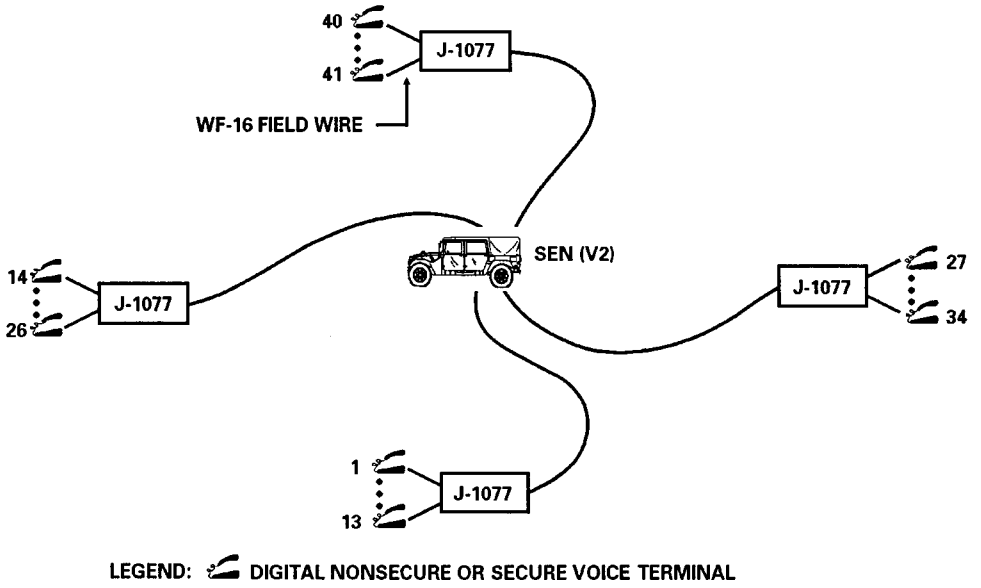


Figure 2-6. Sample small extension node switch interface (V2).

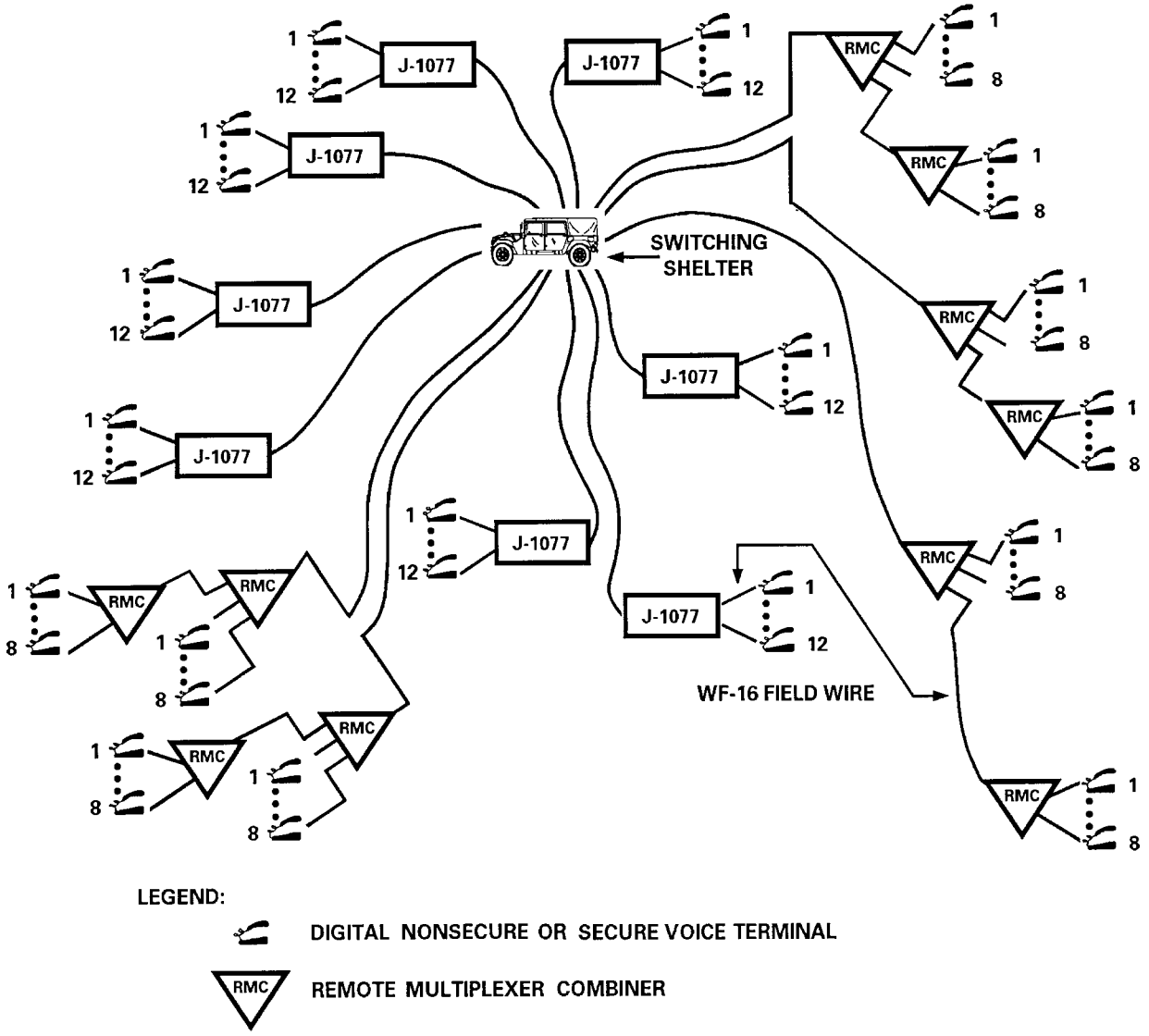


Figure 2-7. Sample large extension node switch interface.

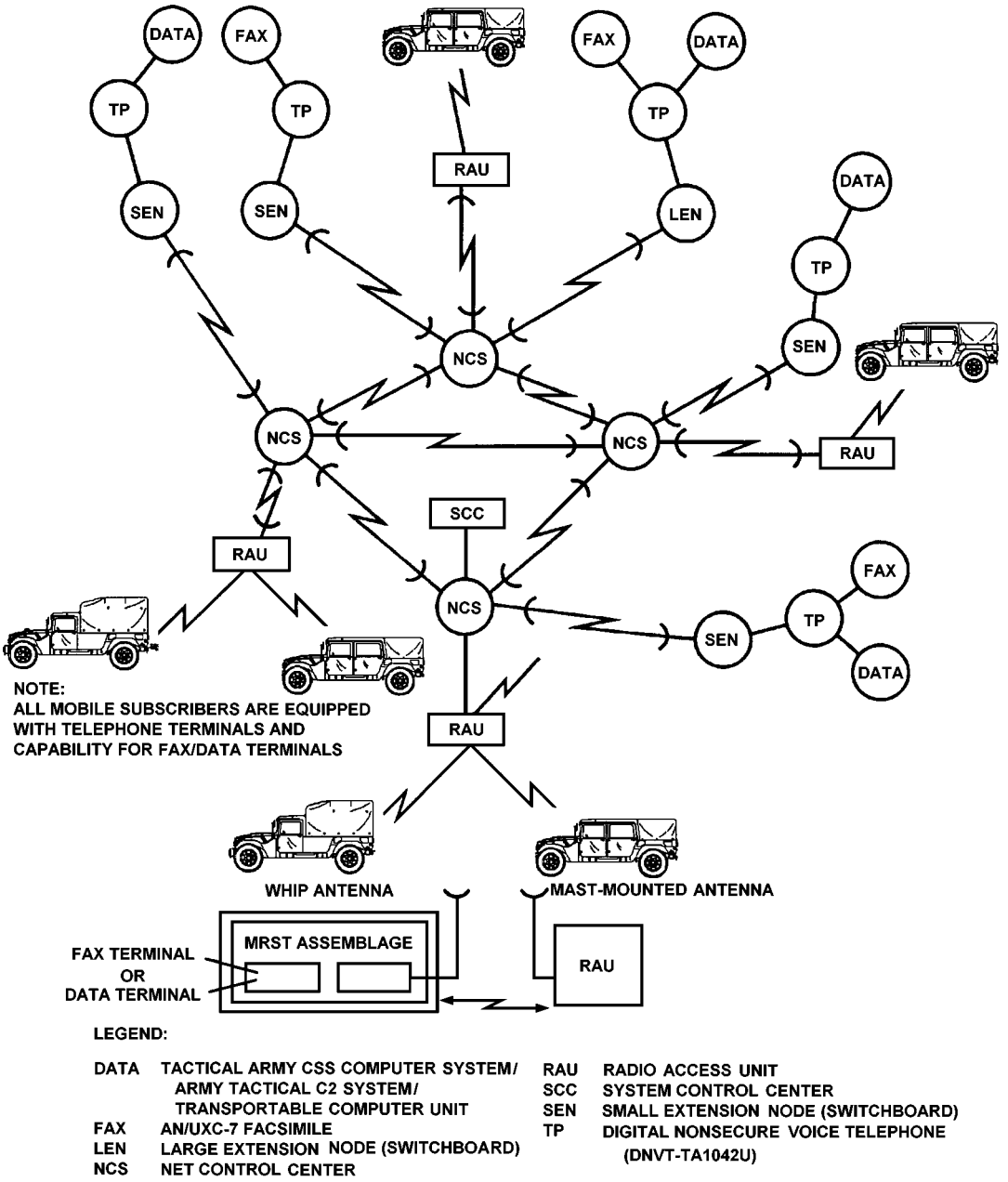


Figure 2-8. Typical mobile subscriber equipment connectivity and mobile subscriber radiotelephone terminal interface.

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. 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 mode that can be changed as needed.

2-6. Satellite Communications

The battalion headquarters has two radio sets (AN/PSC-5) which are used for SATCOM. The radio set, AN/PSC-5, is a line of sight and SATCOM terminal. This system enables the battalion to communicate with its home station when deployed to an overseas location, or to communicate with a subordinate unit if it is deployed to another theater.

2-7. 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 (US Army) (S2)/ Operations and Training Officer (US Army) (S3) section which is located in the battalion CP. In addition, ASMB headquarters personnel or sections monitor the following nets:

- Area support medical battalion commander—medical commands and medical brigade command and operations nets.

- Area support medical battalion S2/S3—

  - Area support group or battalion command and operations nets.

  - Medical evacuation battalion command and operations nets.

  - Area support medical battalion Supply Officer (US Army) (S4)/medical supply (MEDSUP)—medical brigade administration and logistics net.

a. Area Support Medical Company's Command Nets-FM. The ASMCs nets (Figure 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 (AE) support.

b. Area Support Medical Battalion's 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 evacuations, and medical regulating of patients to corps hospitals. This net links the ASMB and ASMCs with the MEDCOM/brigade, which is the NCS for the corps CHS operations net. The ASMB and ASMC wire nets are depicted in Figures 2-12 and 2-13.

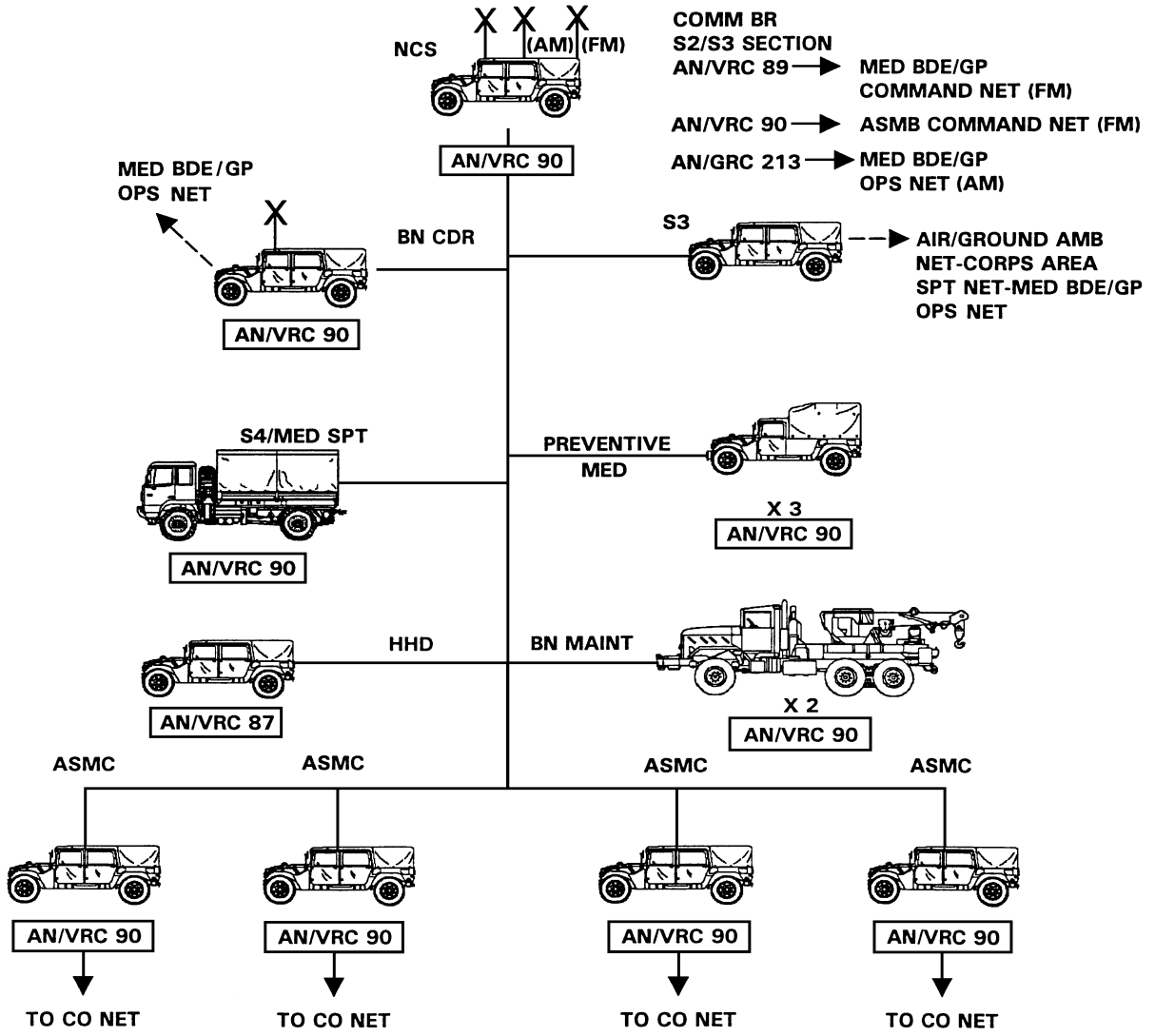


Figure 2-9. Area support medical battalion command net/FM radios.

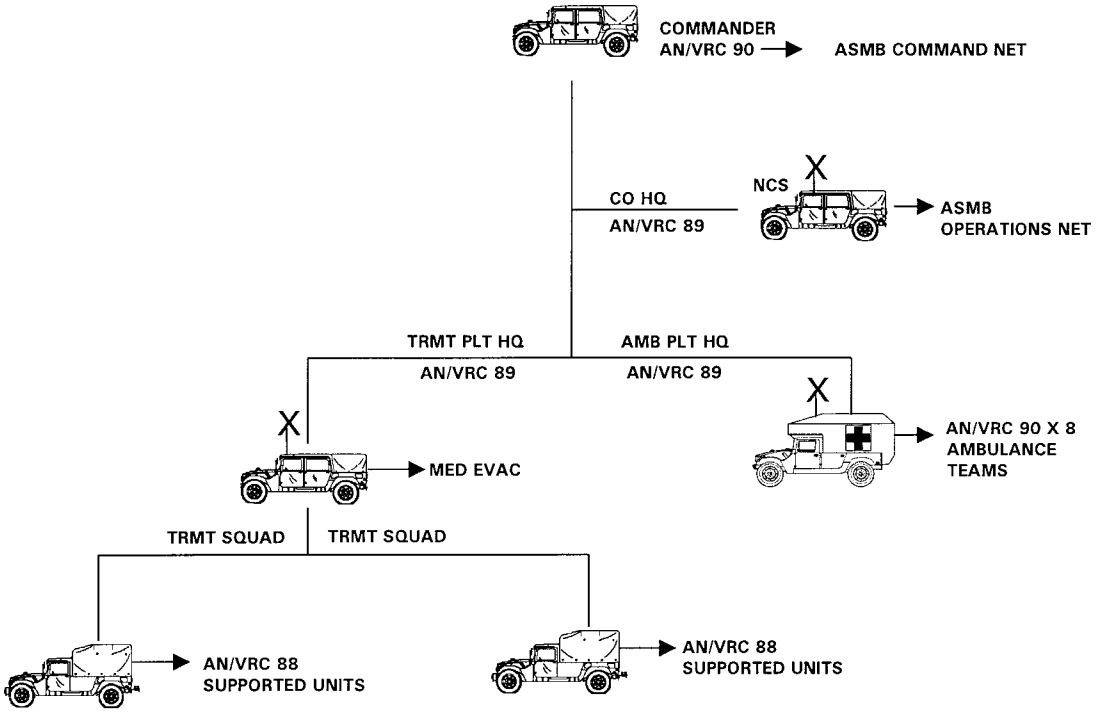


Figure 2-10. Headquarters and headquarters detachment and area support medical companies' command net (FM).

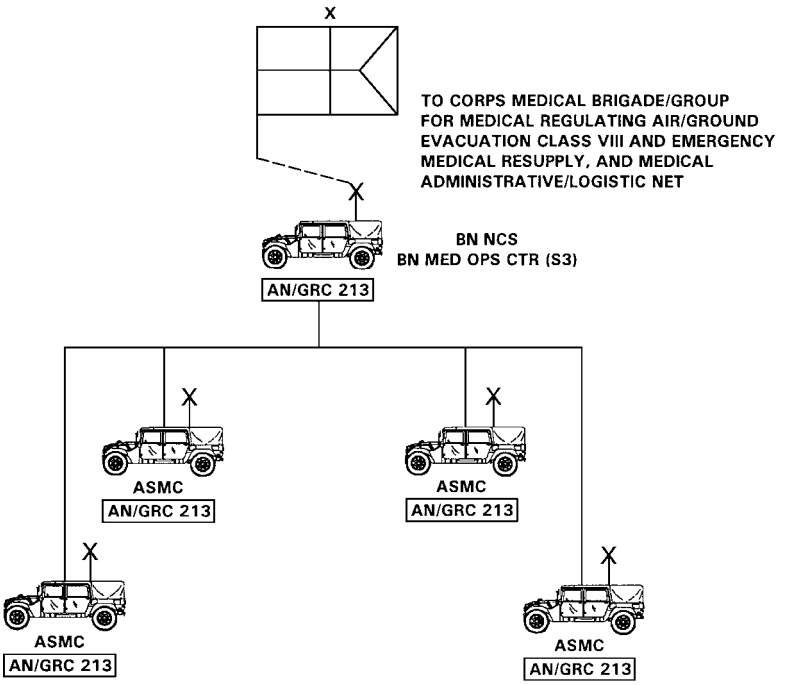


Figure 2-11. Area support medical battalion, medical operations net (AM).

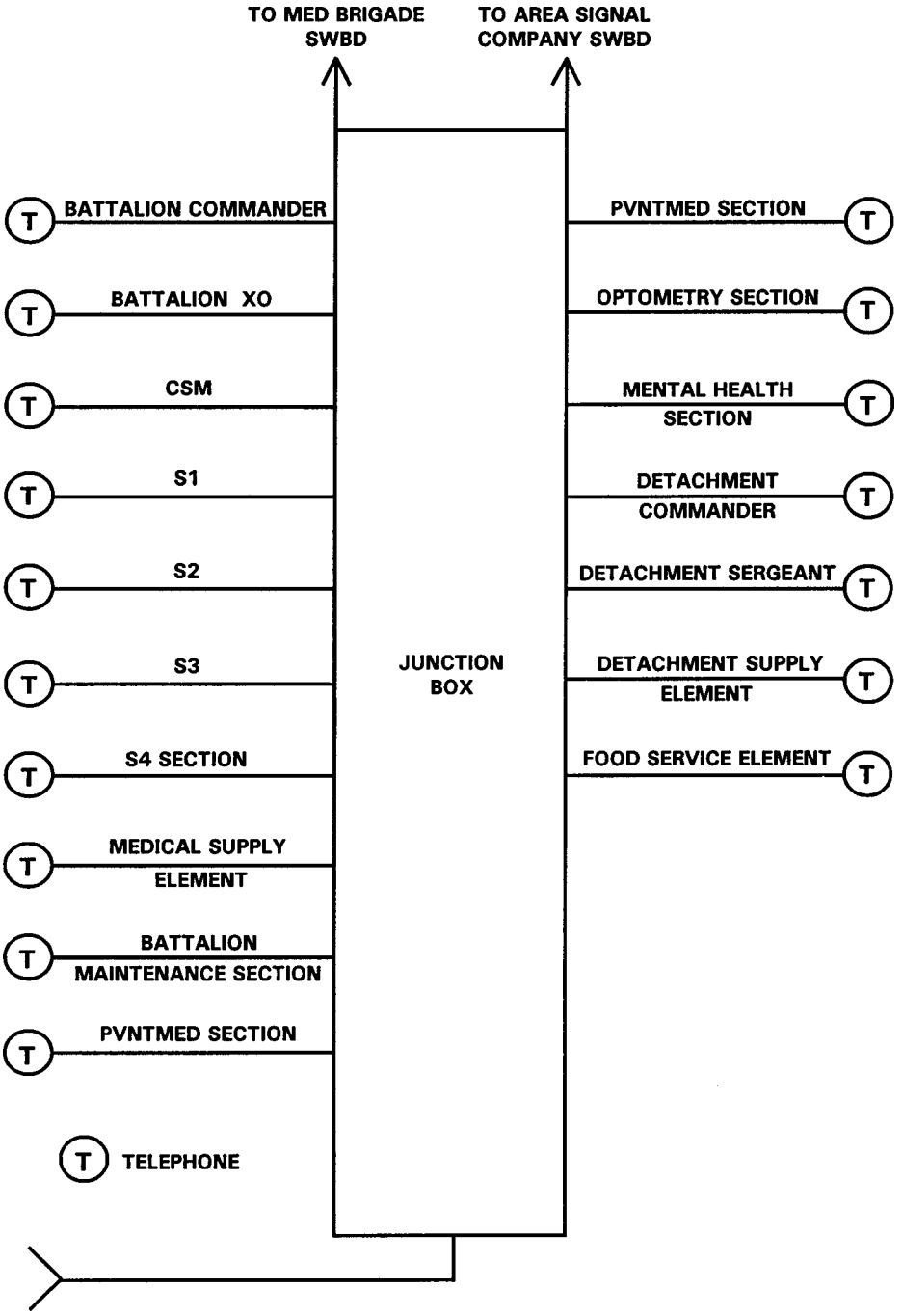


Figure 2-12. Area support medical battalion wire net.

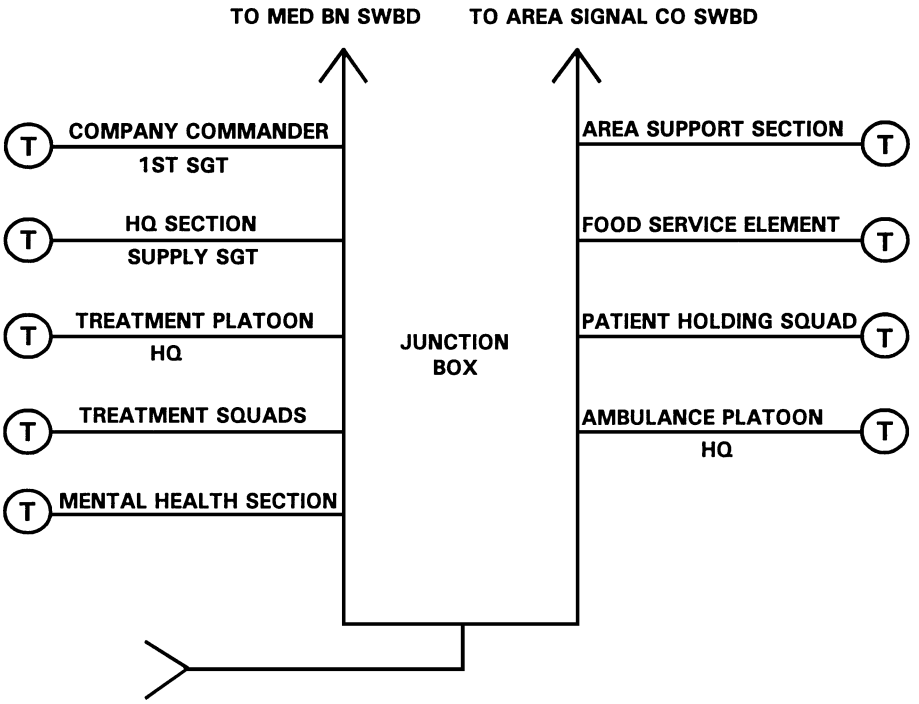


Figure 2-13. Area support medical company wire net.

2-8. 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.
- 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 NCS.
- Using lowest transmitter power output consistent with good communications.
- Avoiding significant surges in traffic on single-channel radio nets.

Section III. BATTALION HEADQUARTERS ELEMENT

2-9. Organization and Functions

The battalion headquarters is a major functional element organized under the HHD (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 (US Army) (S1) section.
- Intelligence/operations and training section.
- Supply/MEDSUP 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 CHS 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 CHS elements.

NOTE

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

2-10. Command Section

The battalion's command section (Table 2-1) consists of the battalion commander and his immediate staff. These personnel supervise the functions of the organizational elements of the battalion headquarters.

Table 2-1. Area Support Medical Battalion Command Section

BATTALION COMMAND SECTION
BATTALION COMMANDER (LTC, AOC 60A00)
BATTALION EXECUTIVE OFFICER (XO) MAJ, AOC 67A00)
BATTALION S1 (CPT, AOC 70F67)
BATTALION S2/S3 (MAJ, AOC 70H67)
BATTALION S4 (CPT, AOC 70K67)
COMMAND SERGEANT MAJOR (E-9, MOS 00Z50)
VEHICLE DRIVER (E-3, MOS 91B10)

a. Battalion Commander. The battalion commander is responsible for the C2 and coordination of CHS (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 executive officer (XO), under the commander's directions, 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 Adjutant Section. The battalion S1 advises the commander on administrative and personnel matters. He has responsibility for battalion administrative/personnel matters and operates the battalion Personnel and Administration Center (PAC). The section 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 Intelligence/Operations and Training Section. The battalion S2/S3 comprises the plans, operations, and intelligence section. The battalion S2/S3 advises and assists the battalion commander in the following areas:

- Collecting staff estimates.
- Planning CHS operations.
- Conducting CHS operations.
- Ensuring security requirements are met (operations, physical documents, sensitive items, 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.

The battalion S2/S3 also authenticates and supervises the preparation and distribution of orders.

e. Battalion Supply Section. The battalion S4 is responsible for battalion logistics support. The battalion S4 conducts the logistics activities of the battalion and advises and assists the battalion commander in all matters pertaining to logistics. The section is responsible for directing Class VIII supply, medical equipment repair support, and blood resupply for the battalion. This section coordinates with the S3 section in planning and implementing damage control measures.

f. Command Sergeant Major. The command sergeant major (CSM) (E-9, 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 oversees NCO development and soldier training and is a key player in the development of the battalion's training program. The CSM is a key staff member who gets involved, as required, to ensure staff compliance with command directives and to ensure the battalion headquarters operates efficiently. He also assists the commander in the inspection of subordinate units.

2-11. Battalion Adjutant Section

The S1 section (Table 2-2), 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.

Table 2-2. Area Support Medical Battalion Adjutant Section

BATTALION S1 SECTION
BATTALION S1* (CPT, AOC 70F67) PERSONNEL SERGEANT (E-7, MOS 75H40) ASSISTANT PERSONNEL SERGEANT (E-6, MOS 75H30) PERSONNEL ADMINISTRATIVE SPECIALIST (E-4, MOS 75B10) LEGAL SPECIALIST (E-4, MOS 75B10) POSTAL CLERK (E-3, MOS 71L10)

*Located in the command section.

2-12. Battalion Intelligence/Operations and Training Section

The battalion S2/S3 section (Table 2-3) serves as the main operations and planning element for the battalion. This section coordinates task-organizing battalion elements and other units assigned to the battalion to provide CHS for the battalion's AO. It coordinates patient evacuation from medical treatment facilities (MTFs) to other corps/COMMZ treatment facilities. This section's responsibilities include—

- Developing staff estimates for supporting the battalion's area of responsibility.
- Developing the battalion CHS OPLANs.
- Developing/issuing operation orders (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 CHS operations in the battalion AO.
- Coordinating support arrangements with units in the AO unless delegated to the ASMCs or other staff sections.

Table 2-3. Organization and Staffing of the Area Support Medical Battalion Intelligence/Operations and Training Section

INTELLIGENCE/OPERATIONS AND TRAINING SECTION *BATTALION S2/S3 (MAJ, AOC 70H67)	
PLANS AND OPERATIONS BRANCH	**COMMUNICATIONS BRANCH**
MEDICAL OPERATIONS OFFICER (ASSISTANT S2/S3, CPT, AOC 70H67)	BATTALION COMMUNICATIONS CHIEF (E-7, MOS 31U40)
BATTALION OPERATIONS SERGEANT (E-8, MOS 91B50)	SENIOR RADIO OPERATOR/MAINTAINER (E-5, MOS 31C20)
PLANS SERGEANT (E-7, MOS 91B40)	RADIO OPERATOR/MAINTAINER (E-4, MOS 31C10)
INTELLIGENCE AND SECURITY NCO (E-7, MOS 91B40)	SIGNAL INFORMATION SYSTEMS SPECIALIST (E-3, MOS 31U10)
NUCLEAR, BIOLOGICAL, AND CHEMICAL NCO (E-6, MOS 54B30)	RADIO OPERATOR/MAINTAINER (E-3, MOS 31U10)
PATIENT ADMINISTRATION SPECIALIST (E-4, MOS 71G10)	SIGNAL SUPPORT SYSTEMS SPECIALIST (E-3, MOS 31U10)

* Located in the command 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-TC 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 HHD's 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.

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's signal communications TSOP.

- Assures communications systems interface between the battalion and the medical command/brigade and between the ASMB and its subordinate units.

- Operates the battalion switchboard and serves as the NCS for the battalion's command/operations (FM voice) net and the CHS operations (AM voice) net.

- Provides for technical training to battalion users of communications-electronics (CE) equipment.

2-13. Battalion Supply/Medical Supply Section

The S4/MEDSUP section is comprised of two separate functional elements, which are shown in Table 2-4. This section provides Class VIII and blood resupply, medical equipment maintenance support, 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 and medical equipment maintenance 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 HHD, ASMCs, and other medical units that 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. In the COMMZ, Class VIII resupply of the ASMB is provided by the MEDLOG battalion located at EAC.

Table 2-4. Organization and Staffing of the Area Support Medical Battalion Supply/Medical Supply Section

BATTALION SUPPLY/MEDICAL SUPPLY SECTION *BATTALION S4 OFFICER (CPT, AOC 70K67)	
S4 ELEMENT	**MEDICAL SUPPLY ELEMENT**
SUPPLY SERGEANT (E-7, MOS 92Y40) SUPPLY ACCOUNTING SPECIALIST (2) (E-4 AND E-3, MOS 92Y10)	HEALTH SERVICE MATERIEL OFFICER (1LT, AOC 70K67) MEDICAL SUPPLY SERGEANT (E-6, MOS 76J30) MEDICAL SUPPLY SPECIALIST (E-4, MOS 76J10) STERILE PHARMACY NCO (E-6, MOS 91Q30) MEDICAL EQUIPMENT REPAIRER (2) (E-4 AND E-3, MOS 91A10)

*Located in the command section.

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

b. Medical Supply Element. The MEDSUP 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 MEDSUP element include development and maintenance of prescribed loads of contingency medical supplies, management of the medical quality control program, and supervision of unit medical maintenance support. This element provides routine and emergency Class VIII resupply to include blood (packed red blood cells are provided to Echelon II MTFs) 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 landlines; 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 MEDSUP 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 company.

(1) The MEDSUP element is responsible for—

- Developing and maintaining prescribed loads of contingency medical supplies and medical repair parts for the 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 characteristics of the AO.

- Managing the battalion's combat health logistics quality control program.

- Monitoring the ASMB's medical assemblage management program.

- Coordinating logistical planning for preconfigured Class VIII packages.

- Managing the battalion's blood program.

(2) The reconstitution mission of the MEDSUP element include—

- Reconciling the Class VIII 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 equipment sets (MES) required to field an operationally ready MTF.

- Coordinating with the MEDLOG battalion to monitor the status and number of MES due in.

- Coordinating with the corps movement control center to move supplies from the MEDLOG battalion. (The health services materiel officer [HSMO] directs quick fixes using available assets and controlled exchanges for medical equipment to maximize the capabilities of MTFs.)

- Alerting the appropriate company when MES are arriving.

- Allocating MES to the unit based on the commander's priorities. (The HSMO coordinates through the battalion S2/S3 with the medical command/brigade to identify transportation assets to transport medical assemblages [MES and medical supplies] to the units being reconstituted.)

- Preparing the critical items listing and consolidating the critical shortages by ASMC.

(3) The two medical equipment repairers provide unit-level medical maintenance for the ASMB. They exercise their responsibilities by—

- Scheduling and performing preventive maintenance checks and services (PMCS).

- Performing electrical safety inspections and tests.

- Accomplishing 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 supplies 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.

2-14. Battalion Maintenance Section

The battalion maintenance section (Table 2-5) functions under the staff supervision of the battalion S4. This section provides unit-level maintenance for wheeled vehicles assigned to the HHD. 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 HHD. 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 9-43-1.

Table 2-5. Organization and Staffing of the Area Support Medical Battalion Maintenance Section

BATTALION MAINTENANCE SECTION	
SECTION HEADQUARTERS	
BATTALION MOTOR OFFICER (UNIT MAINTENANCE TECHNICIAN [LIGHT]) (CW2, AOC 95A10)	
BATTALION MOTOR SERGEANT (E-6, MOS 63B30)	
EQUIPMENT RECORDS/ PARTS SPECIALIST (2)—(PERFORMS DUTIES AS THE SHOP CLERK AND THE PLL CLERK) (E-5, MOS 92A20 AND E-4, MOS 92A10)	
***MOTOR VEHICLE REPAIR SHOP**	**POWER GENERATOR REPAIR**
LIGHT-WHEELED VEHICLE MECHANIC (2) (E-5, MOS 63B20 AND E-3, MOS 63B10)	POWER-GENERATION EQUIPMENT REPAIRER (E-4, MOS 52D10)
RECOVERY VEHICLE OPERATOR (E-4, MOS 63B10)	

*2-contact team capability.

a. Battalion Maintenance.

(1) The battalion maintenance section is responsible for—

- 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, the section is responsible for—

- Implementing maintenance-related training and safety programs for operators and supervisors of battalion vehicles and power-generation equipment.

- Inspecting battalion units to ensure maximum use of equipment and vehicle assets.

- Scheduling semiannual services for subordinate units.

b. Equipment Records and Parts. The shop clerk 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 needed tools to motor vehicle and power-generation repair personnel as required.

c. Prescribed Load List. The PLL clerk 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.

d. Light-Wheeled Vehicle Maintenance Element. The light-wheeled vehicle maintenance element is responsible for—

- Preparing daily work sheets and charts.

- Conducting maintenance and repair services.

- Implementing the AOAP.

- Performing maintenance procedures in accordance with appropriate TMs.

- Performing vehicle recovery operations.

- Providing technical assistance to supported units.

e. Power Generator Repair. The power generator maintenance element 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. This element 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 test, measurement, and diagnostic equipment (TMDE) 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 PMCS on shop equipment.

- Maintaining and accounting for tools issued.

2-15. Preventive Medicine Section

a. 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 health threat assessment, 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 Table 2-6. 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 health threat and risk assessments.

- Assisting the battalion S2/S3 in determining requirements for medical intelligence assessments, particularly with respect to toxic industrial chemicals and disease prevalence.

- Conducting surveillance of units in the AO to ensure implementation of PVNTMED measures at all levels and to identify actual or potential health threats and recommending corrective action as required.

- Assisting 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.

- Conducting health surveillance of the supported units, to include 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.

- Operating independently or in conjunction with the theater area medical laboratory/area medical laboratory (under MRI) and NBC reconnaissance vehicles performing environmental monitoring to verify the presence or absence of industrial chemicals and low-level radiation in the environment.

- 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.

- Training supported unit field sanitation teams.

- 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.

Table 2-6. Organization of the Area Support Medical Battalion Preventive Medicine Section

PREVENTIVE MEDICINE SECTION
PREVENTIVE MEDICINE OFFICER (MAJ, AOC 60C00) *ENVIRONMENTAL SCIENCE OFFICER (CPT, AOC 72D67) PREVENTIVE MEDICINE SERGEANT (E-6, MOS 91S30 AND E-5, MOS 91S20) PREVENTIVE MEDICINE SPECIALIST (TWO E-4 AND TWO E-3, MOS 91S20)
*Either a Sanitary Engineer or an Environmental Science officer could fill this position.

b. Preventive Medicine Detachments. The PVNTMED detachment provides technical consultation support on PVNTMED issues throughout the corps. The unit provides specialized PVNTMED support in the areas of disease and nonbattle injury (DNBI) surveillance, health physics, disease vector identification and abatement, environmental engineering, sanitation, health threat profiles, and health hazard assessment. The detachment conducts surveillance of troop assembly areas to ensure adequacy of preventive medicine measures (PMMs), particularly those performed by individual and small units to protect themselves. When such measures are inadequate, the detachment offers on-site advice to unit leaders. When requested, the detachment conducts training on PMMs for unit members. The detachment may function as a single operational activity or may split into a headquarters section and three teams to provide support to a greater number of units. When the teams are operating in the split mode, they must maintain contact with the detachment headquarters for instructions and guidance. A team may be attached to other units for support. The detachment will provide additional support to the ASMB's PVNTMED section, as required. The PVNTMED detachment is normally assigned to the MEDCOM or medical brigade in the corps and to the MEDCOM in the COMMZ. The PVNTMED detachment may be further attached to the ASMB.

2-16. 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 Table 2-7.

Table 2-7. Area Support Medical Battalion Optometry Section

OPTOMETRY SECTION
OPTOMETRIST (2) (CPT, AOC 67F00) EYE SERGEANT (E-5, MOS 91B20P3) OPTICAL LABORATORY SERGEANT (E-5, MOS 42E20) EYE SPECIALIST (E-4, MOS 91B10P3)

2-17. Mental Health Section

The ASMB's mental health (MH) section is the medical element with primary responsibility for assisting units in the corps rear to control combat stress. As in the division, combat stress is controlled through vigorous prevention, consultation, and restoration programs. These programs are designed to maximize the RTD rate of BF soldiers by identifying combat stress reactions and providing rest/restoration within or near their unit areas. Also, the prevention of posttraumatic stress disorders is an important objective in both division and corps CSC programs. Under the direction of the ASMB psychiatrist, the MH sections provide MH/CSC services throughout the ASMB's AO. The battalion MH section is assigned to the HHD of the ASMB. Also, each ASMC has a MH section. The battalion psychiatrist has staff responsibility for establishing policy and guidance for the prevention, diagnosis, and management of NP, BF, and misconduct stress behavior cases seen by ASMB physicians and the MH sections. He also has technical responsibility for the psychological aspect of surety programs. He provides and oversees MH and stress control training for unit leaders and their staffs, chaplains, medical personnel, and troops. Through the battalion and company MH sections, the battalion psychiatrist monitors morale, cohesion, and mental fitness of supported units. He has technical control over all MH personnel assigned to the ASMB and provides guidance as required for the successful accomplishment of their responsibilities. These responsibilities include—

- Providing command consultation and making recommendations for reducing stressors.

- Evaluating NP, BF, and misconduct stress behavior cases.

- Providing consultation and triage, as requested, for patients exhibiting signs of combat stress reactions or mental disorders.

- Providing selective short-term restoration for HOLD category BF cases.

- Coordinating support activities with the medical company and detachment and CSC elements, when attached or in support of the ASMB.

a. Mental Health Support. The ASMB S3 and the battalion MH section monitors and prioritizes MH support missions in coordination with the MEDCOM/ brigade headquarters.

b. Battalion Mental Health Section Staff. The ASMB MH section is staffed as shown in Table 2-8. The dispersion of multidisciplinary MH professionals throughout the battalion ensures that expertise is present for—

- Training and supervising the MH specialists.
- Providing staff input to supported commands.
- Providing clinical evaluation and appropriate treatment or referral for all NP and problematic BF cases.
- Providing a MH professional for interface with supported brigades, groups, and corps resources.
- Providing rapid assistance with critical incident/events debriefing for the ASMB's area of responsibility.

Table 2-8. Area Support Medical Battalion Mental Health Section

MENTAL HEALTH SECTION STAFF
PSYCHIATRIST (MAJ, AOC 60W00) MENTAL HEALTH SPECIALIST (E-4, MOS 91X10) MENTAL HEALTH SPECIALIST (E-3, MOS 91X10)

Section IV. HEADQUARTERS DETACHMENT

2-18. Organization and Functions of the Detachment Headquarters Elements

The headquarters detachment and battalion headquarters are organized under the ASMB HHD (refer to Figure 2-2). At the TOE authorized level of organization, the HHD is dependent upon 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 (MA).
- Echelon commander's support for securing and handling EPW patients.
- Security during tactical movement.
- Area damage control.

2-19. Detachment Headquarters

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

- Planning, directing, and supervising unit training and security for its unit elements and providing general supply support for all elements of the HHD.

- Planning and supervising the headquarters detachment's operational area of responsibility as directed by the battalion commander.

Table 2-9. Organization and Staffing of the Detachment Headquarters

DETACHMENT HEADQUARTERS		
COMMAND ELEMENT	**SUPPLY ELEMENT**	**FOOD SERVICE ELEMENT**
COMMANDER (CPT, AOC 70B67) DETACHMENT NCO (E-7, MOS 91B40) VEHICLE DRIVER (E-3, MOS 91B10)	SUPPLY SERGEANT/ARMORER (E-5, MOS 92Y20)	FOOD OPERATIONS SERGEANT (E-6, MOS 92G30) FIRST COOK (E-5, MOS 92G20) COOK (E-4, 92G10)

a. Command Element. The command element is responsible for providing billeting, security, training, administration, and discipline of assigned personnel.

b. Food Service Element. The food service element is responsible for providing food service support for staff and patients of the HHD and to other medical elements dependent upon the HHD for support. The Army staffs and equips units to provide cadre with the capability for one hot-cooked prepared meal per day based on METT-TC. Additional meals are selected from either heat-and-serve tray packs or individual combat meals (AR 30-21). This section is responsible for conducting food service operations according to FMs 10-23 and 21-10.

NOTE

Food service personnel (MOS 92G) assigned to Echelon II CHS units are not trained or prepared to provide any special diets. Patients requiring advanced dietary support or special diets are evacuated to corps/COMMZ hospitals 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 the CSHs.

c. Supply Element. The supply element provides supply (less medical) and armorer support for the HHD and attached units. The supply sergeant also performs the additional duties as the detachment armorer.

CHAPTER 3

AREA SUPPORT MEDICAL COMPANY

3-1. Mission, Organization, and Functions

The ASMC has the overall mission of providing Echelon I and Echelon II CHS to units located in its AO. It is dependent on the same corps and COMMZ elements that support the HHD (see paragraph 2-18). The ASMC is organized into a company headquarters, a treatment platoon, an ambulance platoon, and an MH section.

3-2. Company Headquarters

The company headquarters (Table 3-1) is organized into a command element, a food service element, a supply element, an operations and communications element, and a maintenance element. The company headquarters provides C2 for the company and other medical units that may be attached. It also provides general and MEDSUP/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 switchboard (see Chapter 2). Personnel of this section supervise unit operations, general supply, MEDSUP, field kitchen operations, communications, and power-generation operations.

Table 3-1. Organization and Staffing of an Area Support Medical Company Headquarters Section

COMMAND ELEMENT	
COMPANY COMMANDER (MAJ, AOC 62B00) EXECUTIVE OFFICER (CPT, AOC 70B67) FIRST SERGEANT (E-8, MOS 91B5M)	
FOOD SERVICE ELEMENT	**SUPPLY ELEMENT**
FOOD OPERATIONS SERGEANT (E-6, MOS 92G30) FIRST COOK (E-5, MOS 92G20) COOK (2) (E-4 AND E-3, MOS 92G10)	MEDICAL SUPPLY SERGEANT (E-6, MOS 76J30) UNIT SUPPLY SERGEANT (E-5, MOS 92Y20) SUPPLY SPECIALIST/ARMORER (E-4, MOS 92Y10)
OPERATIONS AND COMMUNICATIONS ELEMENT	**MAINTENANCE ELEMENT**
NBC OPERATIONS SPECIALIST (E-4, MOS 54B10) DECONTAMINATION SPECIALIST (E-4, MOS 54B10) SIGNAL SUPPORT SYSTEMS MAINTAINER (E-4, MOS 31U10) FORWARD SIGNAL SUPPORT SPECIALIST (E-4, MOS 31U10)	MOTOR SERGEANT (E-6, MOS 63B30) SENIOR LIGHT-WHEELED VEHICLE MECHANIC (E-5, MOS 63B20) EQUIPMENT RECORDS /PARTS SERGEANT (E-5, MOS 92A20) LIGHT-WHEELED VEHICLE MECHANIC (2) (E-4 AND E-3, MOS 63B10) POWER GENERATOR EQUIPMENT REPAIRER (E-4, MOS 52D10)

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 and attached personnel. It is typically staffed with a company commander, an XO, and a first sergeant (1SG).

b. Food Service Element. The food service element is responsible for providing food service support for the staff and patients of the ASMC and to other medical elements dependent upon the ASMC for support. This element is responsible for conducting food service operations according to FMs 10-23 and 21-10.

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 MEDSUP sergeant, a unit supply sergeant, and an armorer. See FM 8-10-9 for definitive information of MEDSUP operations and FMs 10-27-3 and 10-27-4 for definitive information on unit supply operations and property accountability.

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's 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.

e. Maintenance Element. This element provides unit-level maintenance for wheeled vehicles and power generators assigned to the ASMC.

(1) *Vehicle maintenance.* The three light-wheeled vehicle mechanics are under the technical supervision of the ASMB's senior mechanic. These personnel perform organization PMCS and repairs on the gasoline- and diesel-fueled, light-wheeled vehicles of the company and attached units.

(2) *Power generator repair.* A power generator equipment repairer performs unit or DS/GS maintenance functions. This includes overhauling, but not rebuilding, power-generation equipment up through 200-kw capacity. Generator maintenance performed at the ASMC will include—

- Servicing and scheduling maintenance.
- Inspecting equipment and determining category of maintenance and extent of repairs required.
- Repairing tactical utility and precise power-generation equipment.
- Maintaining maintenance records on all power-generation equipment.

3-3. Treatment Platoon

The treatment platoon operates a 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 areas 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 seven tactical radios. See Table 3-2 for organization and staffing of the treatment platoon.

Table 3-2. Organization and Staffing of an Area Support Medical Company

TREATMENT PLATOON HEADQUARTERS

*PLATOON LEADER (MAJ, AOC 62B00)
#PHYSICIAN ASSISTANT (MAJ, AOC 65D00)
HEALTH SERVICE ADMINISTRATIVE ASSISTANT (LT, AOC 70B67)
PLATOON SERGEANT (E-7, MOS 91B40)
PATIENT ADMINISTRATION SPECIALIST (E-4, MOS 71G10)

TREATMENT SECTION

TREATMENT SQUAD (1ST SQUAD)

FIELD SURGEON (CPT, AOC 62B00) "A"
PHYSICIAN ASSISTANT (CPT, AOC 65D00) "B"
EMT NCO (E-6, MOS 91B30) "A"
EMT NCO (E-5, MOS 91B20) "B"
EMT NCO (E-5, MOS 91B20) "A"
MEDICAL SPECIALIST (E-4, MOS 91B10) "B"
MEDICAL SPECIALIST (E-3, MOS 91B10) "A"
MEDICAL SPECIALIST (E-3, MOS 91B10) "B"

TREATMENT SQUAD (2D SQUAD)

FIELD SURGEON (CPT, AOC 62B00) "A"
PHYSICIAN ASSISTANT (CPT, AOC 65D00) "B"
EMT NCO (E-6, MOS 91B30) "A"
EMT NCO (E-5, MOS 91B20) "B"
EMT NCO (E-5, MOS 91B20) "A"
MEDICAL SPECIALIST (E-4 AND E-3, MOS 91B10) "B"
MEDICAL SPECIALIST (E-3, MOS 91B10) "A"

AREA SUPPORT SECTION

AREA SUPPORT TREATMENT SQUAD

*FIELD SURGEON (MAJ, AOC 62B00)
#PHYSICIAN ASSISTANT (MAJ, AOC 65D00)
EMT NCO (E-6, MOS 91B30)
EMT NCO (E-5 [2], MOS 91B20)
MEDICAL SPECIALIST (E-4, MOS 91B10)
MEDICAL SPECIALIST (E-3 [2], MOS 91B10)

AREA SUPPORT SQUAD

GENERAL DENTAL OFFICER (CPT, AOC 63A00)
RADIOLOGY SERGEANT (E-5, MOS 91P20)
RADIOLOGY SPECIALIST (E-4, MOS 91P10)
DENTAL SPECIALIST (E-4, MOS 91E10)
MEDICAL LABORATORY SPECIALIST (2) (E-4 AND E-3, MOS 91K10)

PATIENT-HOLDING SQUAD

MEDICAL SURGICAL NURSE (CPT, AOC 66H00)
PRACTICAL NURSE (E-5, MOS 91C20)
PRACTICAL NURSE (E-4, MOS 91C10)
MEDICAL SPECIALIST (E-4 AND E-3, MOS 91B10)

LEGEND:
"A"—Alpha Team
"B"—Bravo Team

* Serves as platoon leader and field surgeon of the area support section.
# Serves as assistant platoon leader and physician assistant on area support section.

a. Headquarters Element. The headquarters element directs, coordinates, and supervises platoon operations. The platoon leader assumes command of the company when the commander is absent. The headquarters element directs the activities of the ASMC's clearing station and monitors Class VIII supplies, blood usage, and inventory levels, and keeps the commander informed. The headquarters element is responsible for the management of platoon operations, operations security (OPSEC), communications, administration, organizational training, supply transportation, patient accountability and statistical reporting functions, and coordination for patient evacuation. The treatment platoon headquarters is also responsible for—

- Supervising the treatment platoon support activities.
- Coordinating the movement of treatment squads within the ASMC's area of responsibility.
- Accomplishing the logistics functions for the platoon.

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 ASMC for limited periods of time. Each squad has the capability to split and operate as separate treatment teams (Team A and Team B) for limited periods of time. While operating in these separate modes, they may operate up to four treatment stations. They can be assigned to reinforce or reconstitute similar treatment squads.

c. Area Support Section. The area support section of the treatment platoon is composed of an area support 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 ASMCs. The treatment squad provides trauma care and routine sick call care to personnel assigned to units located near the ASMC. The area support squad provides emergency dental services, limited laboratory and 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 RTD within 72 hours from the time they are held for treatment. 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) *Area support treatment squad.* The area support treatment squad is the base medical treatment element of a 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 ASMC's radio and wire communications nets.

(2) *Area support squad.* The area support squad includes a dental element, a medical laboratory element, and an x-ray element, which has field x-ray capabilities. The area support squad provides for basic services commensurate with Echelon II medical treatment. It is typically staffed with a dental officer, a dental specialist, two medical laboratory specialists, and two x-ray specialists. The dental officer supervises the activities of the area support squad.

(*a*) *Dental element*. The dental element provides emergency dental care (to include treatment of minor maxillofacial injuries), general dental care (designed to prevent or intercept potential dental emergencies), limited preventive dentistry, consultation services, and dental x-ray services.

(*b*) *Medical laboratory element*. The medical laboratory element performs clinical laboratory and blood banking procedures to aid physicians and PAs in the diagnosis, treatment, and prevention of diseases. Laboratory functions include performing elementary laboratory procedures consistent with the Echelon II laboratory MES. This element is responsible for—

- Storing and issuing blood (liquid red blood cells).
- Performing hematocrit procedures.
- Performing/estimating total white blood cell count and differential white blood count 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.

(*c*) *X-ray element*. The x-ray element operates radiological equipment consistent with the Echelon II x-ray MES. This element performs routine clinical x-ray procedures to aid physicians and PAs in the diagnosis and treatment of patients. Specific functions performed by this element include—

- Interpreting physicians' orders, applying radiation and electrical protective meas-ures, 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 monitoring, surveying, and documentation procedures.

- Serving on the radiological monitoring and surveying 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 of 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. The medical-surgical nurse assigned to the patient-holding squad provides nursing care supervision. Since Echelon II facilities such as the ASMCs 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.

3-4. 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 element 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 ASMC 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. The ambulance platoon headquarters element directs and coordinates ground evacuation of patients within the ASMC's AO. This element supervises the platoon and plans for its employment. It establishes and maintains contact with supported units and treatment squads of the ASMC. The ambulance headquarters element makes route reconnaissance and develops and issues strip maps. It also coordinates and establishes ambulance exchange points (AXPs) for both air and ground ambulances as required.

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 ASMC. The ambulance squads consist of 4 aide/evacuation NCOs and 12 aide/drivers. Ambulance squad personnel perform EMT, evacuate patients, and provide for their continued care en route. They also operate and maintain assigned radios. Ambulance squad personnel provide the EMT necessary to prepare patients for movement. They operate vehicles to evacuate the sick and wounded and perform PMCS on ambulances and associated equipment. Ambulance squad personnel 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).

3-5. Mental Health Section

a. Mental Health Staff. The ASMC MH staff consists of a behavioral science officer and a MH specialist (Table 3-3). The MH specialist assists the behavioral science officer with the accomplishment of his duties. The behavioral science officer participates in staff planning to represent and coordinate MH/CSC activities throughout the AO. The behavioral science officer and MH specialist are especially concerned with assisting and training—

- Small unit leaders.
- Unit ministry teams and staff chaplains.
- Battalion medical platoons.
- Patient-holding squad and treatment squad personnel of the ASMC.

Table 3-3. Area Support Medical Company Mental Health Section

AREA SUPPORT MEDICAL COMPANY MENTAL HEALTH SECTION STAFF
BEHAVIORAL SCIENCE OFFICER (CPT, AOC 67D00) MENTAL HEALTH SPECIALIST (E-3, MOS 91X10)

b. Combat Stress Control Support. The ASMC MH section provides training and advice in the control of stressors, the promotion of positive combat stress behaviors, and the identification, handling, and management of misconduct stress behavior and BF soldiers. It coordinates CSC training for supported units through the ASMC commander and battalion psychiatrist, as required. The section collects and records social and psychological data and counsels personnel with personal, behavioral, or psychological problems. General duties for personnel assigned to this section include—

- Assisting in a wide range of psychological and social services.
- Providing classes in stress control.
- Compiling caseload data.
- Providing counseling to soldiers experiencing emotional or social problems.
- Referring soldiers to specific hospital NP services or CSC unit facilities, physicians, or agencies when indicated.

- Conducting or facilitating group debriefings, counseling, and therapy sessions, and leading group discussions.

- Providing individual case consultation to commanders, NCOs, chaplains, battalion surgeons, and PAs within the supported AO.

- Collecting information from units regarding unit cohesion and morale, which include—

  - Obtaining data on disciplinary actions.

  - Collecting information with questionnaires.

  - Conducting structured interviews.

  - Collecting information on individual BF cases pertaining to the prior effectiveness of the soldier, precipitating factors causing the soldier to have BF, and the soldier's RTD potential.

The company MH section uses the ASMC clearing station as the center for its operations, but it is mobile throughout the AO. The section's primary functions are to promote positive stress behaviors, prevent unnecessary evacuations, and coordinate RTD, not to treat cases. Through the treatment platoon and ambulance platoon leaders and company commander, the section keeps abreast of the tactical situation and plans and projects requirements for CSC support when units are pulled back for rest and recuperation.

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 CHS mission. The process is further complicated by the ASMB's area support mission that 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 and risk assessments. It also involves planning, issuing instructions, and supervising.

a. Complexity. The complexity of the CHS 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 command/brigade 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 the innovativeness to get the job done. They must be well trained in communications and the decision-making process, see FM 101-5 to review the military decision-making process. They must also understand their organization and Army doctrine. They must comprehend 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 CHS.
- Ensure radio and data transmission nets are effectively used.
- Execute the plan as directed but coordinate and make adjustments, as required, to support mission accomplishment.
- State their capabilities in meaningful terms to the MEDCOM/brigade commander.

- Stay personally involved in and apprised of CHS operations and the tactical situation and/or threat.

- Comply with the law of land warfare, especially with respect to civilians, civil affairs, EPW, CMO, and Geneva Conventions requirements governing CHS operations (FMs 8-10 and 27-10).

- Understand their obligation to the soldiers under their command.

4-2. Medical Threat Assessment

a. A critical element of the CHS assessment is a thorough appraisal of the medical threat. This assessment includes the medical threat to the deploying forces and to the residents in the AO. The US soldier is placed at increased risk in stability operations and support operations scenarios as the incidence and exposure to infectious diseases and environmental hazards are greater in man-made or natural disaster areas and in developing nations. The medical threat is derived through established intelligence channels and from a variety of informational sources outside of the military.

b. The ability to obtain, interpret, and use medical intelligence is critical to the success of the CHS mission. Regardless of whether the operation is conducted within the US or abroad, man-made and natural disasters can cause a resurgence of diseases once thought to be at low epidemiological levels. This may result in environmental contamination. A combination of factors can result in the spread of communicable diseases in epidemic proportions and an increased opportunity for exposure to NBC hazards. These factors are—

- Disruption of sanitation services (such as garbage disposal or sewer systems).

- Contamination of food and water.

- Development of new breeding grounds for rodents and arthropods (such as in rubble or in stagnant pools of water).

- Disruption of industrial operations.

- Dispersion of biological or radiological waste by improper handling or terrorist activity.

(1) Medical intelligence is the product resulting from the collection, evaluation, analysis, integration, and interpretation of all available general health and bioscientific information. Medical intelligence is concerned with one or more of the medical aspects of foreign nations or the AO and which is significant to CHS or general military planning. Until medical information is processed, it is not considered to be medical intelligence. Medical threat information in AOs outside the US can be obtained from the Armed Forces Medical Intelligence Center (AFMIC). Medical threat information in AOs within the US can be obtained from—

- United States Army Medical Command.

- United States Army Medical Department medical centers and activities within the immediate area.
- United States Army Special Operations Command.
- United States Civil Affairs and Psychological Operations Command.
- Local public health officials.
- American Public Health Association (FM 8-33).
- Centers for Disease Control and Prevention.
- World Health Organization.

(2) The special training of PVNTMED personnel, as well as other medical professionals, is used to provide a clear assessment of the medical threat. Preventive medicine personnel are specifically trained and equipped to collect, analyze, and interpret health information. When the assessment includes oral, dental, or maxillofacial considerations, the dental public health officer has similar specialized training in his field. The veterinary officer can provide expertise in the public health ramifications of zoonotic diseases and biological and chemical warfare agents. These personnel can make recommendations for types of activities to be accomplished and their priority for support. Using these skills maximizes the efficient use of limited CHS resources. For consultation purposes during the assessment, the medical personnel conducting the assessment must have access to all medical professionals within the CHS force and the local medical community.

c. Combat health support planners must acquaint themselves with the currently existing intelligence products. These products include national-level intelligence products such as the Medical Capabilities Studies, the AFMIC MEDIC CD-ROM, and Disease Occurrence Worldwide and access to Intellink which is located at brigade or higher level. These reports are specifically produced to support US military CHS operations conducted outside continental United States (OCONUS). These reports can be obtained through operational and medical intelligence channels (such as the medical group S2 or the corps surgeon's office). (Refer to FM 8-10-8 for specific information.)

d. As CHS plans and operations progress, the requirements for additional medical intelligence will occur. All such requirements should be requested through intelligence channels as soon as they are validated; when required, coordination should be effected with local agencies.

e. In OCONUS operations, the CHS planner must make himself aware of the medical threat posed by the disaster (such as continued flooding, earthquakes and aftershocks, or further explosions) and groups, factions, opponents, terrorists, or enemy forces operating within the AO. This threat also includes the capabilities and potential use of weapons systems and munitions, such as NBC, directed-energy (DE) weapons or devices, or conventional armaments, and the potential for terrorist attacks or incidents, including the use of CW and BW agents without weapons delivery systems. Combat health support planning and force survivability necessitates that CHS units remain abreast of the complete intelligence picture.

f. The medical threat includes the stress threat. The stress threat encompasses all stressors in the environment which are likely to threaten the mission and the soldier's current and future well-being. The stress threat can result in—

- Misconduct stress behaviors.
- Posttraumatic stress disorder.
- Battle (conflict) fatigue.
- Neuropsychiatric disorders including organic mental disorders.

g. Should CHS personnel gain information of potential medical intelligence value while in the performance of their duties, they are required to report it to their supporting intelligence element (FM 8-10-8).

h. For additional information on infectious diseases and their prevalence, refer to FM 8-33.

i. For additional information on the medical threat and intelligence preparation of the battlefield, refer to FM 8-10-8 and FM 8-55.

4-3. Combat Health Support Planning

The ASMB commander has overall responsibility for the development of the CHS plan. The S3 is the primary staff element involved with coordinating and collecting information from other staff elements and subordinate units that will be used to develop the plan. Combat health support estimates developed by the ASMB staff and subordinate units are also provided to the MEDCOM/brigade for use in developing the CHS estimates for the corps or COMMZ. All factors must be considered during the initial development stages of the CHS plan. The CHS plan is updated as required to meet tactical or CHS operational requirements. Field Manuals 8-55 and 8-42 provide an in-depth discussion of the planning process and the considerations for CHS operations. The ASMB commander should consider the following factors as he develops and reviews the ASMB's CHS plan or provides input to the MEDCOM's/brigade's CHS plan:

- Mission.
- Rules of engagement.
- Threat.
- Force protection.
- Medical command/brigade commander's estimates, guidance, and intent.
- Operational conditions.
- Operational constraints.

- Terrain/environmental factors (weather).
- Military population supported to include allied and host nation (HN).
- Personnel status (ASMB headquarters and subordinate elements).
- Equipment status of the ASMB.
- Supply status (Class VIII and nonmedical).
- Host-nation support.
- Medical 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 (commander critical information requirements such as medical intelligence updates, maps, and essential elements of friendly information [EEFI] updates).
- Blood status.
- Policy and procedure updates.
- Humanitarian aid to local nationals.
- Potential EPW support requirements.
- Potential civilian/refugee actions.

4-4. Combat Health Support Estimates

The ASMB staff and ASMC commanders prepare CHS 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 (see Table 4-1). These recommendations are used by the commander to determine and select the best courses of actions. Adequate CHS plans are dependent on early and continuing estimates by the ASMB staff and ASMC commanders. 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.

a. Products of the mission analysis will be restated in the ASMB mission, which becomes paragraph 2 of the battalion's OPORD.

b. Battalion course of action development/analysis and wargaming are accomplished after mission analysis. Course of action development and wargaming result in the production of the OPORD and the CHS Annex of the supported combat arms, CS, or CSS units. The following is an example of key areas which will be looked at during this process:

- Were casualty estimates developed (is the breakdown to the lowest level possible, by task force, by phase line, and so forth)?
- Were task organizations established (if required, are they different from habitual DS relationships)?
- What is the range of enemy indirect fire weapons as they affect CHS assets?
- What is the likely target area of enemy chemical weapons strike and types of agents?
- What actions are being implemented if required to combat the medical threat?
- What is the current CHS slant (maintenance status on all ASMB's key items of equipment both medical and nonmedical)?

Table 4-1. Estimate of the Situation

1. MISSION ANALYSIS.

A. MISSION AND INTENT OF COMMANDER TWO LEVELS UP.
B. MISSION AND INTENT OF IMMEDIATE COMMANDER.
C. ASSIGNED TASKS (SPECIFIED AND IMPLIED).
D. CONSTRAINTS AND LIMITATIONS.
E. MISSION-ESSENTIAL TASKS.
F. RESTATED MISSION.
G. TENTATIVE TIME SCHEDULE.

2. ESTIMATE THE SITUATION AND DETERMINE COURSES OF ACTION.

A. TERRAIN AND WEATHER.

(1) TERRAIN—OBSERVATION AND FIELDS OF FIRE CONCEALMENT AND COVER, OBSTACLES, KEY TERRAIN, AND AVENUES OF APPROACH.
(2) WEATHER—VISIBILITY, MOBILITY, AND SURVIVABILITY.

B. ENEMY SITUATION AND COURSES OF ACTION.

(1) COMPOSITION.
(2) DISPOSITION.
(3) RECENT ACTIVITIES.
(4) CAPABILITIES.
(5) WEAKNESS.
(6) MOST PROBABLE COURSE OF ACTION (ENEMY USE OF METT-TC).
(7) MOST DANGEROUS COURSES OF ACTION.

C. FRIENDLY SITUATION—METT-TC.

D. FRIENDLY COURSES OF ACTION. DEVELOP A MINIMUM OF TWO.

3. ANALYSIS OF COURSES OF ACTION.

A. SIGNIFICANT FACTORS.

B. WARGAME.

4. COMPARISON OF COURSES OF ACTION.

5. DECISION.

c. Once the supported units receive their OPORD, they conduct mission analysis and decide their scheme of maneuver. Part of deciding their scheme of maneuver is the placement of medical treatment units/elements . This information is coordinated with the ASMB's S3 (medical plan/operations), so that he can review the plans from the battalion-level perspective. The battalion S3 will issue the battalion OPORD for the ASMCs and attached units based on the MEDCOM/brigade OPLAN/OPORD. The ASMB OPORD

is issued by the MEDCOM/brigade for the ASMB. Provided below in Table 4-2 is an example of an OPORD format. The ASMB S3 staff is responsible to the ASMB commander for staff supervision of the battalion's CHS operations. The S3 is also responsible for coordinating the DS relationships of organic medical units and medical elements OPCON or attached to the supported units. The battalion commander oversees CHS operations and ensures the supported units are provided adequate support.

d. The MEDCOM/brigade OPLAN and OPORD, when published, are developed by the MEDCOM/brigade S3 section using input from each of the staff elements of the MEDCOM/brigade headquarters and input from subordinate units. The OPLAN may be revised or updated as required, based on mission analysis or changes in CHS requirements.

Table 4-2. Operation Order or Plan Outline Format

(CLASSIFICATION)
(CHANGE FROM ORAL ORDERS, IF ANY)

COPY _____ OF _____ COPIES
ISSUING HEADQUARTERS
PLACE OF ISSUE
DATE-TIME GROUP OF SIGNATURE
MESSAGE REFERENCE NUMBER

OPERATION PLAN (ORDER) _____(CODE NAME).
(NUMBER)

REFERENCES:

TIME ZONE USED THROUGHOUT THE PLAN (ORDER):

TASK ORGANIZATION:

1. SITUATION.
A. ENEMY FORCE.
B. FRIENDLY FORCE.
C. ATTACHMENTS AND DETACHMENTS.
D ASSUMPTION (OPLAN ONLY).

2. MISSION.

3. EXECUTION.
INTENT:
A. CONCEPT OF OPERATIONS.
(1) MANEUVER.
(2) FIRES.
(3) RECONNAISSANCE AND SURVEILLANCE.
(4) INTELLIGENCE.
(5) ENGINEER.
(6) AIR DEFENSE.
(7) INFORMATION OPERATIONS.

Table 4-2. Operation Order or Plan Outline Format (Continued)

B. TASK TO MANEUVER UNITS.
C. TASKS TO COMBAT SUPPORT UNITS.
(1) INTELLIGENCE.
(2) ENGINEER.
(3) FIRE SUPPORT.
(4) AIR DEFENSE.
(5) SIGNAL.
(6) NBC.
(7) PROVOST MARSHAL.
(8) PSYOP.
(9) CIVIL MILITARY.
(10) AS REQUIRED.
D. COORDINATING INSTRUCTIONS.
(1) TIME OR CONDITION WHEN A PLAN OR ORDER BECOMES EFFECTIVE.
(2) COMMANDER'S CRITICAL INFORMATION REQUIREMENTS.
(3) RISK REDUCTION CONTROL MEASURES.
(4) RULES OF ENGAGEMENT.
(5) ENVIRONMENTAL CONSIDERATIONS.
(6) FORCE PROTECTION.
(7) AS REQUIRED.

4. SERVICE SUPPORT.
A. SUPPORT CONCEPT.
B. MATERIEL AND SERVICES.
C. MEDICAL EVACUATION AND HOSPITALIZATION.
D. PERSONNEL.
E. CIVIL MILITARY.
F. AS REQUIRED.

5. COMMAND AND SIGNAL.
A. COMMAND.
B. SIGNAL.

ACKNOWLEDGE:

NAME: (COMMANDER'S LAST NAME)
RANK: (COMMANDER'S RANK)

OFFICIAL:
NAME AND POSITION

ANNEX E:

(CLASSIFICATION)

Section II. CONDUCTING COMBAT HEALTH SUPPORT FOR MILITARY ACTIONS

4-5. Force Projection

a. The force projection process involves eight related activities. These activities include mobilization; predeployment; deployment (including basing); entry (including reception, staging, onward movement, and integration [RSO&I]) and force buildup; decisive operations; postconflict and postcrisis actions; redeployment; and demobilization. For detailed information on the force projection process, see FMs 100-7 and 100-17.

b. The first rule of anticipation for the ASMB's staff in a force projection era is to be prepared for deployment. If the ASMB has been assigned a region of focus in peacetime, planning should occur long before alert and deployment. Appropriate actions include ordering and posting maps, studying available infrastructures, familiarizing soldiers with the predominant language, training soldiers for deployment and sensitizing soldiers to AO cultures. Key to successful force projection operations is continuous force tracking, total asset visibility during deployment, and continuous intelligence preparation of the battlefield (IPB) of the contingency area.

c. Many of the ASMB missions assigned to support US Army forces will be received as short-notice deployments. The advance preparation time will be limited. Normally, due to the sensitivity of the OPSEC level of the operation, the number of individuals engaged in the planning process may also be restricted. It is, therefore, necessary for the ASMB commander to ensure that his unit is administratively ready for a short-notice deployment. For definitive information on short-notice deployments for stability operations and support operations, see FMs 8-42 and 100-5.

4-6. Deployment and Entry Operations

a. In an ideal situation secure bases are available in the AO for RSO&I and continuous support to the deploying forces. Other situations, because of the risk factors, will require that an intermediate staging base (ISB) be located in the TO and outside the CZ and AO. If established, this base may serve as the theater reception and staging facility into the TO. Area support medical battalion, ASMC, and subordinate unit commanders must have the means for maintaining C2 when they have arrive at the ISB. All essential equipment and material for C2 should be transported with personnel. After debarkation from strategic lift, these units reassemble and prepare for onward movement.

b. Upon arrival at the ISB, 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. Onward movement from the ISB to the CZ may be multimodal and require some level of reassembly in the AO. Transportation assets employed in onward movement will normally include strategic and theater assets including trucks, rail, sea, and airlift. These movements are a part of deployment and should be included in the time-phased force deployment data (TPFDD).

c. The medical command/brigade headquarters element assists the ASMB and its subordinate units with their initial entry into the theater and AO. As part of the initial orientation, the battalion is briefed on current operating policies and procedures. In addition, the battalion is provided all operation orders/ fragmentary orders and warning orders with information pertaining to—

- Force protection.
- Security requirements.
- Current threat update, to include the medical threat.
- Preventive medicine requirements.
- Mission update.
- Personnel restrictions.
- Rules of engagement.
- Emergency warning signals.
- Combat health support issues.
- Hospitalization support.
- Supply procedures.
- Blood support.
- Available support (including HN).
- Vehicle/unit movement requirements.
- Local laws and customs.
- Personnel replacements.
- Religious support.
- Uniform requirements.
- Finance support.
- Personnel support.
- Morale support.

- Supported and supporting units.
- Status of Forces Agreements.

4-7. Rear Operations

a. The corps conducts rear operations to assure freedom of maneuver and the continuity of operations, including sustainment, clear C2 arrangements, and dedicated fire support. The corps must synchronize the rear operations functions of terrain management, security, sustainment, and movements with the corps' close and deep operations, in keeping with the corps commander's concept and intent.

b. While the Assistant Chief of Staff, G3 (Operations and Plans) and the S3 are responsible, overall, for terrain management, commanders of rear CPs usually position supporting units in rear areas. Once in position, these units become a base (a unit or multiunit position with a definite perimeter) or part of a base cluster (a mission grouping of bases and/or security requirements that lack a clearly defined perimeter). Corps medical units are located within these base clusters. Of interest, AR 600-20 prohibits medical unit commanders (Medical Corps officer only) from commanding a base or a base cluster containing nonmedical units.

c. Rear area operations include security operations to ensure sustainment is not interrupted. Three levels of responses to threat activities serve as guides for planning rear operations. Rather than focusing on the size or the type of threat, the following levels focus on the nature of friendly actions needed to defeat the threat:

- Level I threats can be defeated by base or base cluster self-defense measures.
- Level II threats are beyond base or base cluster self-defense capabilities but can be defeated by response forces, normally military police (MP) units with supporting fires.
- Level III threats necessitate a command decision to commit a corps combined arms tactical combat force (TCF) to defeat them. An MP brigade, properly augmented, may be designated as the TCF.

d. Continuous reconnaissance and timely intelligence-collection and dissemination are essential for successful rear operations. Based on a thorough IPB and counterintelligence risk assessments, rear operations planning must include—

- Base and base cluster self-defense.
- A response to defeat Level II attacks that exceed base and base defense cluster capabilities.
- The commitment of a TCF to defeat a Level III threat.

e. Rear area operations include planning and directing sustainment. Synchronizing these actions with the concept of operations is critical to the success of close and deep operations. Rear operations also

ensure that sustainment is not degraded by and does not limit the force commander's freedom of maneuver and continuity of operations.

f. Movement control includes planning, prioritizing, deconflicting, and executing movement plans, both internal and external (other US forces and HN) to a unit. The G3 and S3 staffs are responsible, overall, for directing the movement of tactical units through or within AOs.

g. Rear CPs are generally responsible for administrative moves and for prioritizing and deconflicting movements within rear areas as well as planning for sustainment of tactical movements within the division rear.

h. The commander must give one specific individual, normally the deputy corps commander, the responsibility and authority to control all aspects of corps rear operations. His responsibilities include—

- Command and control of units task-organized for rear operations.

- Coordinating and synchronizing corps rear operations with close and deep operations in keeping with the commander's intent.

- Planning, organizing, directing, and coordinating assigned and attached units to accomplish sustainment, terrain management, movement, and security.

i. For definitive information on rear operations, see FM 100-15.

4-8. Combat Health Support for the Offense and Defense

a. Support to the Offense.

(1) The offense is the decisive form of war, the commander's only means of attaining a positive goal or of completely destroying an enemy force (FM 100-5). Rapid movement, deep penetrations, aggressive action, and the ability to sustain momentum regardless of counterfires and countermeasures characterize the offense.

(2) When considering the CHS plans to support the offense, the CHS planner must consider many factors (FM 8-55). The forms of maneuver, as well as the enemy's capabilities, influence the character of the patient workload and its time and space distribution. The analysis of this workload determines the allocation of CHS resources and the location or relocation of MTFs.

(3) Combat health support for the offensive operations must be responsive to several essential characteristics. As operations achieve success, the areas of casualty density move away from the supporting MTF. This causes the routes of medical evacuation to lengthen. Heaviest patient workloads occur during disruption of enemy main defenses, at terrain or tactical barriers, during the assault on final objectives, and during enemy counterattacks. The accurate prediction of these workload points by the CHS planner is essential if medical evacuation operations are to be successful.

(4) In traditional combat operations, the major casualty area of the operation is normally the zone of the main attack. As the main attack accomplishes the primary task of the tactical combat force, it receives first priority in the allocation of combat power. The allocation of combat forces dictates roughly the areas that are likely to have the greatest casualty density. As a general rule in the corps, Echelon I and Echelon II MTFs are located initially as close as combat operations permit. This allows the maximum use of these MTFs before lengthening medical evacuation lines force their displacement.

(5) In operations that feature deep battles with weapons of mass destruction targeted at supporting logistical bases, mass casualty operations may be conducted in rear areas.

(6) As advancing combat formations extend control of the battle area, supporting medical elements have the opportunity to clear the battlefield. This facilitates the acquisition of the battle wounded and reduces the vital time elapsed between wounding and treatment. There are two basic problems confronting the supporting medical units and medical evacuation elements. First, contact with the supported units must be maintained. Responsibility for the contact follows the normal CHS pattern—rear to front.

NOTE

On the nonlinear battlefield, the word "front" pertains to the area where maneuver elements are engaged in battle. The word "rear" is used to identify areas where CSS and other support element are positioned to support the battle.

The contact is maintained by forward deployed air and ground evacuation resources. Secondly, the mobility of the MTFs supporting the combat formations must be maintained. Periodically, ASMCs, FSTs, and CSHs are cleared so that they may move forward. This requirement for prompt medical evacuation of patients from forward MTFs requires available ambulances to be echeloned well forward from the outset. Air ambulance and also ground ambulance support beyond the capabilities of the ASMB is requested from the corps medical evacuation battalion. The requirement for the periodic movement of large numbers of patients from divisional and corps facilities further stresses the medical evacuation system.

(7) Types of operations in the offense include:

(*a*) *Movement to contact*. Medical evacuation support in movement to contact is keyed to the tactical plan. Prior deployment of ASMC ground ambulances with the TCF's organic medical platoons permits uninterrupted and effective medical evacuation support.

(*b*) *Exploitation and pursuit*. Medical evacuation support of exploitation and pursuit operations resemble those discussed for the envelopment (paragraph 4-9*a*[2]). Since exploitation and pursuit operations can rarely be planned in detail, evacuation operations must adhere to TSOPs and innovative C2. These actions are often characterized by—

- Decentralized operations.

- Unsecured ground evacuation routes.
- Exceptionally long distances for evacuation.
- Increased reliance on convoys and air ambulances.

(*c*) *Attack*. Refer to paragraph 4-9*a*(4).

b. *Support to the Defense*. There are three forms of the defense: area defense, mobile defense, and retrograde. The area defense concentrates on denying enemy access to designated terrain for a specific period of time, rather than on the outright destruction of the enemy. The mobile defense focuses on denying the enemy force by allowing him to advance to a point where he is exposed to a decisive counterattack by the striking force. The primary defeat mechanism, the counterattack, is supplemented by the fires of the fixing force. The third form of defense is the retrograde. The retrograde is an organized movement to the rear and away from the enemy. The enemy may force these operations or a commander may execute them voluntarily. Within the retrograde operation there are three forms—delay, withdrawal, and retirement.

(1) Support is generally more difficult to provide in the defense. The patient load reflects lower casualty rates, but enemy actions and the maneuver of combat forces complicate forward area patient acquisition. Medical personnel are permitted much less time to reach the patient, complete vital EMT, and remove him from the battle site. Increased casualties among exposed medical personnel further reduce the medical treatment and evacuation capabilities. Heaviest patient workloads, including those produced by enemy artillery and NBC weapons, may be expected during the preparation or initial phase of the enemy attack and in the counterattack phase. The enemy attack may disrupt ground and air routes and delay evacuation of patients to and from treatment elements. The depth and dispersion of the defense create significant time and distance problems for evacuation assets. Combat elements may be forced to withdraw while carrying their remaining patients to the rear. The enemy exercises the initiative early in the operation, which may preclude accurate prediction of initial areas of casualty density. This makes the effective integration of air assets into the medical evacuation plan essential. The use of air ambulances must be coordinated with the medical evacuation battalion and integrated into the CHS annex to the OPORD, and also into the Army airspace command and control (A2C2) annex.

(2) The CHS requirements for retrogrades may vary widely depending upon the tactical plan, the enemy reaction, and the METT-TC factors. Firm rules that apply equally to all types of retrograde operations are not feasible, but considerations include—

- Requirement for maximum security and secrecy in movement.
- Influence of refugee movement, which may impede medical evacuation missions, conducted in friendly territory.
- Integration of evacuation routes and obstacle plans should be accomplished.
- Difficulties in controlling and coordinating movements of the force which may produce lucrative targets for the enemy.

- Movements at night or during periods of limited visibility.

- Time and means available to remove patients from the battlefield. In stable situations and in the advance, time is important only as it affects the physical well-being of the wounded. In retrograde operations, time is more important. As available time decreases, CHS managers at all echelons closely evaluate the capability to collect, treat, and evacuate all patients.

- Medical evacuation routes will also be required for the movement of troops and materiel. This causes patient evacuation in retrograde movements to be more difficult than in any other type of operation. The enemy may disrupt command, control, and communications. Successful medical evacuation requires including ambulances on the priority list for movement; providing for the transportation of the slightly wounded in cargo vehicles; and providing guidance to subordinate commanders defining their responsibilities in collecting and evacuating patients. Special emphasis must be placed on the triage of patients and consideration given to the type of transportation assets available for evacuation.

- When the patient load exceeds the means to move them, the tactical commander must make the decision as to whether patients are to be left behind. The medical staff officer keeps the tactical commander informed in order that he may make a timely decision. Medical personnel and supplies must be left with patients who cannot be evacuated. (Refer to FM 8-10 for additional information.)

4-9. Combat Health Support for Choices of Maneuver and Enabling Operations

a. Choices of Maneuver.

(1) *Penetration*. In this tactic, the attack passes through the enemy's principal defensive position, ruptures it, and neutralizes or destroys the enemy forces. Of all forms of offensive maneuver, the penetration of main enemy defenses normally produces the heaviest medical evacuation workload. Patient acquisition starts slowly, but becomes more rapid as the attack progresses. The evacuation routes lengthen as the operation progresses. Heavy preparatory fires which may evoke heavy return fire often precede the penetration maneuver. These enemy fires may modify the decision to place evacuation assets as far forward as possible. A treatment team may be deployed forward in support of maneuver battalion BAS. Patient evacuation may be slow and difficult due to damage to roads or the inaccessibility of patients. Medical evacuation support problems multiply when some combat units remain near the point of original penetration. This is done to hold or widen the gap in enemy defenses while the bulk of TCFs exploit or pursue the enemy. Treatment elements are placed near each shoulder of the penetration; ground evacuation cannot take place across an avenue of heavy combat traffic. Because of the heavy traffic, the area of the penetration is normally a target for both conventional and NBC weapons.

(2) *Envelopment*. In the envelopment, the main or enveloping attack passes around or over the enemy's principal defensive positions. The purpose is to seize objectives which cut his escape routes and subject him to destruction in place from flank to rear. Since the envelopment maneuver involves no direct breach of the enemy's principal defensive positions, the medical evacuation system is not confronted with a heavy workload in the opening phase. Ambulances are echeloned well forward in all echelons of CHS to quickly evacuate the patients generated by suddenly occurring contact. Medical treatment facilities

moving with their respective formations assist with clearing the battlefield to reduce delays in treatment. After triage and treatment, the patients are evacuated to MTF in the rear by supporting ground ambulance from the medical evacuation battalion or from ASMB ambulance assets. When the isolated nature of the envelopment maneuver precludes prompt evacuation, the patients are carried forward with the treatment element. Again, nonmedical vehicles may be pressed into emergency use for this purpose. When patients must be carried forward with the enveloping forces, CHS commanders use halts at assembly areas and phase lines to arrange combat protection for ground ambulance convoys through unsecured areas. Further, the commander may take advantage of friendly fires and suppression of enemy air defenses to call for pre-arranged air ambulance support missions, or emergency use of medium-lift helicopter backhaul capabilities.

(3) *Infiltration*.

(*a*) Infiltration is a choice of maneuver used during offensive operations. The division can attack after infiltration or use it as a means of obtaining intelligence and harassing the enemy. Though it is not restricted to small units or dismounted actions, the division employs these techniques with a portion of its units, in conjunction with offensive operations conducted by the remainder of its units.

(*b*) Combat health support of infiltration is restricted by the amount of medical equipment, supplies, and transportation assets that can be introduced into the attack area. No deployment of ASMCs without their organic transportation should be attempted. Elements of unit-level CHS should be accompanied by their organic vehicles, and ambulances should receive priority for deployment. It may be necessary to man-carry enough BAS equipment into the attack area to provide EMT and ATM; this, however, results in degrading mobility. When the element is committed without its ambulances, patients are evacuated to the BAS by litter bearer teams. This requires reinforcement of the medical platoon by corps medical personnel or improvisation of litter teams using combat troops (if available and approved by the tactical commander). Patient evacuation from the BAS and medical resupply of the force may be provided by litter bearers, depending upon distances and degree of secrecy required.

(*c*) When airborne and air assault forces are used, infiltrating elements may land at various points within the enemy's rear area and proceed on foot to designated attack positions. As in surface movement, the amount of medical equipment taken may be limited. In airborne operations, the evacuation of patients will be by litter bearers or frontline ambulances to collecting points or the BAS and then by ASMC ambulances to the clearing station operated by the ASMC treatment platoon. In air assault operations, the evacuation is by litter bearers to collecting points or to the BAS and then by air ambulances to a clearing station. Once the combat element begins the assault on the objective, secrecy is no longer important and its isolated location requires CHS characteristic to airborne and air assault operations until ground linkup.

(4) *Turning movement*. The turning movement is a variant to the envelopment in which the attacker attempts to avoid the defense entirely; rather, the attacker seeks to secure key terrain deep in the enemy's rear and along his lines of communication (LOC). Faced with a major threat to his rear, the enemy is thus "turned" out of his defensive positions and forced to attack rearward at a disadvantage.

- General MacArthur's invasion at Inchon during the Korean War is an example of a classic turning movement. Casualties were initially light as the main defenses were avoided; however, as

the invasion developed, resistance stiffened and higher casualty rates were experienced. Further, as fighting occurred in a populated area (Seoul), significant civilian casualties resulted. The lack of Korean health care providers caused many of these civilians to seek medical aid from US field medical units.

- Medical evacuation support to the turning movement is provided basically in the same manner as to the envelopment. As the operation is conducted in the enemy's rear area, LOC and evacuation routes may be unsecured resulting in delays in resupply and evacuation. In the Inchon example, a hospital ship was located off the coast to accept patients evacuated from the fighting. However, due to the precarious tides, evacuation and resupply were often delayed for hours and sometimes days since the harbor could not be navigated by small vessels. It was not until Kimpo Airfield fell that timely evacuation could occur. The deployed CHS units must be able to quickly clear the battlefield of patients, evacuate them from the forward areas, and sustain the patients in rear areas until evacuation routes are established.

b. Enabling Operations.

(1) *Passage of lines*. This situation presents a challenge for the CHS planner. There will be a number of medical evacuation units using the same air and road networks. Coordination and synchronization are essential if confusion and overevacuation are to be avoided. The information required to operate in the division AO includes—

- Radio frequencies and call signs.
- Operations plans and TSOPs.
- Location of MTFs.
- Location of patient collecting points and AXPs.
- Main supply route (MSR), forward arming and refueling points, and A2C2 data.

(2) *Security operations*. The covering forces are dependent upon organic resources found in the maneuver battalion medical platoon for initial support. The level of command for the covering force determines the responsibility for the subsequent evacuation plan. In a corps covering force, for example, the corps CHS structure has the responsibility for establishing and operating the medical evacuation system to support the forward deployed corps forces. This is done to prevent the TCF following the covering forces from becoming overloaded with patients prior to the hand off and passage of lines. The use of patient collecting points, AXPs, and nonmedical transportation assets (casualty evacuation) to move the wounded is essential. The covering force battle may be extremely violent. Patient loads will be high and the distance to MTFs may be much longer than usual. The effectiveness of the medical evacuation system depends upon the forward positioning of a number of ground ambulances and the effective integration of corps air ambulances into the evacuation plan.

(3) *Advance, flank and rear guards*. These forces normally receive medical evacuation support through the attachment of evacuation teams. The teams evacuate patients to predesignated patient collecting points along a main axis of advance or to the nearest treatment element providing area support. Employment of air ambulances provide a measure of agility and flexibility.

(4) *River crossing operations*. The river barrier itself exerts decisive influence on the use of medical units. Attack across a river line creates a CHS delivery problem comparable to that of the amphibious assault. Combat health support elements cross as soon as combat operations permit. Early crossing of treatment elements reduces turnaround time for all crossing equipment that is used to load patients on the far shore. Maximum use of air ambulance assets is made to prevent excessive patient buildup in far shore treatment facilities. Near shore MTFs are placed as far forward as assault operations and protective considerations permit to reduce ambulance shuttle distances from off-loading points. For detailed information on river crossing operations refer to FM 90-13.

(5) *Reconnaissance operations*. The reconnaissance in force is an *attack* to discover and test the enemy's position and strength or to develop other intelligence. The TCF usually probes with multiple combat units of limited size, retaining sufficient reserves to quickly exploit known enemy weaknesses. Combat health support techniques follow those discussed for a movement to contact discussed above. Ambulances are positioned well forward and moved at night to enhance secrecy. The echeloning of ambulances is an indication to the enemy that an attack is imminent due to the forward placement of CHS. Clearing stations are not established until a significant patient work load develops. Patients received at BAS of reconnoitering units are evacuated to clearing stations as early as practical, or are carried forward with the force until a suitable opportunity for evacuation presents itself. Maximum possible use of air ambulance assets is made to cover extended distances and to overcome potentially unsecured ground evacuation routes.

(6) *Unified action*. The majority of the operations occurring at the present time are joint, interagency, or multinational operations. The CHS planner must determine in the initial planning stages of these operations whose responsibility it is to provide medical evacuation support to the force. The CHS planner must also ensure that duplications in support do not exist, guidelines are established as to eligible beneficiaries and when individuals are to be returned to their own nation's health care delivery system, and what mechanisms exist for reimbursement of services. For additional information refer to FM 8-42.

(7) *Integrated warfare operations*. Medical evacuation in an NBC environment is discussed in paragraph 5-6.

4-10. Combat Health Support for Stability Operations

a. Overview of Stability Operations.

(1) Stability operations apply military power to influence the political environment, facilitate diplomacy, and interrupt specified illegal activities. They include both developmental and coercive actions. *Developmental actions* enhance a government's willingness and ability to care for its people. *Coercive actions* apply carefully prescribed limited force and the threat of force to achieve objectives. The types of activities conducted in stability operations include—

- Peace operations.
- Operations in support of diplomatic efforts.

- Combatting terrorism operations.
- Counterdrug operations.
- Noncombatant evacuation operations (NEO).
- Arms control.
- Nation assistance and foreign internal defense.
- Support to insurgencies.
- Support to counterinsurgencies.
- Shows of force.
- Civil disturbance operations.

(2) While each operation in this environment is unique, there are seven broad imperatives that enhance the deployed forces' ability to develop concepts and schemes for executing stability operations. These imperatives are:

- Stress force protection.
- Emphasize information operations.
- Maximize interagency, joint, and multinational cooperation.
- Display the capability to apply force without threatening.
- Understand the potential for disproportionate consequences to individual and small-unit actions.
- Apply force selectively and discriminatingly.
- Act decisively to prevent escalation.

b. Combat Health Support for Stability Operations.

(1) Combat health support to forces deployed for stability operations is dependent upon the specific type of operation, anticipated duration of the operation, number of forces deployed, theater evacuation policy, medical troop ceiling, and anticipated level of violence. In most situations, CHS follows the traditional support provided to combat forces. If there is a shortened theater evacuation policy, a limited medical troop ceiling, and limited hospitalization assets within the AO, organic and DS ambulance support is provided from the point of injury to the supporting Echelons I or II MTF and, once the patient is stabilized for further evacuation, from the treatment element to an airfield for evacuation out of the theater.

(2) During NEO, those persons who are injured, wounded, or ill are treated and stabilized by the medical element accompanying the NEO force. Once stabilized, the NEO force evacuates them. In NEO conducted in a permissive environment (no apparent physical threat to the evacuees), sick, injured, or wounded persons should be evacuated on dedicated medical evacuation platforms, if at all possible. In an uncertain or hostile environment, the transportation assets used to insert and extract the NEO force are normally used to evacuate the patients. The medical personnel accompanying the force provide en route medical care until the NEO force reaches an ISB or safe haven. Those evacuees requiring medical care are then transferred to dedicated medical evacuation platforms for further evacuation to MTFs capable of providing the required care.

(3) During combatting terrorism operations, planning considerations for CHS include—

- Using medical and nonmedical transportation assets to evacuate casualties in mass casualty situations. If nonmedical assets are used, planning should include augmenting these assets with medical personnel to provide en route medical care.

- Applying techniques for acquiring and evacuating patients under hostile fire or on adverse terrain (from rubble or from above or below ground level). (Refer to FM 8-10-6 for additional information.)

- Ensuring security measures (such as establishing checkpoints, screening personnel and vehicles, and limiting access to the MTF area) are implemented.

(4) In nation assistance, support to insurgencies, and support to counterinsurgencies, medical personnel may be called upon to assist in the development of a medical evacuation system for the supported nation/group; to teach civilian, military, or paramilitary personnel basic evacuation techniques and the treatment protocols for providing provision of en route medical care; and/or to provide the more traditional support from the point of injury to the supporting treatment element.

(5) For additional information, refer to FM 8-42.

4-11. Combat Health Support for Support Operations

a. Support operations provide essential supplies and services to assist designated groups. They are conducted mainly to relieve suffering and help civil authorities respond to crises. In most cases, Army forces achieve success by overcoming conditions created by man-made or natural disasters. The ultimate goal of support operations is to meet the immediate needs of designated groups and transfer responsibility quickly and efficiently to appropriate civilian authorities. Support operations, which consist of humanitarian assistance and environmental assistance accomplish one or more of the following: save lives; reduce suffering; recover essential infrastructure; improve quality of life; and restore situations to normal. The seven broad support imperatives are—

- Secure the force.

- Provide essential support to the largest number of people.
- Coordinate actions with other agencies.
- Hand over to civilian agencies as soon as feasible.
- Establish measures of success.
- Conduct robust information operations.
- Ensure operations conform to legal requirements.

b. Humanitarian assistance operations can include a number of activities such as disaster relief, domestic support, refugee assistance, the provision of medical care to isolated populations, and refeeding programs resulting from famines or natural disasters. Medical evacuation assets may be used to evacuate the injured from disaster sites, to provide the emergency transport of critically needed medical supplies and personnel to remote locations, or to perform emergency rescues during times of flooding, wild fires, or other natural disasters.

c. Further, medical personnel may perform community assistance missions such as the Military Assistance to Safety and Traffic program, where an air ambulance unit provides evacuation support to the nearby civilian community.

4-12. Mass Casualty Operations

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

4-13. Combat Health Support in Nuclear, Biological, and Chemical Defensive Operations

Nuclear, biological and chemical weapons of mass destruction and strategic delivery systems exist throughout the world. The corps' and division's sustainment and support capabilities are prime target for the enemy's NBC weapons. The ASMB and subordinate units can expect to conduct operations in an NBC environment. Although the ASMB or its subordinate units may not be specifically targeted, locating close to supported CS and CSS units and near road junctions make them vulnerable to NBC weapons of mass destruction. Prompt notification of, and reaction to, downwind messages in the event of NBC employment will enhance both unit and individual NBC defensive measures. Defensive measures include all measures necessary to increase the effectiveness of operations and reduce the degradation to operational tempo and to minimize casualties. These measures may be either proactive or reactive in nature. They include contamination avoidance and control, protection, and decontamination. Field Manuals 3-3, 3-3-1, and 3-4 provide

specific guidance for NBC avoidance protection. For definitive information on CHS in an NBC environment, see FMs 8-10-7 and 8-9.

a. Combat health support planning factors for nuclear, biological, and chemical defensive operations include—

- Increased casualties.
- Supply and resupply disruption.
- Contamination of unit equipment, supplies, and personnel.
- Compromised medical evacuation.
- Mission performance degradation due to individual protective postures.
- Prolonged treatment procedures due to decontamination.
- Disruption of LOC.
- Equipment damage (electromagnetic pulse).
- Targeting of specific areas.
- The need to adjust CHS to meet the complexities generated.

b. The battlefield operations under NBC conditions may present mass casualty situations which will develop quickly and have long-lasting residual effects. The range of enemy weapons, NBC weapons/ agents, DE weapons, and weapon delivery systems may cause high casualty rates, especially in poorly trained and improperly equipped troops and units. Medical treatment facilities may well be in target areas; this will compromise medical treatment and other CHS services.

c. The flexibility of Echelons I and II medical units and their modular design allows reconstitution of other Echelons I and II units, or the ability to task-organize to meet the CHS requirements of the supported units.

d. The requirement for patient selection/sorting (RTD and NRTD) is of extreme importance. Many of the patients, particularly those with mild symptoms or combat stress, have excellent RTD potential. These individuals, if promptly and properly treated, may RTD within hours or a couple of days which may significantly influence the outcome of the battle. Additionally, many of these soldiers who only have BF will present physical signs and symptoms which resemble true exposure. It is important not to evacuate the soldiers with minimal or no exposure to NBC hazards to hospitals. Putting these soldiers in hospitals could reinforce their perceptions or beliefs that there is really something wrong with them other than simple fatigue and stress. It could influence their thinking and cause them to exaggerate the severity of their conditions. Also, hospitalization could slow their recovery and possibly result in their developing a chronic disability.

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

4-14. Force Protection and Security Measures

a. Force protection is a complex process in which each action impacts upon many others. Planning for force protection is a continuous process. Force protection in stability operations and support operations scenarios can pose significant challenges.

b. The ASMB commander is responsible for providing security for his unit and the patients under his care. In some scenarios, a combat or CS unit may provide security forces to assist in the defense of medical units. In other situations, the medical unit may not be collocated with other types of CSS units and the medical commander must then provide completely for his own security. In the corps, the ASMCs are normally located in areas of troop concentration in a base cluster. The base cluster commander has the overall responsibility for the security of units located within his base cluster.

c. In stability operations and support operations, medical units may be deployed into a given geographical area prior to the deployment of combat and CS forces. During humanitarian assistance and disaster relief operations, the perceived terrorist threat may be low, but the commander must ensure that his security measures are adequate for the appropriate threat level. Further, he must ensure he has the capability to increase these protective measures should the operational scenario change and mission creep occur. If the political, social, or economic status of the HN or region deteriorates, an increase in the potential for terrorist activity may also be experienced. The CHS commander must continuously evaluate the potential for terrorist activity and adjust his force protection plan accordingly.

d. Unit and individual protective measures are discussed in detail in Joint Publication (Pub) 3-07.3.

4-15. Area Support Medical Battalion Tactical Standing Operating Procedures

The ASMB commander is responsible for the development of the 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-TC factors. If a specific decision is required each time, it should not be included in the TSOP. The ASMB commander is assisted in the development of the TSOPs by the ASMB headquarters staff and subordinate elements. The ASMB's TSOPs are based on the MEDCOM/brigade TSOPs and serve as the foundation for subordinate detachments and ASMCs to develop their TSOPs. The ASMB's TSOPs should be clear and concise, yet provide sufficient detail of procedural requirements. Their TSOPs must reflect procedural guidance that supports current mission and doctrinal requirements. The ASMB's TSOPs should be maintained and reviewed at least every 6 months and revised as required. A sample TSOP is provided in Appendix B.

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

4-16. Interface with the Medical Brigade

In the COMMZ and CZ (corps area), the ASMB's higher headquarters is the medical brigade. The medical brigade and ASMB headquarters staff members interface on a daily basis. This interface is essential to ensure synchronization of CHS operations. If the medical brigade is not deployed, the ASMB may be under the C2 of the MEDCOM. Depending on the size, type, and phase of the military operations supported, the MEDCOM may consist of an early entry module or a functional element that is being used for either stability operations or support operations. Based on CHS requirements, the MEDCOM/brigade headquarters develops OPLANs/OPORDs to ensure all CHS 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 MEDCOM/medical brigade staff elements includes the following subject areas:

- Combat health support operations.
- Assignment or attachment of medical command/brigade 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.
- Operation plans.
- Contingency plans
- Operation 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.
- Workload.
- 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.
- Medical equipment maintenance support.
- Mass casualty plan.

4-17. Interface with Major Commands

The ASMB interfaces with the major commands within the battalion AO, either through the MEDCOM/brigade or through direct contact as authorized by the MEDCOM/brigade commander. Direct contact is the preferred method because it provides faster communications and coordination. This interface pertains to

CHS provided by the battalion and to support requirements for ASMB elements providing CHS to the units within the major commands. The ASMB headquarters staff and subordinate units/elements coordinate the following basic subject areas with the supported command and supported units:

- Combat health 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.
- Medical equipment maintenance 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).

4-18. Interface with Supported Units

The ASMB and its subordinate elements are normally deployed to areas of major troop concentrations. The ASMB provides Echelon I CHS for all units without organic medical support and Echelon II CHS for all units 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 above in paragraph 4-17 and may also include—

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

b. Supported Battalions or Companies. Interactions between supported units/elements 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 AO.
- Reinforcement of the ASMB's medical assets.
- A mass casualty evacuation plan.
- Patient-collecting points.
- Ambulance exchange point operations.
- Status of medical element operating in support of corps/COMMZ elements.
- Class VIII resupply.
- Maintenance support (if required).
- Patient-holding procedures.
- Resupply of nonmedical items to ASMB elements (if required).
- Displacement operations.

4-19. Area Support Medical Battalion Coordination with its Area Support Medical Companies and Subordinate Units

The ASMB staff elements coordinate on a daily basis with the headquarters detachment, ASMCs, and other subordinate units. 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 CHS operational requirements within their assigned AOs. Information exchange between the battalion headquarters and the headquarters detachment is through direct contact with battalion staff and through submission of required reports. Coordination and information exchange between battalion headquarters staff elements with ASMCs and other subordinate units 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/detachment 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 CHS 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 THE AREA SUPPORT MEDICAL BATTALION COMMAND POST

4-20. 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—

- Maintain situational awareness of the tactical situation and CHS 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 CHS, the battalion CP receives, analyzes, coordinates, and disseminates information that is critical to the successful accomplishment of the command's CHS mission. The ASMB commander also establishes procedures that 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 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 4-3 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.

Table 4-3. ASMB Staff Organized in Two Shifts

PERSONNEL WHO OCCUPY THE COMMAND SECTION

GRADE	TITLE
LTC	COMMANDER
MAJ	XO
E-9	CSM
E-3	DRIVER

STAFF REPRESENTATIVES AS DESIGNATED BY THE COMMANDER

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

PEAK ACTIVITY		REDUCED ACTIVITY	
GRADE	TITLE	GRADE	TITLE
MAJ	S2/S3	CPT	MEDICAL OPERATIONS OFFICER
CPT	S1	E-8	BATTALION OPERATIONS SERGEANT
LT	S4	E-7	INTELLIGENCE NCO (MEDICAL)
E-7	NBC NCO	E-6	ASSISTANT PERSONNEL SERGEANT
E-7	PLANS SERGEANT	E-5	SENIOR RADIO OPERATOR/MAINTAINER
E-7	BATTALION COMMUNICATIONS CHIEF	E-4	SIGNAL SUPPORT SYSTEMS SPECIALIST
E-7	PERSONNEL SERGEANT	E-4	RADIO OPERATOR/MAINTAINER
E-4	PERSONNEL ADMIN SPECIALIST	E-4	LEGAL CLERK
E-4	PATIENT ADMINISTRATION SPECIALIST	E-3	POSTAL CLERK
E-3	SIGNAL INFORMATION SYSTEMS SPECIALIST	E-3	PATIENT ADMINISTRATION SPECIALIST
E-3	RADIO OPERATOR/MAINTAINER		

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 good communications with higher, lower, and adjacent organizations. The CP should be located near routes that 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. Garages, warehouses, and other buildings of opportunity 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 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 HHD, ASMCs, and other subordinate units) 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 garrison. 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.

4-21. Command Post Layout

Command posts can be organized in many different ways and still accomplish their missions. The description and diagrams that follow show one way an HHD, ASMB CP can be organized and deployed. The optimum configuration of the battalion CP requires that as many radios as possible be remote from the CP and that 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 HHD and the staff sections. The communications tent (Figure 4-6) contains the battalion NCS, message center, and battalion switchboard.

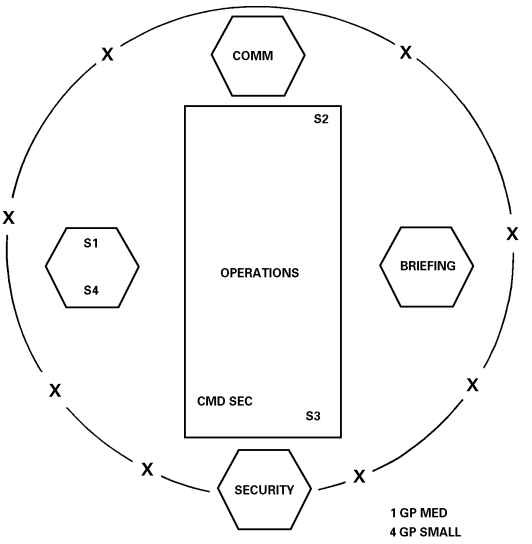


Figure 4-1. Area support medical battalion physical mode.

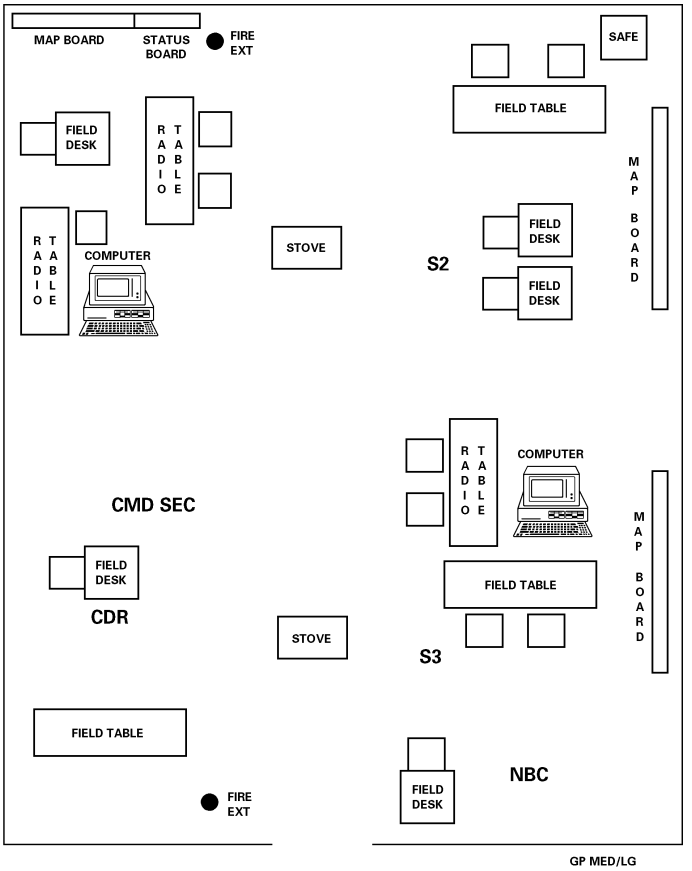


Figure 4-2. Area support medical battalion command post operations cell.

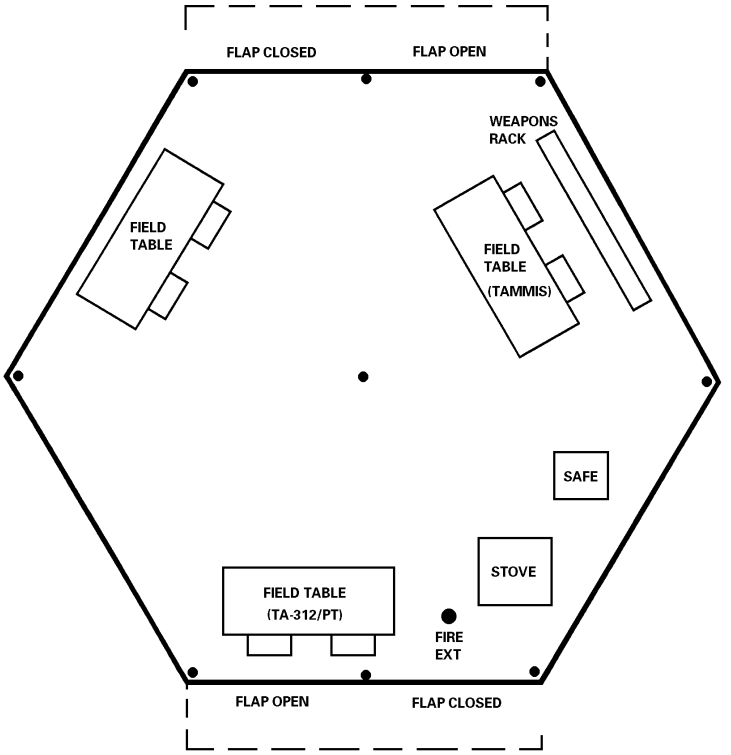


Figure 4-3. Battalion adjutant/supply.

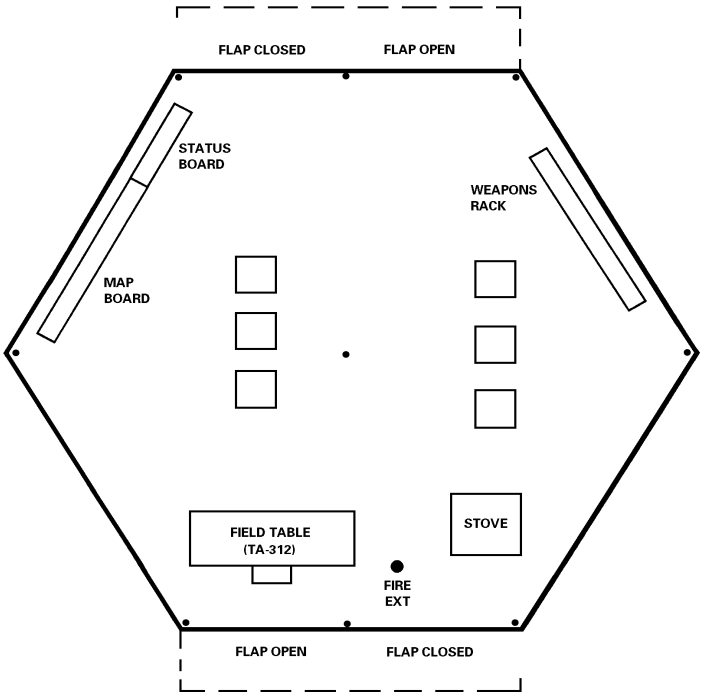


Figure 4-4. Briefing tent.

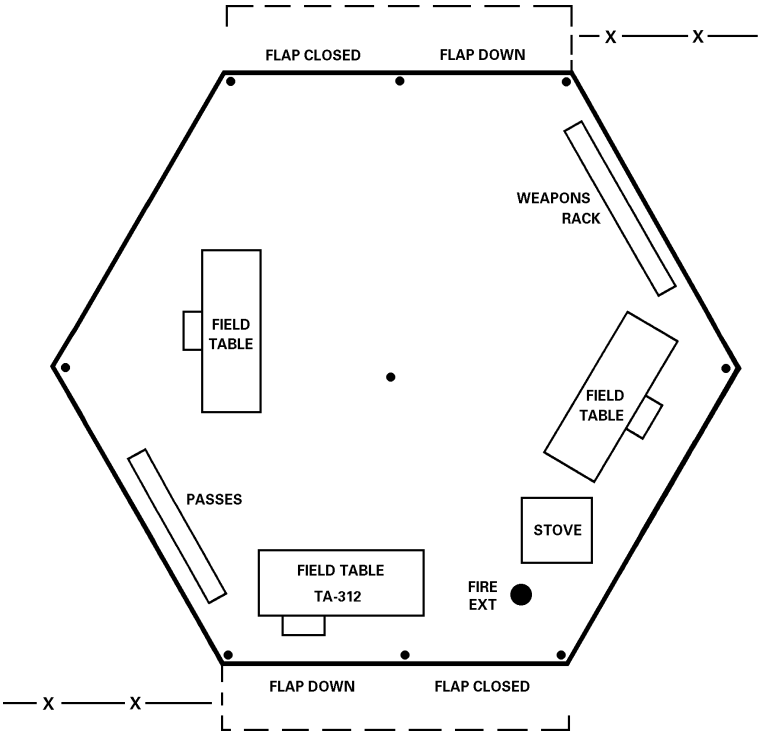


Figure 4-5. Security tent.

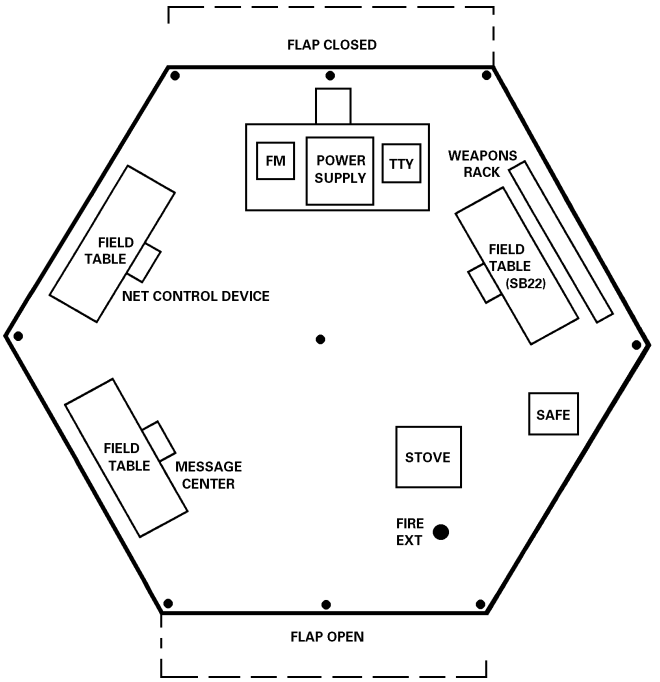


Figure 4-6. Communications tent.

Section V. EMPLOYMENT OF BATTALION HEADQUARTERS' ASSETS

4-22. Logistics/Medical Supply

The S4 is responsible for overseeing the battalion's medical and nonmedical logistics and blood resupply operations. He also has staff oversight for battalion maintenance section. The S4/MEDSUP operations facilities are established adjacent to each other and are normally placed in an area that provides an entrance, exit, and turnaround for customers and organic resupply vehicles. The site selected within the ASMB perimeter for establishment of the S4/MEDSUP facilities should have a hard surface that accommodates traffic into and out of the area. The facilities should not be placed in any area that has the potential for flooding. The area should have good drainage which does not allow standing water. 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. 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 MEDSUP element initiates combat health 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 MEDSUP element operates out of MEDSUP sets that 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 MEDSUP section uses the Theater Army Medical Management Information System (TAMMIS) MEDSUP program. This system interfaces with the MEDLOG battalion using the ATCCS computers. The MEDSUP 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 MEDSUP section normally stocks a 5- to 15-day level of selected MEDSUP items. The number of days of supply and any additional items maintained by the MEDSUP element are determined by the ASMB's mission, its location, and guidance from the MEDCOM/brigade commander and the MEDCOM/brigade health services support officer/manager.

(1) During the initial employment phase, each ASMC receives a preconfigured push-package every 48 hours from the ASMB MEDSUP element until the 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 MEDSUP 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 the supporting MEDLOG battalion. While resupply by preconfigured packages is intended to provide support during the initial phase, continuation on an as-required basis may be dictated by operational needs. Planning for such a contingency must be directly coordinated with the battalion S4/HSMO who coordinates further Class VIII resupply requirements with the supporting MEDLOG battalion. Shipment of medical materiel from the battalion MEDSUP element is coordinated through the medical command/brigade medical materiel management officer with the corps movement control center. Delivery of Class VIII supplies may also 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 the requesting unit.

(*a*) *Routine*. The MEDSUP 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 MEDSUP element and issued to the requesting unit. The S4/HSMO has the responsibility to monitor all emergency requirements not immediately filled by his section. The battalion S4/HSMO coordinates with the medical command/brigade HSMO for the transportation of emergency Class VIII, as required.

(2) Requests received from the MEDSUP element.

(*a*) *Routine*. The MEDSUP 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 a supply point distribution.

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

(*c*) *Medical command/brigade health services materiel officer*. The MEDCOM/brigade HSMO is informed by the ASMB MEDSUP 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 a TAMMIS failure, a backup manual system must be implemented; see Appendix B for sample formats.)

d. Area Support Medical Maintenance. The maintenance of medical equipment is an important responsibility of the ASMB MEDSUP element. Medical equipment repairers are assigned to the ASMB MEDSUP 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 the appropriate maintenance and is operational. Implementation of the following programs or functions ensures the readiness of medical equipment.

(1) *Periodic services*. Services consist of preventive maintenance, safety checks, and calibration. These services must be scheduled on a periodic basis and should be placed on unit training schedules. The frequency of each scheduled service 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/or 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 2406, Materiel Condition Status Report.

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

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

(*f*) DA Form 2409, Equipment Maintenance Log.

(*g*) Department of Defense (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.

4-23. Battalion Maintenance Section Employment

a. Maintenance Operations. 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 may dispatch maintenance teams based upon requests from supported 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 manage the maintenance work flow through an effective production control process. The motor officer and motor sergeant allocate work assignments for 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 workload.
- Backlogged work.
- Reasons for stoppage.
- Status of required supplies/parts.
- Calendar date of current planned actions.
- Realistic production schedules.

The maintenance request register is maintained according to DA Pamphlet 738-750. 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.

b. Battalion Petroleum, Oils, and Lubricants Functions. Maintenance section personnel oversee battalion petroleum, oils, and lubricants (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 10-67-1.
- 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 10-67-1.
- 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 when they attempt to perform any unsafe act.

4-24. 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 and fittest 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 protective measures.
- Ensuring the deployment of a healthy and fit force.
- Monitoring the command's immunization status (see AR 40-562).
- Monitoring potable water supplies.
- Monitoring the status of individual and small unit PMM (see FMs 21-10 and 21-10-1).
- Monitoring PMM against heat and cold injuries and food-, water-, and arthropod-borne diseases (see FMs 8-33 and 8-250, TM 5-632, TBs Med 81, 507, 530, and 577).
- Ensuring training in PMM which will assist in countering the medical threat.
- Monitoring the use of prophylaxis such as antimalarial tablets.

- Ensuring adequate unit field sanitation supplies.

(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—

- If mosquito-borne diseases are endemic to troop assembly areas, and known or suspected vectors are present, mosquito control efforts should be initiated.

- Inadequate sanitation practices must be corrected before the first case of enteric disease appears.

- Site surveys must be conducted prior to the establishment of bivouac locations to ensure they meet environmental and health standards.

(3) It should be anticipated—

- That sanitation break-downs 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.

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 PVNTMED support. The PVNTMED section of the ASMB is capable of deploying two 2- to 3-person teams 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 CHS estimates by identifying the medical threat.

- Assisting the ASMB commander in determining disease prevalence in the AO.

- Assisting the ASMB commander in assessing the health status of unit soldiers.

- Conducting surveillance of supported units to ensure implementation of PMM at all levels and to identify actual or potential medical threats and recommending corrective action as required.

- Assisting supported units by providing training in PMM 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 PMM 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 PMM 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 command/brigade, 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.

4-25. Mental Health Section Employment

The ASMB's MH section and the ASMC's MH sections are the medical elements with primary responsibility for assisting units in the corps rear to control combat stress. As in the division, combat stress is controlled through vigorous prevention, consultation, and restoration programs. These programs are designed to maximize the RTD rate of BF soldiers by identifying combat stress reactions and providing rest/restoration within or near their unit areas. Also, the prevention of posttraumatic stress disorders is an important objective in both division and corps CSC programs. Under the direction of the ASMB psychiatrist, the MH sections provide MH/CSC services throughout the ASMB's AO. The battalion MH section is assigned to the HHD of the ASMB. The battalion psychiatrist has staff responsibility for establishing policy and guidance for the prevention, diagnosis, and management of NP, BF, and misconduct stress behavior cases seen by ASMB physicians and the MH sections. He also has technical responsibility for the psychological aspect of surety programs. He provides and oversees MH and stress control training for unit leaders and their staffs, chaplains, medical personnel, and troops. Through the battalion and company MH sections, the battalion psychiatrist monitors the morale, cohesion, and mental fitness of supported units. He has technical control over all MH personnel assigned to the ASMB and provides guidance as required for the successful accomplishment of their responsibilities. These responsibilities include—

- Providing command consultation and making recommendations for reducing stressors.
- Evaluating NP, BF, and misconduct stress behavior cases.
- Providing consultation and triage, as requested, for patients exhibiting signs of combat stress reactions or mental disorders.
- Providing selective short-term restoration for HOLD category BF cases.
- Coordinating support activities with the medical company and detachment and CSC elements, when attached or in support of the ASMB.

a. Mental Health Support. The ASMB S3, MEDCOM/brigade headquarters, and the battalion MH sections monitor and prioritize MH support missions in coordination with the MEDCOM/brigade headquarters.

b. Battalion Mental Health Section Staff. The ASMB MH section is staffed with a psychiatrist and two mental health specialists. The dispersion of multidisciplinary MH professionals throughout the battalion ensures that expertise is present to—

- Train and supervise the MH specialists.
- Provide staff input to supported commands.
- Provide clinical evaluation and appropriate treatment or referral for all NP and problematic BF cases.

- Provide a MH professional for interface with supported brigades, groups, and corps resources.

- Provide rapid assistance with critical incident/events debriefing for the ASMB's area of responsibility.

4-26. Optometry Section Employment

The optometry section deploys with the battalion headquarters. It normally establishes operations near an ASMC. 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.

CHAPTER 5

EMPLOYMENT AND OPERATION OF AREA SUPPORT MEDICAL COMPANIES

Section I. EMPLOYMENT

5-1. Employment of Area Support Medical Companies

The ASMCs are deployed to their assigned AO and establish corps and COMMZ clearing stations. They provide Echelon I and Echelon II CHS in assigned areas. When deployed in the corps and COMMZ, 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 on a number of factors. The senior commander (normally not the medical unit commander) 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 CHS mission. The base cluster commander normally has no command or control over CHS operations. The ASMB HHD coordinates, as authorized by the MEDCOM/brigade commander, initial support requirements for each of its ASMCs and attached units. This coordination is with supporting units and each of the BCOCs as ASMCs displace and establish operations. The 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 BCOC 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. Each ASMC should verify the locations and identify the best routes to—

- Class I supply point (ration breakdown).
- Water distribution point.
- Class III supply points (bulk and package).
- Class II, IV, and VII supply points.
- Class VI supply point.
- Class IX supply point.
- Mortuary affairs collection point.
- Enemy prisoners of war collection point.
- Hospital (if not located in the same base).

- Supported units.
- Ammunition transfer point.
- Casualty collection points (if established).
- Ambulance exchange points (if established).

The HHD normally locates with one of its ASMCs or locates near the MEDCOM/brigade. The HHD participates in the initial reconnaissance of the new area and assists with site selection for establishment of the battalion headquarters. Area support medical companies deploy to their separate geographical locations (area of responsibility) within the battalion's AO. The ASMB HHD coordinates convoy clearances and security for the movement of ASMCs to their AO 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. The S3 of the ASMB coordinates with the supported units' BCOCs to ensure they plan for adequate space and the placement of ASMCs within their base cluster.

b. Site Selection. Site selection is an important factor impacting on the accomplishment of the 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 an ASMC include—

(1) *Commander's plan and mission.* The specifics of the OPLAN, the manner in which it will be executed, and the unit's assigned mission can affect the selection of a site. The requirements for an area that 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, may be used.

(2) *Routes of evacuation and accessibility.* Ground ambulance is the principle means of medical evacuation for wounded/injured patients. 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 difficulty locating the MTF.

(3) *Expected areas of patient density*. To ensure the timely delivery of CHS, 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 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*.

(*a*) 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.

(*b*) 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.

(*c*) 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.

(*d*) 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 HHD and an ASMC 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 including—

- 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.

In some cases such as MSRs, the facility should be located in the vicinity of the MSR for accessibility but not directly on it.

(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, four significant areas must be addressed.

(*a*) 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, treatment, and holding areas. Using overlapping internal traffic patterns should be minimized.

(*b*) 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.

(*c*) 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.

(*d*) Traffic patterns of the other units in the base cluster must be considered when determining internal routes.

(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 the needed shielding rather than having to rely solely 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 the 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 supported units and the ASMB HHD. All security precautions and requirements must be met according to unit and base cluster operating procedures. Only essential equipment is set up 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 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 Conventions.

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 include—

- Combat health 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 Echelon II 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 supply 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 the 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 set up 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 report 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.

(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. 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 large tent be erected. In the vicinity near a patient-holding area, a water point (Lyster bag or collapsible fabric drums), a latrine, and a handwash 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 the establishment of the medical platoon area and/or preparing for further deployment within the ASMC's AO to conduct aid station/dispensary-type operations.

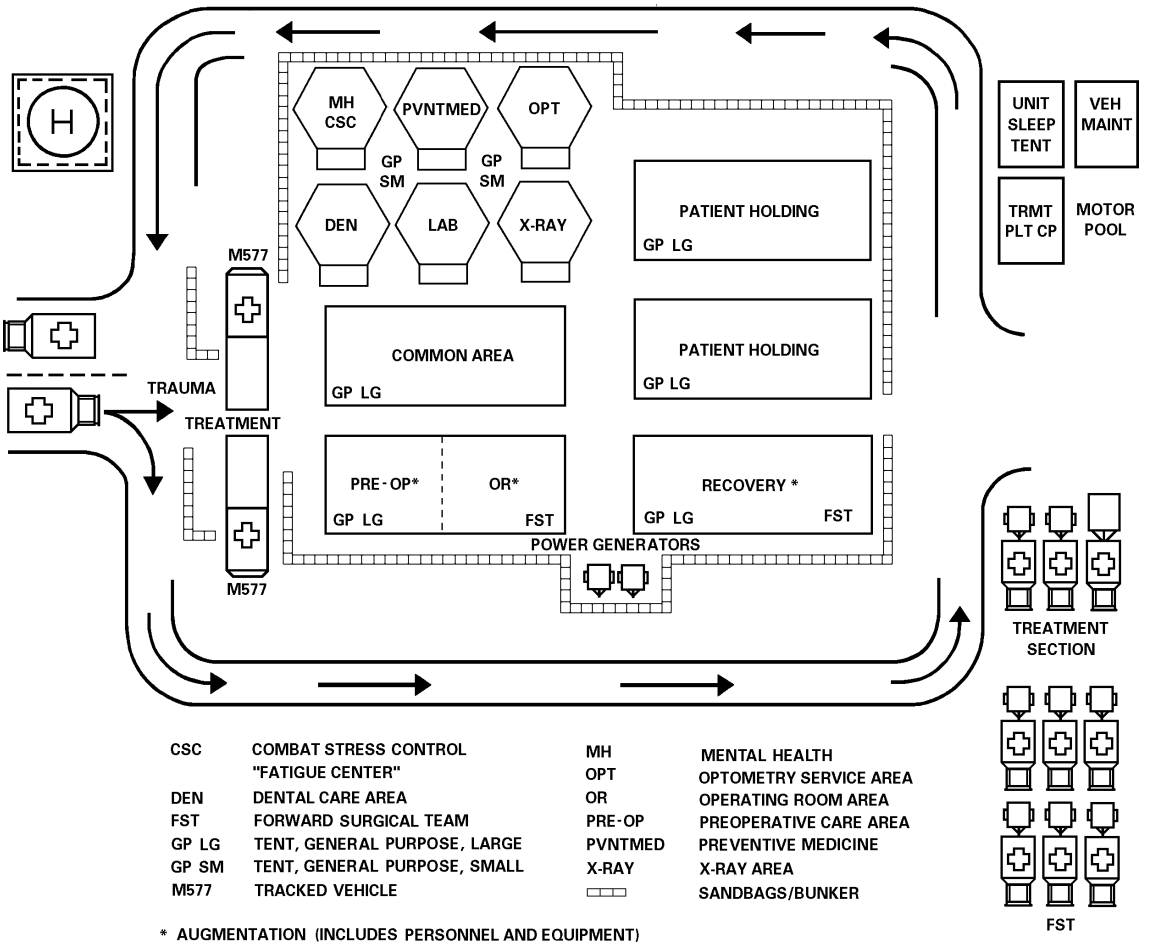


Figure 5-1. Suggested layout for a clearing station.

5-4. Employment of the Ambulance Platoon

The ASMCs ambulance platoon locates with the treatment platoon for mutual support. The ambulance platoon is 100 percent 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 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 maps and strip maps are provided to platoon personnel. 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 AXPs as required by the medical evacuation mission. Ambulance platoon personnel assist with the establishment of the ASMCs and provide available personnel as tasked by the 1SG.

Section II. OPERATION

5-5. Staff Surgeons

When employed in their AO, medical and dental officers of the 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, CHS requests (including AE, 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 the requests, or they may go directly to the ASMB HHD or ASMCs. Area support medical battalion ground ambulances from ASMCs' ambulance platoons evacuate casualties from Echelon I or from treatment stations (ASMC's treatment teams) to corps clearing station (operated by an ASMC) or directly to corps/COMMZ hospitals according to the OPLAN. Casualties treated by an ASMC 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 MEDCOM/brigade medical regulating office(r) (MRO). Requests for AE from the corps/COMMZ clearing station (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 HHD or any of its medical companies/treatment elements. Requests may also be transmitted directly to the supporting air ambulance element in accordance with SOI and the TSOP.

a. Patient Treatment. Battle injured or trauma patients arriving at ASMB's clearing stations are treated using EMT and ATM techniques. Disease and nonbattle injury 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 a 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/Assistant Chief of Staff, G1 [Personnel]).

- Verifying the information contained on the DD Form 1380.

- Monitoring, when necessary, for radiological contamination prior to medical treatment (refer to FM 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 B) 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, additional Class VIII supplies to support operational contingencies based on OPORDs or OPLANs.

5-7. Mortuary Affairs Responsibilities

All commanders are responsible for unit 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 the ASCC 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 CHS mission necessitates continuous interface with MA personnel. The headquarters section of the ASMCs is responsible for coordinating disposition of remains **(only medical company personnel and patients**) and personal 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 DD Form 1380 (reviewed and signed by a physician) attached. (An exception to this procedure may be made during mass casualty situations. The remains may be tagged according to the 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 Joint Pub 4-06. The form should be protected from the weather and body fluids whenever possible (see FMs 10-27-2 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 (provided in Table 5-1) governing medical disposition of deceased personnel. 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 THAT IS SIGNED BY A MEDICAL OFFICER PRIOR TO THEIR DEPARTURE FROM MA COLLECTION POINT.

5-8. Patient Disposition and Reporting Procedures

a. 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 is necessary for the maintenance of a responsive personnel replacement system and the Army Casualty System. Patient accountability and statistical reporting (see Figure 5-2 for samples distribution of those reports) 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 CHS estimates.

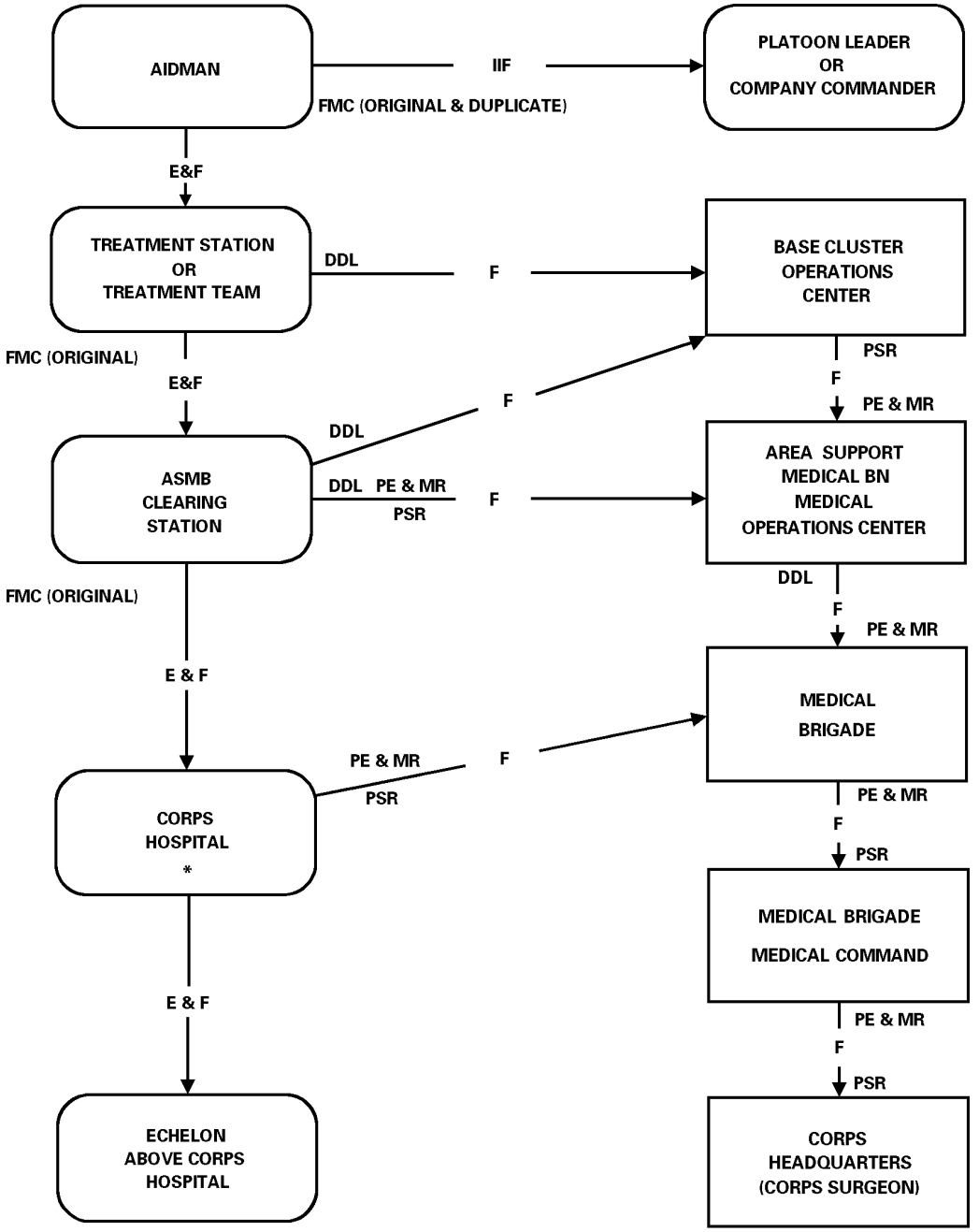


Figure 5-2. Patient accountability and status reporting for the corps area.

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

b. 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 B for sample formats for patient reporting).

c. Patients being evacuated from the theater usually enter the Worldwide Joint Patient Movement System from an Echelon III MTF. When patients enter this system, their accountability becomes the Joint responsibility. This system involves the coordinated use of intratheater and intertheater evacuation assets in support of patient regulating decisions made by medical personnel. This system is designed to coordinate the movement of patients from the site of injury or onset of disease, through successive echelons of medical care, to an MTF that can meet the needs of the patient. Major components of this system include—

- Global Patient Movement Requirements Center—a joint activity that is the Department of Defense's single manager for the strategic and CONUS regulation and movement of uniformed Services patients.

- Theater Patient Movement Requirements Center (TPMRC)—an organization that is a functional merger of some of the functions of two existing organizations, the Joint Medical Regulating Office and the Aeromedical Evacuation Control Center (AECC). The TPMRC communicates patient movement requirements to the AECC and the Service component that is responsible for executing the mission.

d. The Worldwide Patient Movement System provides limited in-transit visibility of patients and evacuation requirements planning for intertheater AE and intratheater AE for CONUS. For definitive information on patient movement in joint operations, see Joint Pub 4-02.2.

5-9. Guide for Geneva Conventions Compliance

As the US is a signatory to the Geneva Conventions, all medical personnel should thoroughly understand the provisions that apply to CHS 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 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 contra-indicated.

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

- 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 M113) 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 CHS 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

AREA SUPPORT MEDICAL BATTALION ARMY OF EXCELLENCE LIVING TABLES OF ORGANIZATION AND EQUIPMENT, NUMBERS 08456L000 AND 08457L000, 1 APRIL 1987

Section I. ORGANIZATION AND FUNCTIONS

NOTE: This appendix mirrors Chapters 2 and 3 where information is provided on the new MRI ASMB and ASMC. Therefore, only the information that pertains to the AOE and is different from the MRI units will be provided.

A-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 CHS and medical staff advice and assistance for all assigned and attached elements. See paragraph 2-1.

A-2. Organization

The ASMB is modular in design and consists of a battalion headquarters (Figure A-1), a headquarters and support company (HSC) (Figure A-2), and three ASMCs (Figure A-3). It is normally assigned to a medical brigade in the COMMZ and to a medical group in the corps.

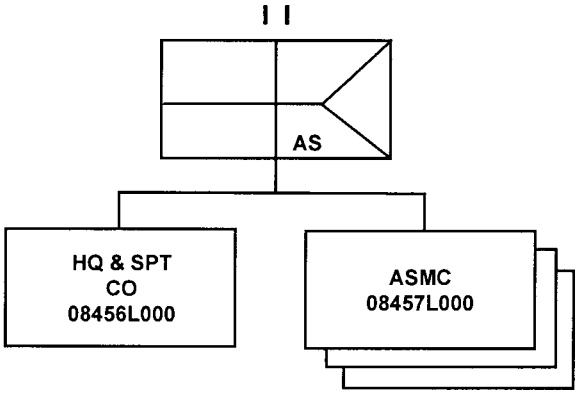


Figure A-1. Area support medical battalion.

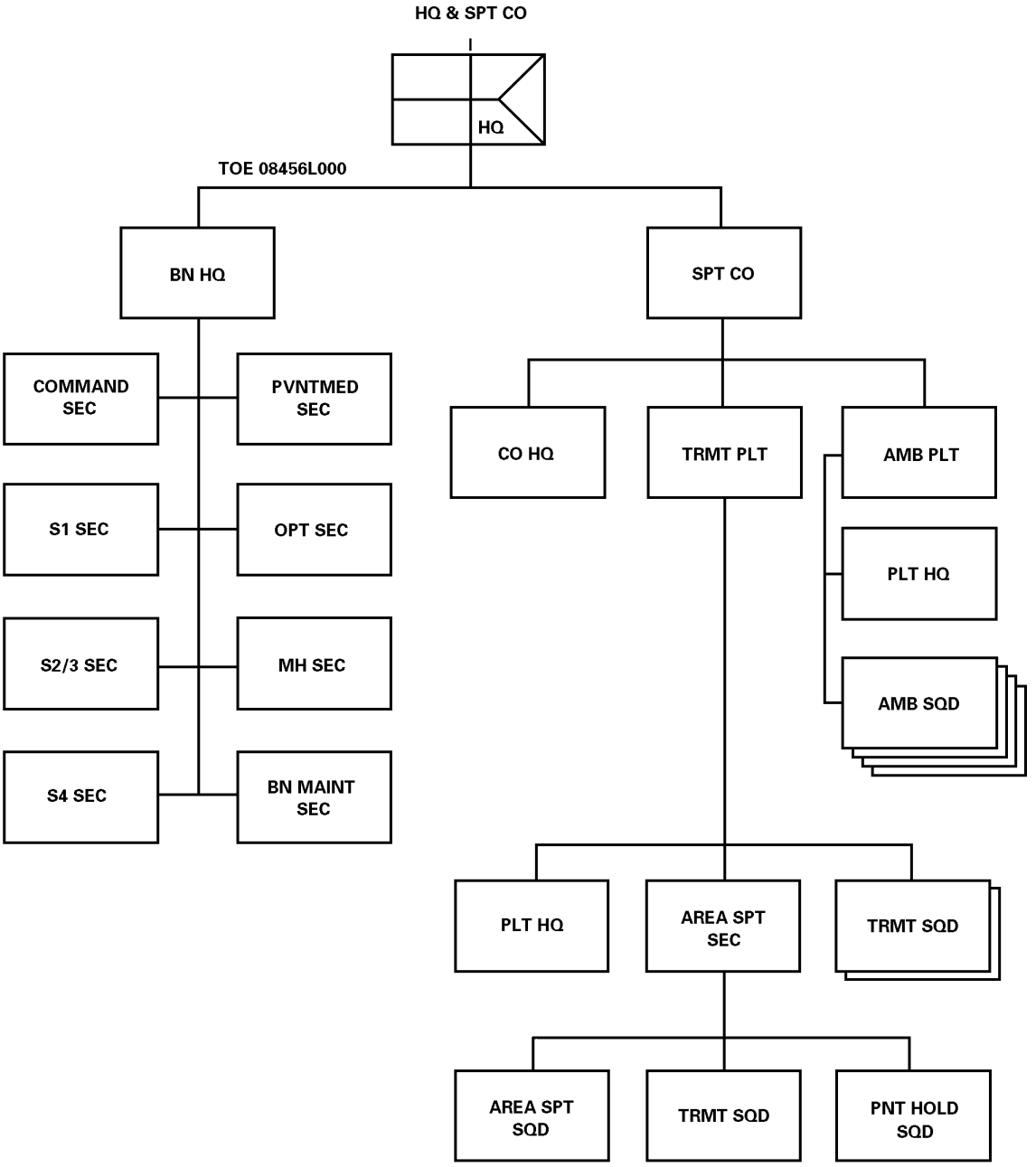


Figure A-2. Headquarters and support company, area support medical battalion.

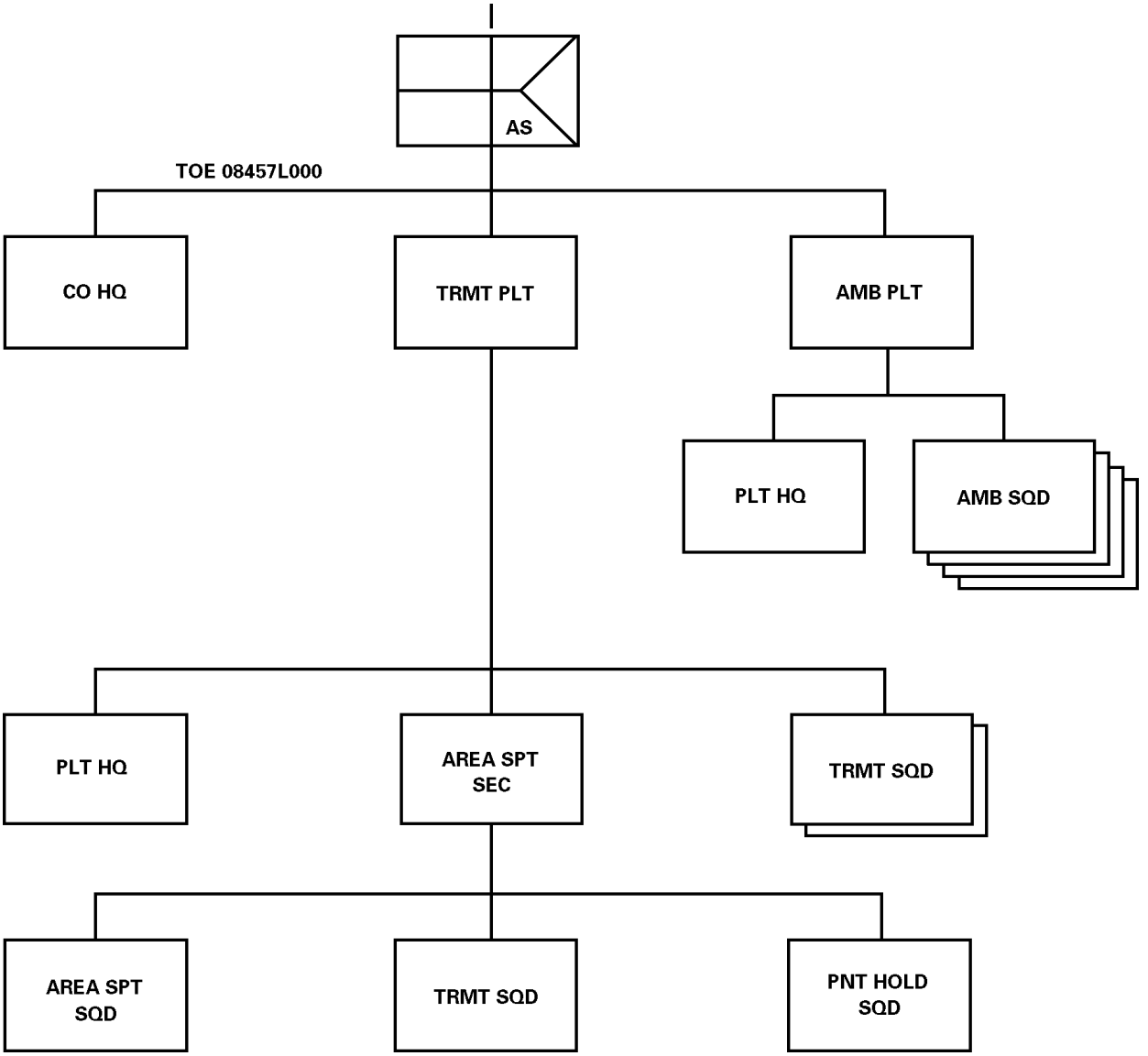


Figure A-3. Area support medical company.

a. *Employment in the Theater*. See paragraph 2-2*a*.

b. *Mission*. See paragraph 2-2*b*.

A-3. Command and Technical Relationships

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

b. *Area Support Medical Company Commander*. See paragraph 2-3*b*.

c. *Area Support Medical Battalion Staff*. See paragraph 2-3*c*.

Section II. COMMUNICATIONS

A-4. Battalion Communications

See paragraph 2-4 and Figures A-4—A-5 .

A-5. Combat Net Radio System

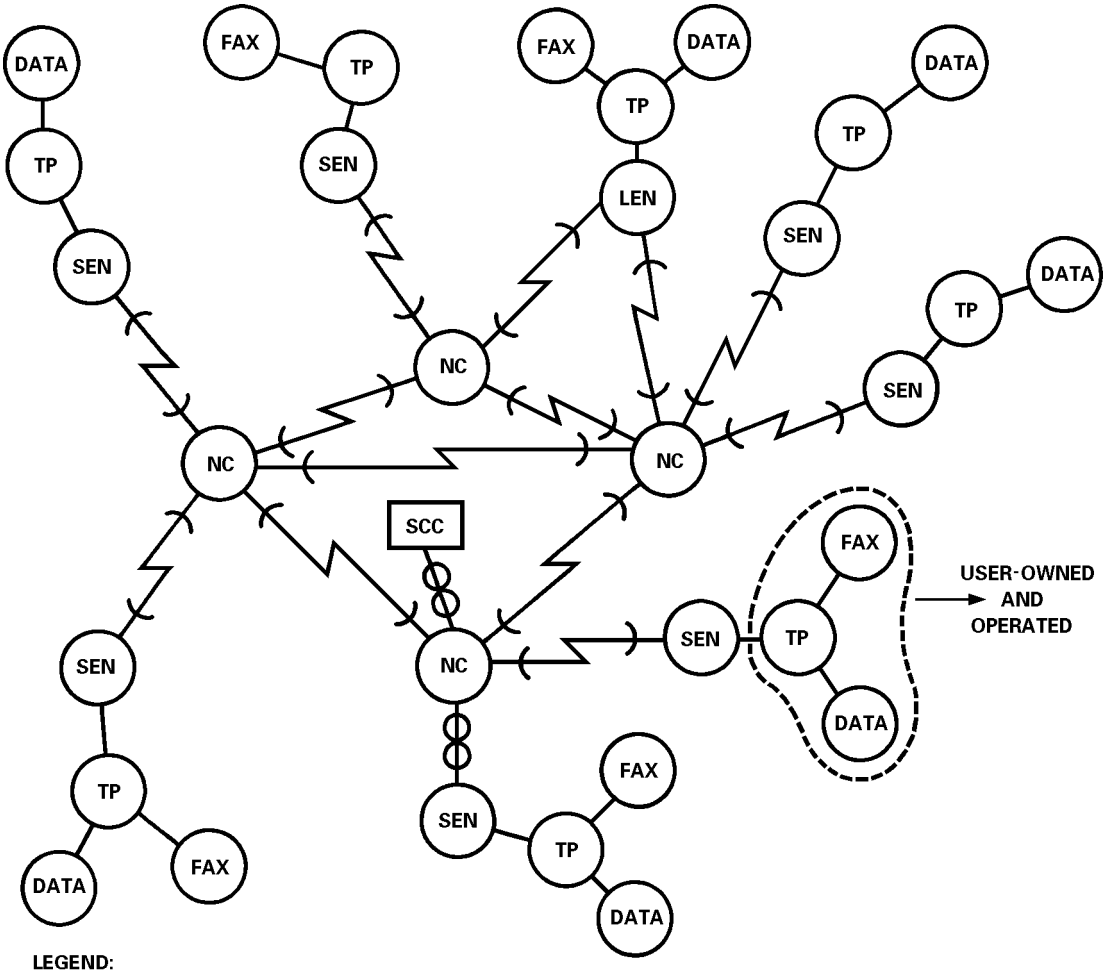
See paragraph 2-5.

A-6. Area Support Medical Battalion Radio Nets

See paragraph 2-7.

A-7. Signal Security

See paragraph 2-8.



LEGEND:

DATA	TACTICAL ARMY CSS COMPUTER SYSTEM/ ARMY TACTICAL C2 SYSTEM/ UNIT-LEVEL COMPUTER	NC	NODE CENTER
FAX	AN/UXC-7 FACSIMILE	SCC	SYSTEM CONTROL CENTER
LEN	LARGE EXTENSION NODE (SWITCHBOARD)	SEN	SMALL EXTENSION NODE (SWITCHBOARD)
		TP	DIGITAL NONSECURE VOICE TELEPHONE (DNVT-TA1035U)

Figure A-4. Area support medical battalion wire net.

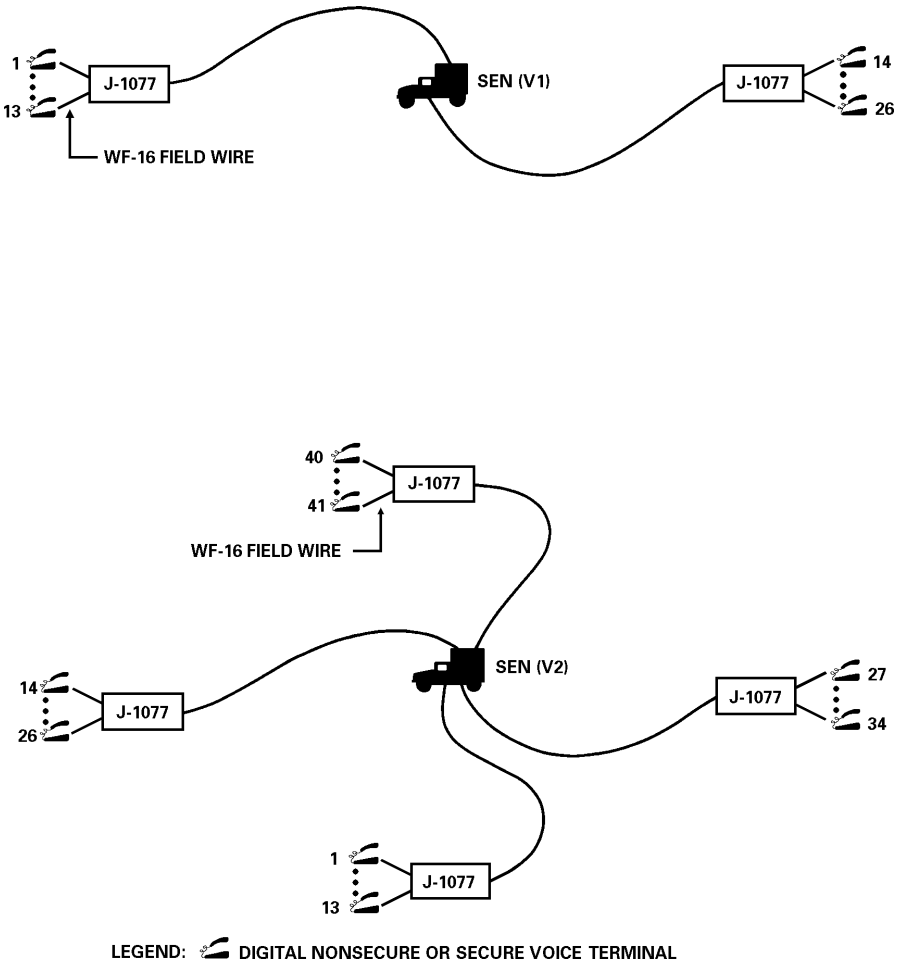


Figure A-5. Area support medical company wire net.

Section III. BATTALION HEADQUARTERS ELEMENT

A-8. Organization and Functions

The battalion headquarters is a major functional element organized under the HSC (see paragraph 2-9 and Figure A-2).

A-9. Command Section

See paragraph 2-10.

A-10. Battalion Adjutant Section

See paragraph 2-11.

A-11. Battalion Intelligence/Operations and Training Section

See paragraph 2-12 and Table A-1.

Table A-1. Organization of the Area Support Medical Battalion S2/S3 Section

S2/S3 SECTION BATTALION S2/S3*	
PLANS AND OPERATIONS BRANCH	**COMMUNICATIONS BRANCH**
MEDICAL OPERATIONS OFFICER (ASSISTANT S2/S3) BATTALION OPERATIONS SERGEANT PLANS SERGEANT INTELLIGENCE AND SECURITY SERGEANT NUCLEAR, BIOLOGICAL, AND CHEMICAL NCO PATIENT ADMINISTRATION SPECIALIST (2)	BATTALION COMMUNICATIONS CHIEF SIGNAL SUPPORT SYSTEMS SPECIALIST/TEAM CHIEF SIGNAL SUPPORT SYSTEMS SPECIALIST (2)

*Located in the command section.

A-12. Battalion Supply/Medical Supply Section

See paragraph 2-13.

A-13. Battalion Maintenance Section

The battalion maintenance section (Table A-2) 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 9-43-1. See paragraph 2-14*a* for responsibilities of the maintenance section.

Table A-2. Organization of the Area Support Medical Battalion Maintenance Section

BATTALION MAINTENANCE SECTION	
SECTION HEADQUARTERS BATTALION MOTOR OFFICER BATTALION MAINTENANCE SERGEANT SHOP CLERK PRESCRIBED LOAD LIST CLERK	
***MOTOR VEHICLE REPAIR SHOP** SENIOR MECHANIC (1) LIGHT-WHEELED VEHICLE MECHANIC (13) RECOVERY VEHICLE OPERATOR (1)	**POWER GENERATOR REPAIR** POWER-GENERATION EQUIPMENT REPAIRER
*2-contact team capability.	

A-14. Preventive Medicine Section

See paragraph 2-15 and Table A-3.

Table A-3. Organization of the Area Support Medical Battalion Preventive Medicine Section

PREVENTIVE MEDICINE SECTION
PREVENTIVE MEDICINE OFFICER SANITARY ENGINEER/ENVIRONMENTAL SCIENCE OFFICER PREVENTIVE MEDICINE SERGEANT (2) PREVENTIVE MEDICINE SPECIALIST (5)

A-15. Optometry Section

See paragraph 2-16.

A-16. Mental Health Section

The MH section is the medical element with the primary responsibility for assisting the command in controlling combat stress. Combat stress is controlled through sound prevention programs and maximizing the RTD rate with 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—

- Training and supervising the MH specialists.
- Providing staff input to supported commands.
- Providing clinical evaluation and appropriate treatment or referral for all NP and problematic BF cases.
- Providing a MH professional for interface with supported brigades, groups, and corps resources.
- Providing rapid assistance with critical incident/events debriefing for the ASMB's area of responsibility.

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 that 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 that 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 field hospital or general hospital for evaluation.

a. *Mental Health Support*. See paragraph 2-17*a*.

b. *Mental Health Section Staff*. See paragraph 2-17*b* and Table A-4.

Table A-4. Area Support Medical Battalion Mental Health Section Staff

MENTAL HEALTH SECTION STAFF
PSYCHIATRIST SOCIAL WORK OFFICER MENTAL HEALTH NCO (E-7) MENTAL HEALTH SERGEANT (E-6 & [3] E-5) MENTAL HEALTH SPECIALIST (3)

Section IV. SUPPORT COMPANY ELEMENTS

A-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 A-2). At the TOE authorized level of organization, the HSC is dependent upon the following:

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

- Religious.
- Legal.
- Finance.
- Laundry, shower, and clothing repair.
- Personnel and administrative 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 HN facilities.

b. Design. The support company is similar in design to the ASMC. Its major functional components (Figure A-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 that are capable of operating independently of the HSC for limited periods of time.

- Provide limited medical laboratory and 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.

A-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 Table A-5. For communications, the company headquarters employs both AM and FM tactical radios and operates on the battalion's command and operation nets. The HSC's wire communications net is the same as 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.

Table A-5. Typical Support Company Headquarters Organization

SUPPORT COMPANY HEADQUARTERS		
COMMAND ELEMENT	**SUPPLY ELEMENT**	**FOOD SERVICE ELEMENT**
COMMANDER	SUPPLY SERGEANT	FOOD SERVICE SERGEANT
EXECUTIVE OFFICER	ARMORER	FIRST COOK
FIRST SERGEANT		COOK (3)

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 1SG.

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-TC. 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 CHS units are not trained or prepared to provide any special diets. Patients requiring advanced dietary support or special diets are evacuated to corps/COMMZ hospitals.

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.

NOTE

Medical resupply is accomplished through the S4 medical supply element.

A-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 treatment 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.

b. Treatment Section. The treatment section contains two treatment squads that 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).

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, limited laboratory and 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.

(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.

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 medical-surgical nurse, a practical nurse NCO, and two medical specialists.

A-20. Ambulance Platoon

See paragraph 3-4.

Section V. AREA SUPPORT MEDICAL COMPANY

A-21. Mission, Organization, and Functions

The ASMC has the overall mission to provide Echelon I and Echelon II CHS to units located in its AO. It is dependent on the same corps and COMMZ elements that support the HSC as stated above. The ASMC

shares identical functions with the HSC but has slightly different support requirements when displaced away from the battalion. It is organized (see Table A-6) 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.

A-22. Company Headquarters

See paragraph 3-2.

Table. A-6. Area Support Medical Company Headquarters

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)

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.

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

c. Supply Element. See paragraph 3-2*c*.

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 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.

A-23. Area Support Medical Company Treatment Platoon

The ASMC's treatment platoon is organized and performs the same functions as the HSC's treatment platoon.

A-24. Area Support Medical Company Ambulance Platoon

The ASMC's ambulance platoon is organized and functions the same as the HSC's ambulance platoon.

APPENDIX B

SAMPLE TACTICAL STANDING OPERATING PROCEDURE FORMAT

B-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.

B-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.

B-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 ASMB commander authenticates the TSOP.

B-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 under which the unit normally operates. Specific task organizations for the campaign are 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 DA Pam 611-21 and FM 101-5.

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

B-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 sample 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, headquarters detachment commander, ASMC commanders, and CSM, provides the C2 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—

(1) 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, situation 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 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.

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

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

b. Annex C—Headquarters Detachment 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:

(1) Unit-level administration.

(2) Reenlistment and extension programs.

(3) Billeting, to include fire safety, sanitation, and key control.

(4) Security, assignment, accountability, and maintenance of weapons.

(5) Welfare and recreational activities.

(6) Unit supply.

(7) Duty rosters.

(8) Physical fitness.

(9) Training.

(10) Uniform Code of Military Justice action.

(11) Commander's critical information requirements.

c. Annex D—Command Post.

(1) *Definition*. The CP is the command element of the ASMB containing communications and personnel required to C2 and coordinate CHS 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 CHS 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 radiotelephone 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 CHS 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 CHS plans for supporting tactical operations outside of the security area is prohibited.

(5) *Composition of the command post operations cell.* Personnel comprising the operations cell normally include 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; and delineates procedures for preparing outgoing messages, to include 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 OPSEC 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 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 the OPSEC analysis of CHS 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 down-grading/declassification and classification authority.

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

- 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 that 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 storing COMSEC equipment.
- Maintaining power units.

e. Annex F—Intelligence and Security. This annex pertains to intelligence requirements and procedures and OPSEC 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) *Operations Security*.

- *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 area commander appoints the base cluster and base commanders. These commanders have the overall responsibility for the base cluster/base defense organizations and plans. The HHD and the 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 to 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 officer and warrant officer personnel arriving into/within the theater during mobilization and wartime. Request for personnel and administrative support will be submitted through the MEDCOM/brigade S1 to the appropriate supporting regional personnel center.

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

(2) *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.

(3) *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 US Government contract personnel, EPW, and civilian internees who become casualties while under the 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.

(4) *Personnel management.*

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

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

- *Leaves.* Ordinary and emergency leave procedures will be outlined per AR 600-8-10. 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 award recommendations 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.

(5) *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 14-100 for detailed information.)

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

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

- *Postal services*. This includes hours of operation and services available. Emergency destruction, 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.

(6) *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 and 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 enemy prisoner of war 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.

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

(8) *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 (9) below).

(9) *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 CHS 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.

(10) *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.

(11) *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 HHD 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 warning how the unit will operate based on METT-TC, 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 1—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 that will be addressed are listed below. A discussion of these areas is provided in appendixes with the inclusion of tabs, if appropriate.

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

Logistics Applications of Automated Marking and Reading Symbols, TACCS, ATCCS, Combat Service Support Control System, 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) *Combat health logistics support*. The combat health logistics concept of operations, requisition and, distribution procedures, accountability, and reports are provided in this appendix.

l. Annex M—Neuropsychiatric/Combat Stress Control Support. This annex prescribes policies and procedures pertaining to NP and CSC support provided by the battalion and ASMC MH sections. 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/HSMO 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, if available.

- 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 BLDREPs and submits one BLDREP (daily) to the servicing blood support detachment (MEDLOG battalion). Each ASMC can maintain an inventory of between 30 to 50 units of group O packed red blood cells and can store whole blood if required and available. The ASMB commander will establish the blood inventory levels to be maintained by the ASMCs. The blood support detachment of the MEDLOG battalion ships blood as requested to the battalion medical supply elements or directly to the requesting ASMC. Unless otherwise specified, 15 percent of blood shipped to requesters will be RH negative. During shipment, blood will be continuously maintained at a temperature within the range of 1 degree to 10 degrees Centigrade. 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 are displaced from the ASMB, requests for blood resupply may be sent directly to the MEDLOG battalion blood support detachment. When ASMCs are collocated with CSHs blood may be obtained through the hospitals medical supply activity.

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

- Reporting/requesting blood.

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

- Area support medical companies will submit their requirements for the following day and the status of blood on hand to the battalion medical supply element. The medical supply element consolidates and submits requirements according to timelines provided by higher headquarters.

- Receiving.

- Storing.

- Issuing.

- Transporting.

- Administering.

- Disposing outdated blood.

- Recalling blood.

n. Annex O—Dental Services. This annex outlines policies and procedures for dental treatment services provided by the ASMB. Dental treatment facilities are located at each ASMC. Dental sick call

hours are established by each ASMC and distributed to supported units. The MEDCOM/brigade establishes policies and procedures for dental services in the corps and EAC. In wartime operations, ASMC (Echelon II MTF) dental services are limited to emergency, preventive, and general dental care (see FM 8-10-19). In support operations, dental services are METT-TC driven; however, as a minimum will include emergency and preventive dental care. In stability operations, preventive, emergency, and general dental care is normally provided. Potential subject areas where additional information may be added 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. The ASMB PVNTMED section oversees PVNTMED activities in the battalion's area of responsibility for supported units. The PVNTMED section is responsible for supervising the ASMB PVNTMED program as described in AR 40-5 for supported units. 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 FST.

- 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 FST 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 the remains of patients who died of wounds.

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 clearance.
- 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.
- Treatment of ocular injuries and diseases.
- Spectacle frame assembly and repair.
- Storage and maintenance of ophthalmic equipment.
- Procedure for requesting eyewear fabrication from the MEDLOG battalion.
- Replacement of optical inserts.
- Procedures for treating 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 civilians 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 treatment areas to include triage, delayed care, immediate care, minimal care, and expectant care areas.
- Support requirements beyond ASMB's capability.
- Medical evacuation.
- Return to duty.
- Records and reports.
- 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 not 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 these 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. Appendixes—Sample Formats for Reports, Tracking Charts, Coordination, and Maintaining Current Operations Charts and Maps. Sample formats are provided in the appendixes. These formats are based on command requirements. Some of the formats in the appendixes 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.

APPENDIX C

TELEMEDICINE TACTICS, TECHNIQUES, AND PROCEDURES

C-1. General

a. Telemedicine combines the domains of clinical medicine, medical computer science, and telecommunications in order to enhance the health care provided to our soldiers and other personnel authorized treatment. Telemedicine is a system designed to reduce the mortality and morbidity rate of soldiers by lowering the died of wounds rate. Also, telemedicine will aid physicians to make early diagnosis of diseases by making expert consultation in a variety of medical specialties available, as needed. Through early diagnosis of infectious disease and proactive PVNTMED measures, the DNBI rate could also be reduced. Advances in telecommunications technology now make the transmission of video, high-resolution still images, voice, and written data more readily available.

b. Today's force projection Army (and the mission it is required to perform) increases the need for rapid acquisition, aggressive initial EMT, and timely medical evacuation of battlefield casualties. Current doctrine provides tactics, techniques, and procedures for providing CHS on the forward battlefield (see FMs 8-10-1, 8-10-4, 8-10-6, and 8-10-14). The use of new technologies and techniques can enhance our abilities to provide CHS. Medical communications for combat casualty care (MC4) provides the essential links with CHS personnel, with each other, and with other units/commands in the operational area, as well as with out of theater organizations/activities. The types of communications equipment employed will vary with the echelons of CHS. Components of the MC4 include telementoring (TMEN) and teleconsultation (TCON) capabilities. Telementoring and TCON are techniques that can increase the survivability of our soldiers who are wounded in action.

c. The future battlefield may be extended over larger areas or in depth with the supporting MTFs spaced at greater distances. The combat medic may be the only medical person available to provide initial care. The physician or PA at the BAS or a treatment team providing area support may have a patient present with life-threatening injuries that require treatment procedures beyond their professional skills. An example is a patient with maxillofacial wounds and respiratory distress; this patient requires treatment by an oral surgeon.

d. Telementoring is a process by which a medical person with greater knowledge and experience guides a medical person with less knowledge who is treating a patient at a remote location. The primary situation is a physician/PA (the mentor) at a BAS guiding a combat medic in the treatment of a wounded soldier on the battlefield. Telementoring uses voice and/or digital information systems to communicate information.

e. Teleconsultation is a process by which two physicians or a physician and a PA discuss a patient's wounds to establish the best treatment protocol. The purpose of TCON is for physicians to share their skills and knowledge to reduce the number of soldiers who are killed in action on the battlefield. Teleconsultation may use voice, digital, text/graphic, and video information systems. Examples of TCON are as follows:

- The PA with a treatment team operating a BAS-minus discussing a patient's condition with the physician at another location in the battalion area.

- The physician or PA at the BAS consulting with a physician at the FSMC clearing station.

- The physician at the FSMC clearing station consulting with a physician or other professional personnel at a corps or higher echelon hospital/health support facility.

C-2. Telementoring Use

Telementoring assists the combat medic in providing lifesaving measures. It enables him to make an accurate assessment of the patient's condition in order that appropriate treatment can be given. The combat medic treats the patient by applying the treatment guidance provided by the mentor. Telementoring is **ONLY** provided on an "as needed" basis. **IT IS NOT USED ON EVERY PATIENT**. The combat medic should request mentoring in the circumstances listed below:

- Management of patients for more than 1 hour due to long evacuation times or the inability to evacuate.

- Treatment of IMMEDIATE and DELAYED patients that begins soon after wounding.

- Treatment provided does not appear to help.

- Required treatment is beyond the skill level of the combat medic on-site.

- Uncertainty as to injury/illness.

- Uncertainty as to the extent/type of treatment to provide.

- To request permission to perform one of the following tasks:

  - Administering multiple doses of morphine.

  - Performing needle chest decompression (thoracentesis).

  - Performing intubation of a patient with suspected inhalation burns.

C-3. Telementoring Procedures

The combat medic requesting mentoring establishes communications with the BAS. Upon establishment of communications, the combat medic states that the request is for telementoring-trauma (TMEN-TRAUMA) or telementoring-disease and nonbattle injury (TMEN-DNBI). The request for TMEN-TRAUMA will be communicated following the format provided in Example A of this appendix. Example: "Alpha 24, this is Bravo 15, Request TMEN-TRAUMA, Over." Once communications are established, the medic will only transmit Lines 1, 2, and 3. (Line 1, "This is Bravo 15, I have an IMMEDIATE patient with a severely

lacerated face and neck wound, Over.") Upon instructions from the mentor, transmit Lines 4 through 8 (only transmit applicable information). The mentor will provide treatment guidance based upon the urgency of the wound. The TMEN-TRAUMA card is used to record selected information and as a guide in identifying the area of the body involved. The TMEN-TRAUMA card is used in conjunction with DD Form 1380 (Field Medical Card [FMC]) to record the patients' condition and treatment provided. The request for TMEN-DNBI will be communicated following the format provided in Example C of this appendix. Example: "Alpha 24, this is Bravo 15, Request TMEN-DNBI, Over." Once communications are established, the medic will transmit all applicable information on the patient (information is transmitted in the sequence outlined in Examples A, B, C, D, and E).

C-4. Teleconsultation Procedures

The physician or PA requesting consultation establishes communications with the consulting physician. Upon establishment of communications, the requester states the type of consultation required. The request will be for teleconsultation-trauma (TCON-TRAUMA) or teleconsultation-disease and nonbattle injury (TCON-DNBI). Patient condition codes are contained in Table C-1. The request for TCON-TRAUMA will be communicated following the format provided in Example D of this appendix. The request for TCON-DNBI will be communicated following the format provided in Example E of this appendix.

C-5. Complete Telementoring/Teleconsultation Session

Complete TMEN/TCON sessions as quickly as possible. Long sessions tie up essential communication assets and may compromise operational security.

C-6. Telementoring/Teleconsultation Communications/Data Equipment and Systems

a. Telementoring/TCON will be conducted on a dedicated communications network. This network will be restricted to use for this purpose only. The network is not used for regular communications traffic such as requesting medical evacuation, resupply of medics/treatment facilities, or other administrative operations. All other traffic will be conducted on the administrative/logistics net or other established communications nets/systems.

b. In the future, the combat medic will employ a hands-free voice/data capable lightweight radio device to obtain global positioning system information on casualties, and to input information into the multifunctional record card or the individual patient record. The hands-free equipment links the combat medic with the BAS for TMEN and situation awareness. The communications equipment will be operated in accordance with the unit's TSOP or OPSEC rules.

c. In the future, Echelon I treatment elements (BAS or treatment team) will employ a hands-free voice/data-capable lightweight radio for TMEN with the combat medic. The same equipment will also be used for TCON between the physician and PA. The BAS will employ voice/data (still imagery) communications for TCON with the medical company clearing station. They will also employ the medical

digital assistant and a device to read and update information in the multifunctional record card or individual patient record. Communications equipment will be operated in accordance with TSOPs or SOIs. The Echelon I medical evacuation element will employ wireless communications with the ASMC and supported unit.

d. The Echelon II (medical company clearing station) will employ voice/data (still imagery) for TCON with the BAS. The FSMC communication link will be via the International Maritime Satellite utilizing a mobile earth station and a rugged video teleconference (VTC) unit to the corps or EAC hospital/ health support facility for TCON. The TCON sessions with corps and EAC hospitals will be on-call sessions. Initially, requests for TCON will be by voice link. Once the session has been established, the TCON session will be via VTC. The VTC mode will enable the physician at the mentoring site to talk to the patient as well as view the actual patient condition in active video mode. The equipment/systems comprising this link are as follows:

- The MTI TCS 9700 mobile earth station provides voice, data, and video links (digital high-speed data) to the supporting MTFs.

- The Remote Clinical Consultation System (RCCS) is a digital still imagery system that transmits still images over the MTI TCS 9700 to the corps or higher-level hospital.

- The CLI 8100 provides a VTC capability. The VTC provides the capability to perform live, interactive VTCs. Video teleconferencing enhances the consultant's ability to view and examine the patient, as well as interview the patient. It allows for an open conversation between the patient and the attending medical officers at both sites.

- The Dynamic Medical Examination Scope Set (DMESS) consists of the otoscope, ophthalmoscope, dermatology scope, and dental scope. The DMESS can send live real-time images during the conference, as well as "frame grabbed" still images which can be viewed immediately on the receiver end. The still images acquired and sent in this manner should not be confused with the high resolution still images which are acquired by RCCS and transmitted over the MTI TCS 9700.

e. The CSH will have the same telecommunications equipment as the Echelon II MTF. This hospital will also employ an intrahospital medical image and record acquisition system/local area network (LAN); included will be the filmless and paperless digital information capability for patient records. Electronically stored x-rays, CT scans, and magnetic-resonance imaging files can be transmitted instantly around the world. This will assist in alleviating the logistical and environmental issues with film and forms and expedite evacuation processing. Hospital management and crisis response will be improved within the hospital by the use of wireless hand-held medical communications. The CHS will provide TCON to the Echelon II MTFs and receive TCON support from an Echelon V hospital. Telecommunications with Echelon V/CONUS-based hospital will not include the DMESS.

f. The Echelon V/CONUS-based hospital will have the same telecommunications capability as corps CHS/Echelon III less the DMESS. The employment of these telecommunication systems enables individuals in an Echelon V/CONUS-based MTF to project their expertise forward to the battlefield. A high data rate communication port for full modalities (audio, video, and digital) using satellite or

terrestrial communication modes will provide direct interface in the out years. Communication interfacing with civilian medical centers will allow the military to diagnose and treat the most widely diverse and individual cases experienced in the field. Additionally, an electronic digital archive for all patient data will augment a LAN for instantaneous storage, retrieval, and display of patient medical data.

C-7. Patient Condition Codes

This paragraph provides the trauma patient condition codes and DNBI descriptions. The trauma patient condition codes are provided in Table C-1. The trauma condition codes are listed using an alphabetical listing rather than the numbers as presented in the trauma master file (the condition code numbers would not be in consecutive number sequence). The alphabetical identifier will not be used; the actual condition code description or an abbreviated description will be used. Example: The combat medic may describe a patient condition as "lacerated facial and neck wound, with severe hemorrhage" whereas the physician may use the entire patient condition code description for this type of wound. See Table C-2 for examples of DNBI for telemedicine initiatives.

Table C-1. Trauma Patient Condition Codes

a. CEREBRAL CONCUSSION, CLOSED, WITH/WITHOUT NONDEPRESSED LINEAR SKULL FRACTURE, SEVERE—LOSS OF CONSCIOUSNESS FROM 2 TO 12 HOURS.

b. CEREBRAL CONTUSION, CLOSED, WITH/WITHOUT NONDEPRESSED LINEAR SKULL FRACTURE, SEVERE—LOSS OF CONSCIOUSNESS GREATER THAN 24 HOURS, WITH FOCAL NEUROLOGICAL DEFICIT.

c. CEREBRAL CONTUSION, CLOSED, WITH NONDEPRESSED LINEAR SKULL FRACTURE, SEVERE—LOSS OF CONSCIOUSNESS GREATER THAN 24 HOURS, WITH/WITHOUT FOCAL NEUROLOGICAL DEFICIT.

d. FRACTURE, FACIAL BONES, CLOSED, EXCLUSIVE OF MANDIBLE, SEVERE—MULTIPLE FRACTURES.

e. FRACTURE, FACIAL BONES, CLOSED, EXCLUSIVE OF MANDIBLE, MODERATE—SINGLE FRACTURE.

f. WOUND, FACE, JAWS, AND NECK, OPEN, LACERATED WITH ASSOCIATED FRACTURES, EXCLUDING SPINAL FRACTURES, SEVERE—WITH AIRWAY OBSTRUCTION.

g. WOUND, FACE AND NECK, OPEN, LACERATED, CONTUSED WITHOUT FRACTURES, SEVERE—WITH AIRWAY OBSTRUCTION OR MAJOR VESSEL INVOLVEMENT.

h. EYE WOUND, LACERATED, MODERATE—WITHOUT RETINAL DETACHMENT OR RETINAL INJURY, NO FOREIGN BODY RETAINED, WITHOUT LOSS OF VITREOUS FLUID, PATIENT HAS HYPHEMA, EYE SALVAGEABLE.

i. FRACTURE, SPINE, CLOSED, WITH CORD DAMAGE, CERVICAL SPINE WITH RESPIRATORY INVOLVEMENT.

j. FRACTURE, SPINE, OPEN, WITH CORD DAMAGE, CERVICAL SPINE WITH RESPIRATORY DISTRESS.

k. FRACTURE, SPINE, OPEN WITH CORD DAMAGE, BELOW CERVICAL SPINE (PROGRESSIVE).

l. BURN, THERMAL, PARTIAL THICKNESS, HEAD AND NECK, GREATER THAN 5 PERCENT BUT LESS THAN 10 PERCENT OF TOTAL BODY AREA AND/OR EYE INVOLVEMENT.

m. BURN, THERMAL, PARTIAL THICKNESS, HEAD AND NECK, LESS THAN 5 PERCENT OF TOTAL BODY AREA AND NO EYE INVOLVEMENT.

n. BURN, THERMAL, FULL THICKNESS, HEAD AND NECK, GREATER THAN 5 PERCENT BUT LESS THAN 10 PERCENT OF TOTAL BODY AREA WITH EYE INVOLVEMENT.

o. BURN, FULL THICKNESS, HEAD AND NECK, LESS THAN 5 PERCENT OF TOTAL BODY AREA AND NO EYE INVOLVEMENT.

p. WOUND, SHOULDER GIRDLE, OPEN, WITH BONE INJURY, SEVERE—JOINT INVOLVEMENT.

q. WOUND, UPPER ARM, OPEN, PENETRATING, LACERATED, WITHOUT FRACTURE, SEVERE—WITH NERVE AND/OR VASCULAR INJURY.

Table C-1. Trauma Patient Condition Codes (Continued)

r. WOUND, UPPER ARM, OPEN WITH FRACTURES AND NERVE AND VASCULAR INJURY, ARM NONSALVAGEABLE.

s. WOUND, UPPER ARM, OPEN WITH FRACTURE AND NERVE INJURY, NO VASCULAR INJURY, ARM SALVAGEABLE.

t. WOUND, FOREARM, OPEN, LACERATED, PENETRATING, WITH FRACTURE AND WITH NERVE AND VASCULAR INJURY, FOREARM NOT SALVAGEABLE.

u. WOUND, FOREARM, OPEN, LACERATED, PENETRATING, WITH FRACTURE AND WITH NERVE AND VASCULAR INJURY, FOREARM SALVAGEABLE.

v. CRUSH INJURY, UPPER EXTREMITY, SEVERE—LIMB SALVAGEABLE.

w. DISLOCATION/FRACTURE, ELBOW, CLOSED, ACUTE, ALL CASES.

x. DISLOCATION, FINGERS, CLOSED ACUTE.

y. AMPUTATION, HAND, TRAUMATIC, COMPLETE, ALL CASES.

z. AMPUTATION, FOREARM, TRAUMATIC, COMPLETE, ALL CASES.

aa. AMPUTATION, FULL ARM, TRAUMATIC, COMPLETE, ALL CASES.

ab. BURN, THERMAL, PARTIAL THICKNESS, UPPER EXTREMITIES, GREATER THAN 10 PERCENT BUT LESS THAN 20 PERCENT OF TOTAL BODY AREA INVOLVED.

ac. BURN, THERMAL, PARTIAL THICKNESS, UPPER EXTREMITY, LESS THAN 10 PERCENT OF TOTAL BODY AREA INVOLVED.

ad. BURN, THERMAL, FULL THICKNESS, UPPER EXTREMITIES, GREATER THAN 10 PERCENT BUT LESS THAN 20 PERCENT OF TOTAL BODY AREA INVOLVED.

ae. BURN, THERMAL, FULL THICKNESS, UPPER EXTREMITY, LESS THAN 10 PERCENT OF TOTAL BODY AREA INVOLVED.

af. FRACTURE, RIBS, CLOSED, SEVERE—MULTIPLE FRACTURES.

ag. FRACTURE, RIB(S), CLOSED, MODERATE.

ah. INJURY, LUNG, CLOSED (BLAST, CRUSH) WITH PNEUMOHEMOTHORAX, SEVERE—ONE LUNG WITH PULMONARY CONTUSION AND ACUTE, SEVERE RESPIRATORY DISTRESS.

ai. INJURY, LUNG, CLOSED (BLAST, CRUSH) WITH PNEUMOHEMOTHORAX, MODERATE—ONE LUNG WITH CONTUSION AND RESPIRATORY DISTRESS.

aj. WOUND, THORAX (ANTERIOR OR POSTERIOR) OPEN, PENETRATING, WITH ASSOCIATED RIB FRACTURE AND PNEUMOHEMOTHORAX, ACUTE, SEVERE RESPIRATORY DISTRESS.

ak. BURN, THERMAL, PARTIAL THICKNESS, TRUNK, GREATER THAN 20 PERCENT BUT LESS THAN 30 PERCENT OF TOTAL BODY AREA INVOLVED.

al. BURN, THERMAL, PARTIAL THICKNESS, TRUNK, GREATER THAN 10 PERCENT BUT LESS THAN 20 PERCENT OF TOTAL BODY AREA INVOLVED.

am. BURN, THERMAL, FULL THICKNESS, TRUNK, GREATER THAN 20 PERCENT BUT LESS THAN 30 PERCENT OF TOTAL BODY AREA INVOLVED.

an. BURN, THERMAL, FULL THICKNESS, TRUNK, GREATER THAN 10 PERCENT BUT LESS THAN 20 PERCENT OF TOTAL BODY AREA INVOLVED.

ao. WOUND, ABDOMINAL WALL (ANTERIOR OR POSTERIOR), LACERATED, ABRADED, CONTUSED, AVULSED WITHOUT ENTERING ABDOMINAL CAVITY, SEVERE—REQUIRING MAJOR DEBRIDEMENT.

ap. WOUND, ABDOMINAL WALL (ANTERIOR OR POSTERIOR), LACERATED, ABRADED, CONTUSED, AVULSED, WITHOUT ENTERING ABDOMINAL CAVITY, NOT REQUIRING MAJOR DEBRIDEMENT.

aq. WOUND, LIVER, CLOSED, ACUTE (CRUSH, FRACTURE), MAJOR LIVER DAMAGE.

ar. WOUND, LIVER, CLOSED, ACUTE (CRUSH, FRACTURE), MINOR LIVER DAMAGE.

as. WOUND, SPLEEN, CLOSED, ACUTE (CRUSH, FRACTURE), ALL CASES.

at. WOUND, ABDOMINAL CAVITY, OPEN, WITH LACERATING, PENETRATING, PERFORATING WOUND TO THE LARGE BOWEL.

au. WOUND, ABDOMINAL CAVITY, OPEN WITH LACERATING, PENETRATING, PERFORATING WOUND TO SMALL BOWEL, WITHOUT MAJOR OR MULTIPLE RESECTIONS.

av. WOUND, ABDOMINAL CAVITY, OPEN, WITH PENETRATING, PERFORATING WOUND OF LIVER, MAJOR DAMAGE.

aw. WOUND, ABDOMINAL CAVITY, OPEN, WITH PENETRATING, PERFORATING ABDOMINAL WOUND WITH LACERATED LIVER.

Table C-1. Trauma Patient Condition Codes (Continued)

ax. WOUND, ABDOMINAL CAVITY, OPEN, WITH PENETRATING, PERFORATING WOUND OF SPLEEN.
ay. WOUND, ABDOMINAL CAVITY, OPEN, WITH LACERATED, PENETRATING, PERFORATING WOUND WITH SHATTERED KIDNEY.
az. WOUND, ABDOMINAL CAVITY, OPEN, WITH LACERATED, PENETRATING, PERFORATING WOUND WITH SHATTERED BLADDER.
ba. WOUND, BUTTOCKS, SEVERE—OPEN, WITH LACERATED, PENETRATING, PERFORATING, AND AVULSED.
bb. DISPLACED FRACTURE OF PELVIS, CLOSED, WITH ASSOCIATED SOFT TISSUE DAMAGE AND PELVIC ORGAN DAMAGE.
bc. NONDISPLACED FRACTURE OF PELVIS, CLOSED, WITH ASSOCIATED SOFT TISSUE DAMAGE.
bd. WOUND, ABDOMEN, OPEN, WITH PELVIC FRACTURE AND PENETRATING, PERFORATING WOUNDS TO MULTIPLE PELVIC STRUCTURES (MALE OR FEMALE).
be. WOUND, ABDOMEN, OPEN, WITH PELVIC FRACTURE AND PENETRATING, PERFORATING WOUNDS TO PELVIC COLON ONLY (MALE OR FEMALE).
bf. WOUND, THIGH, OPEN, LACERATED, PENETRATING, PERFORATING WITH FRACTURE AND NERVE/VASCULAR INJURY, LIMB NOT SALVAGEABLE.
bg. WOUND, THIGH, OPEN, LACERATED, PENETRATING, PERFORATING WITH FRACTURE AND NERVE/VASCULAR INJURY, LIMB SALVAGEABLE.
bh. WOUND, LOWER LEG, OPEN, LACERATED, PENETRATING, PERFORATING, WITH FRACTURE AND NERVE/VASCULAR INJURY, LIMB NOT SALVAGEABLE.
bi. WOUND, LOWER LEG, OPEN, LACERATED, PENETRATING, PERFORATING, WITH FRACTURE AND NERVE/VASCULAR INJURY, LIMB SALVAGEABLE.
bj. CRUSH INJURY, LOWER EXTREMITY, LIMB NOT SALVAGEABLE.
bk. CRUSH INJURY, LOWER EXTREMITY, LIMB SALVAGEABLE.
bl. DISLOCATION, TOES, CLOSED, ACUTE, ALL CASES.
bm. AMPUTATION, FOOT, TRAUMATIC, COMPLETE, ALL CASES.
bn. AMPUTATION, BELOW KNEE, TRAUMATIC, COMPLETE, ALL CASES.
bo. AMPUTATION, TRAUMATIC, COMPLETE, REQUIRING HIP DISARTICULATION.
bp. AMPUTATION, ABOVE KNEE, TRAUMATIC, COMPLETE.
bq. BURN, THERMAL, PARTIAL THICKNESS, LOWER EXTREMITIES AND GENITALIA, GREATER THAN 30 PERCENT BUT LESS THAN 40 PERCENT OF TOTAL BODY AREA INVOLVED.
br. BURN, THERMAL, PARTIAL THICKNESS, LOWER EXTREMITIES AND GENITALIA, GREATER THAN 15 PERCENT BUT LESS THAN 30 PERCENT OF TOTAL BODY AREA INVOLVED.
bs. BURN, THERMAL, FULL THICKNESS, LOWER EXTREMITIES AND GENITALIA, GREATER THAN 30 PERCENT BUT LESS THAN 40 PERCENT OF TOTAL BODY AREA INVOLVED.
bt. BURN, THERMAL, FULL THICKNESS, LOWER EXTREMITIES AND GENITALIA, GREATER THAN 15 PERCENT BUT LESS THAN 30 PERCENT OF TOTAL BODY AREA INVOLVED.

Table C-2. Examples of Disease and Nonbattle Injury for Telemedicine Initiatives

DIARRHEAL

UPPER RESPIRATORY

MALARIA—P. VIVAX VERSUS P. FALCIPARUM

DERMATOLOGICAL

- IMPETIGO
- SHINGLES
- PITYRIASIS ROSEA
- LEISHMANIASIS

EAR

- PERFORATED TYMPANIC MEMBRANE WITH DISLOCATED OSSICLE
- OTITIS EXTERNAL WITH SEVERE PAIN

ELEVATED BODY TEMPERATURE WITH MENINGOCOCCAL RASH

LASER EYE INJURY

EXAMPLE A

TELEMENTORING-TRAUMA REQUEST

The following format is provided for use by the combat medic when requesting TMEN-TRAUMA assistance from the physician or PA at the BAS. The format is outlined in line number sequence.

Line 1. CALL SIGN AND VEHICLE DESIGNATION (if applicable).

Line 2. NUMBER OF PATIENTS BY TRIAGE CATEGORY: IMMEDIATE_____ DELAYED_____.

Line 3. PATIENT CONDITION: Provide a brief description of the patient's wound/injury. Example: Patient has a severely lacerated face and neck wound, a major blood vessel involved.

NOTE: Wait for permission from the mentor to transmit the rest of the request. When instructed, transmit the following information on each patient:

Line 4. PATIENT IDENTIFICATION: NAME_____, SSN_____.

Line 5. DESCRIPTION OF INJURIES (type, location, exam results) IN THE FOLLOWING ORDER:

A. HEAD, C-SPINE, AND NEUROLOGICAL ASSESSMENT (use **A**lert, responds to **V**ocal stimuli, responds to **P**ainful stimuli, and **U**nresponsive [AVPU] or Glasgow Coma Scale Score).
B. THROAT AND CHEST.
C. ABDOMEN.
D. EXTREMITIES (include distal function results).

Line 6. MECHANISM OF INJURY (when applicable):

A. GUNSHOT/FRAGMENTATION WOUND.
B. VEHICLE ACCIDENT.
C. HIGH EXPLOSIVE FIRES.
D. FIRE INSIDE TRACKED VEHICLE.
E. OTHER (list mechanism if not included in A through D above; Example: AIR ATTACK).

Line 7. VITAL SIGNS: PULSE____, RESPIRATION____, BLOOD PRESSURE_____.

Line 8. TREATMENT PROVIDED:

A. AIRWAY (if not maintained).
B. BREATHING (if difficulty remains).
C. BLEEDING (if uncontrolled or tourniquet with time).
D. INTRAVENOUS (IV) FLUIDS (amount and type given).
E. MEDICATIONS GIVEN (name, amount, time[s]).

NOTE: Instructions are provided below.

EXAMPLE A (CONTINUED)

INSTRUCTIONS FOR TELEMENTORING-TRAUMA REQUEST

The request for TMEN-TRAUMA should be prepared and transmitted to include the information indicated for each line item as follows:

Line 1.	CALL SIGN AND VEHICLE.	Include vehicle designation if part of a designation ambulance team. Follow TSOP or SOIs when operating communications equipment.
Line 2.	NUMBER OF PATIENTS BY TRIAGE CATEGORY.	Only triage categories used in TMED-TRAUMA are IMMEDIATE AND DELAYED. Example: "1 IMMEDIATE." Only list patients requiring mentored treatment.
Line 3.	PATIENT CONDITION.	Specify conditions that apply to patient(s) that require mentored treatment. Provide a brief description of the patient's conditions requiring TMEN-TRAUMA. Example: "The patient's condition is a lacerated face and neck wound, with a major blood vessel involved.
Line 4.	PATIENT IDENTIFICATION.	Provide the patient's name and SSN.
Line 5.	DESCRIPTION OF INJURIES.	Provide location, type, and exam results for each wound/injury in each category.
	A. HEAD, C-SPINE, AND NEUROLOGICAL ASSESSMENT.	Provide AVPU Scale or Glasgow Coma Scale Score. Include state of consciousness.
	B. THROAT AND CHEST.	Include airway and breathing problems.
	C. ABDOMEN.	Include bruises, tender areas, or distention.
	D. EXTREMITIES.	Provide distal function results.
Line 6.	MECHANISM OF INJURY.	Only specify mechanism of injury when one of the listed causes apply. Examples: Gunshot wound or vehicle accident. If not listed, enter description. Example: AIR ATTACK.
Line 7.	VITAL SIGNS.	
	PULSE.	Specify rate and quality.
	RESPIRATION.	Specify rate and rhythm.
	BLOOD PRESSURE.	Specify palpated or estimated.
Line 8.	TREATMENT PROVIDED.	
	AIRWAY.	Specify if cannot maintain airway.
	BREATHING.	Specify if continued difficulty.
	BLEEDING.	Specify if uncontrolled or has a tourniquet with time of application.
	IV FLUIDS.	Specify type and amount given.
	MEDICATIONS GIVEN.	Specify drug name, amount, and time.

EXAMPLE B

TELEMENTORING-TRAUMA RECORD CARD

MEDIC AND VEHICLE_____ PATIENT NAME_____ SSN_____
DATE_____ TIME_____

1. Line 1. CALL SIGN:_____

2. Line 2. PATIENT CONDITION: (Life-threatening condition(s) which require TMEN.)

3. Line 3. MECHANISM OF INJURY:
_____
_____
_____
_____

4. Line 4. VITAL SIGNS: P_____R_____BP_____ TIME_____

   P_____R_____BP_____ TIME_____

   P_____R_____BP_____ TIME_____

5. Line 5. TREATMENT PROVIDED:
_____
_____
_____
_____

6. Line 6. RECORD AND NOTIFY BAS OF PATIENT'S CONDITION AFTER TELEMENTORING TREATMENT IS PROVIDED:
_____
_____
_____
_____

7. Line 7. ADDITIONAL INFORMATION:
_____
_____
_____
_____

EXAMPLE C

TELEMENTORING-DISEASE AND NONBATTLE INJURY REQUEST

The following format is provided for use by the combat medic when requesting TMEN-DNBI assistance from the physician or PA at the BAS. The request is in line item format.

Line 1. CALL SIGN AND VEHICLE DESIGNATION (if applicable).

Line 2. CONDITION (as applicable for each patient):

A. SIGNS AND SYMPTOMS (Example: vomiting, diarrhea, increased body temperature).
B. MEDICATIONS BEING TAKEN/GIVEN (specify).
C. SPECIAL MEDICAL CONDITIONS (specify; Example: hypertension).
D. UNIT TREND (number of patients with same signs and symptoms, if applicable).
E. KNOWN ALLERGIES (specify).
F. FOLLOW-UP REQUEST (include date-time group [DTG] of initial request and patient's status).

Line 3. PATIENT NAME_____ SSN_____.

Line 4. VITAL SIGNS: (Report only signs outside normal range.)

TEMPERATURE _____ (98.6 F +/- 1).
PULSE _____ (60-80 beats per minute).
RESPIRATION _____ (14-20 breaths per minute).
BLOOD PRESSURE _____ (120/80 +/- 5).

Line 5. HISTORY BY **AMPLE**:

Allergies_____

Medications_____

Previous occurrence_____

Last meal_____

Events preceding illness/injury_____

Line 6. SUBJECTIVE:

Line 7. OBJECTIVE:

Line 8. ASSESSMENT:

Line 9. PLAN:

EXAMPLE C (CONTINUED)

INSTRUCTIONS FOR TELEMENTORING-DISEASE AND NONBATTLE INJURY REQUEST

The request for TMEN-DNBI should be prepared and transmitted to include the information as indicated for each line item:

Line 1.	CALL SIGN AND VEHICLE.	Include vehicle if part of an ambulance team.
Line 2.	PATIENT CONDITION.	Specify conditions which apply for the patient. Example: Patient has elevated body temperature and rash on chest.
Line 3.	PATIENT IDENTIFICATION.	Provide patient's name and SSN.
Line 4.	VITAL SIGNS.	Provide only vital signs outside of normal range, if able to obtain.
	A. TEMPERATURE.	(98.6 F +/- 1).
	B. PULSE.	(60-80 beats per minute).
	C. RESPIRATION.	(14-20 breaths per minute).
	D. BLOOD PRESSURE.	(120/80 +/- 5).
Line 5.	HISTORY.	**A**llergies—list all known types. **M**edications prescribed or recently taken. **P**revious occurrence of condition. **L**ast meal—when and what was eaten. **E**vents preceding illness/injury.
Line 6.	STATEMENT.	Provide patients' complaints, signs, and symptoms as accurately as possible.
Line 7.	OBSERVATIONS.	Specify examination and report results.
Line 8.	ASSESSMENT.	Repeat the mentor's assessment to ensure you understood.
Line 9.	PLAN.	Repeat the mentor's treatment plan to ensure accuracy. Specify conditions preventing implementation of the plan, such as prescribed medications are not available. If required to evacuate patient to MTF, provide expected arrival time.

EXAMPLE D

TELECONSULTATION-TRAUMA

The format provided in this example is for the physician or PA at the BAS to use when requesting TCON-TRAUMA assistance from the FMSC, or for the FSMC physicians to use when requesting TCON-TRAUMA support from a corps or higher hospital.

Line 1. CALL SIGN AND MTF:_____.

Line 2. TRIAGE CATEGORY OF PATIENT:_____.

Line 3. PATIENT CONDITION:

A. _____.
B. _____.
C. _____.

Line 4. DESCRIPTION OF INJURIES (type, location, exam results) IN THE FOLLOWING ORDER:

A. HEAD, C-SPINE AND NEUROLOGICAL ASSESSMENT—AVPU SCALE OR GLASGOW COMA SCALE: _____.
B. THROAT AND CHEST: _____.
C. ABDOMEN: _____.
D. EXTREMITIES: _____.

Line 5. MECHANISM OF INJURY (when applicable).

A. GUNSHOT/FRAGMENTATION WOUND.
B. VEHICLE ACCIDENT.
C. HIGH EXPLOSIVE FIRES.
D. FIRE INSIDE TRACKED VEHICLE.
E. OTHER (list mechanism if not included in A through D above; Example: AIR ATTACK).

Line 6. VITAL SIGNS: TEMPERATURE____, PULSE____, RESPIRATION____, BP_____.

Line 7. TREATMENT PROVIDED:

A. AIRWAY.
B. BREATHING.
C. BLEEDING.
D. IV.
E. MEDICATIONS GIVEN.

EXAMPLE D (CONTINUED)

INSTRUCTIONS FOR TELECONSULTATION-TRAUMA REQUEST

The TCON-TRAUMA request should be prepared and transmitted using the following information indicated for each line item:

Line 1.	CALL SIGN AND MTF.	Use your communications call sign and MTF identification code. For TCON between the BAS and FSMC, voice communications will be used. For requesting TCON with the supporting corps or EAC hospital, the initial request will be voice or land line communications equipment.
Line 2.	TRIAGE CATEGORY OF PATIENT.	Provide triage category of patient.
Line 3.	PATIENT CONDITIONS.	Specify patient conditions that prompted you to request TCON.
Line 4.	ASSESSMENT OF PATIENT.	Provide exam results for the patient as follows:
	A. HEAD, C-SPINE, AND NEUROLOGICAL ASSESSMENT.	Provide AVPU Scale or Glasgow Coma Scale Score. Include state of consciousness.
	B. THROAT AND CHEST.	Include airway and breathing problems.
	C. ABDOMEN.	Include bruises, tender areas, or distension.
	D. EXTREMITIES.	Provide distal function results.
Line 5.	MECHANISM OF INJURY.	Specify mechanism of injury to assist the consulted physician in his assessment of the injury.
Line 6.	VITAL SIGNS.	Temperature. Pulse. Respiration. Blood Pressure.
Line 7.	TREATMENT PROVIDED.	State treatment provided with resultant outcome.

EXAMPLE E

TELECONSULTATION-DISEASE AND NONBATTLE INJURY REQUEST

The following format is provided for use by the physician or PA at the MTF requesting TCON-DNBI assistance from the physicians at the FSMC. It is also used by physicians and PAs at the medical company requesting TCON-DNBI assistance from a corps or EAC hospital. The request for TCON-DNBI should be prepared and transmitted to include the information as indicated for each line item.

Line 1.	CALL SIGN/MTF IDENTIFICATION.	Use your call sign or MTF identification. Include unit location if not restricted by TSOP.
Line 2.	PATIENT CONDITION.	Specify conditions that apply for the patient. Example: Patient has elevated body temperature and rash on chest.
Line 3.	PATIENT IDENTIFICATION.	Provide patient's name and SSN.
Line 4.	VITAL SIGNS.	Provide only vital signs outside of normal range.
	A. TEMPERATURE.	(98.6 F +/- 1).
	B. PULSE.	(60-80 beats per minute).
	C. RESPIRATION.	(14-20 breaths per minute).
	D. BLOOD PRESSURE.	(120/80 +/- 5).
Line 5.	HISTORY BY **AMPLE**.	**A**llergies—list all known types. **M**edications prescribed or recently taken. **P**revious occurrence of condition. **L**ast meal—when and what was eaten. **E**vents preceding illness/injury.
Line 6.	STATEMENT.	Provide patient's complaints, signs, and symptoms.
Line 7.	OBSERVATIONS.	Specify type and extent of examination.
Line 8.	ASSESSMENT.	Repeat the consulting physician's assessment to ensure you understood.
Line 9.	PLAN.	Establish a treatment regimen decision or evacuate the patient.

APPENDIX D

AREA SUPPORT MEDICAL DETACHMENT

D-1. Mission, Organization, and Assignment

The ASMD has the overall mission to provide Echelon I CHS and ground ambulance support to divisional troop populations temporarily located in the corps or in staging/holding areas. The ASMD is organized into a headquarters and support section, a treatment section, and an ambulance section. The ASMD is assigned to the medical brigade and normally attached to the HHD, ASMB.

D-2. Headquarters and Support Section

The headquarters and support section (Table D-1) is organized into a headquarters element and a support element. The detachment headquarters element provides C2 and administrative support and performs plans and movement for routine and specialized operations. The support element provides general and medical supply/resupply, light-wheeled vehicle maintenance, and generator repair for the detachment.

Table D-1. Organization and Staffing of an Area Support Medical Detachment Headquarters and Support Section

HEADQUARTERS AND SUPPORT ELEMENT	
HEADQUARTERS ELEMENT	**SUPPORT ELEMENT**
DETACHMENT COMMANDER (MAJ, AOC 61H00)	SUPPLY SERGEANT (E-5, MOS 92Y20)
DETACHMENT NCO (E-7, MOS 91B40)	LIGHT-WHEELED VEHICLE MECHANIC (E-4, MOS 63B10)
PERSONNEL ADMINISTRATION SPECIALIST (E-4, 75B10)	POWER GENERATOR EQUIPMENT REPAIRER (E-4, MOS 52D10)

a. Detachment Commander (Major, Medical Corps). This individual provides C2 for the detachment and is a working physician that deploys with an ALPHA treatment team.

b. Detachment Noncommissioned Officer in Charge. This noncommissioned officer in charge (NCOIC) collocates with the HHD and coordinates for administrative and operational support for the detachment.

c. Supply Sergeant. The supply sergeant augments the medical and unit supply of the ASMB to which attached.

d. Power Generator Repairer. The power generator repairer augments the maintenance element of the ASMB to which attached.

e. Light-Wheeled Vehicle Mechanic. This mechanic augments the maintenance element of the ASMB to which attached.

D-3. Treatment Section

Three treatment squads are assigned to the treatment section. The senior EMT NCO is the section sergeant. Each treatment squad can provide two independent treatment teams. These treatment teams may be deployed to six different locations (staging or holding areas) in support of a battalion-sized force. Treatment teams provide routine sick call and EMT (Echelon I CHS) and determine the disposition of patients from supported units. Each treatment team is normally collocated with a ground ambulance team. The ground ambulance team is under the direct supervision and control of the detachment treatment team. The treatment teams are dependent on the ASMCs for Echelon II CHS. Patients will be referred to the ASMC by the treatment team for Echelon II medical treatment and laboratory and x-ray services. For communications, each treatment team has a tactical radio (AN/VRC-90D) and a MSE set. Each treatment team has a physician or a PA. The structure of the ALPHA and the BRAVO treatment teams is shown in Table D-2.

Table D-2. Organization and Staffing of an Area Support Medical Detachment's Treatment Squads

TREATMENT SECTION TREATMENT SQUAD (3 SQUADS)	
ALPHA TEAMS X 3	**BRAVO TEAMS X 3**
*PRIMARY CARE PHYSICIAN "A" (MAJ AND [2] CPTs, AOC 61H00)	PHYSICIAN ASSISTANT (CPT, AOC 65D00) "B"
EMT NCO (E-5, MOS 91B20) "A"	EMT NCO (E-6, MOS 91B30) "B"
MEDICAL SPECIALIST (E-4, MOS 91B10) "A"	EMT NCO (E-5, MOS 91B20) "B"
MEDICAL SPECIALIST (E-3, MOS 91B10) "A"	MEDICAL SPECIALIST (E-3, MOS 91B10) "B"

LEGEND:

"A"—Alpha Team
"B"—Bravo Team
* The detachment commander also serves as a treatment team leader for one of the ALPHA teams.

D-4. Ambulance Section

The ambulance section is composed of three ambulance squads. Each ambulance squad consists of two teams. An ambulance team consists of two aidmen/drivers and one ambulance. The senior aide/evacuation NCO is the section NCOIC. Ambulance teams are deployed with treatment teams and provide ground

ambulance medical evacuation for supported units. Ambulance teams provide medical evacuation from the treatment team's location to an ASMC or to a corps hospital.

D-5. Area Support Medical Detachment Employment

The medical brigade provides C2 to assigned ASMDs and ensures continuous provision of appropriate CHS to troop staging/holding areas. The ASMD will be further attached to the ASMB for C2 and support to the ASMB. When not employed and collocated with supported troop clusters, the elements of the ASMD will augment the treatment and ground ambulance capabilities of the ASMB or other MTFs as directed. The medical company, dental service and the medical company, CSC will provide appropriate support to augment the ASMD's treatment capabilities on an area support basis.

APPENDIX E

STRATEGIC DEPLOYABILITY DATA

E-1. General

This appendix provides strategic deployability data for the HHD, ASMB, the ASMC, and the ASMD. The automated air-loading planning system was used to develop the strategic movement requirements. The data was computed based on requirements and not authorizations. Unit commanders from the above units and medical planners should use the modified TOEs to compute the unit's specific movement data based on unit loads tailored for the mission. These commanders should also ensure that selected staff members of their units attend a unit movement course to enhance strategic deployment. For information on the Unit Movement Officer Deployment Planning Course, contact the Commandant, US Army Transportation School, ATTN: ATSP-TDD-SD, Fort Eustis Virginia 23604-5001. The telephone number is DSN 927-1575, commercial (804) 878-1575.

E-2. Strategic Deployability Data

Table E-1 provides strategic deployability data for the corps and EAC HHD, ASMB, ASMCs and ASMDs.

Table E-1. Strategic Deployability Data

UNIT	SRC	WEIGHT (LBS)	CUBIC FT	SQ FT	TRANSPORT MODES						PASSENGER (AIR)	
					AIR			SURFACE				
					PURE FLEET TOTAL			SHIP BY % SQ FT		RAIL		
					C141	C17	C5	RORO	LMSR	(STD 89' CAR)	PAX	B747 (400 SEAT)
HHD, AREA SPT MED BN*	08456A000	131,395	11,548	1,449	2	1	1	0.8%	0.5%	3	67	17%
HHD, AREA SPT MED BN**	08456A000	415,343	41,001	5,517	9	5	3	3.1%	1.9%	11	67	17%
MED CO, AREA SPT*	08457A000	145,111	12,259	1,538	3	2	1	0.9%	0.5%	3	78	20%
MED CO, AREA SPT**	08457A000	427,898	51,479	6,222	9	5	3	3.5%	2.1%	12	78	20%
MED DET, AREA SPT*	08753A000	42,660	3,548	445	1	1	1	0.3%	0.1%	1	41	10%
MED DET, AREA SPT**	08753A000	127,436	16,641	2,185	3	2	1	1.2%	0.7%	5	41	10%

NOTE: The percentage figures in the RORO, LMSR, and B747 columns are the SRC space requirements of the ship capacity.

LEGEND:

LMSR Large Medium-Speed Roll-On/Roll-Off
PAX Passenger
RORO Roll-On/Roll-Off
SRC Standard Requirement Code
STD Standard

* (MRI-OBJ) without vehicles and equipment
** (MRI-OBJ) with vehicles and equipment

GLOSSARY

ABBREVIATIONS AND ACRONYMS

A2C2 Army airspace command and control

ACR armored cavalry regiment

ACUS area common user system

AE aeromedical evacuation

AECC Aeromedical Evacuation Control Center

AFMIC Armed Forces Medical Intelligence Center

AM amplitude modulation

amb ambulance

AMEDD Army Medical Department

AMEDDC&S Army Medical Department Center and School

AO area of operations

AOAP Army Oil Analysis Program

AOC area of concentration

AOE Army of Excellence

AR Army regulation

AS area support

ASCC Army Service Component Command

ASMB area support medical battalion

ASMC area support medical company

ASMD area support medical detachment

ATCCS Army Tactical Command and Control System

ATM advanced trauma management

attn attention

AVPU Alert, responds to Vocal stimuli, responds to Painful stimuli, and Unresponsive

AXP ambulance exchange point

BAS battalion aid station

BCOC base cluster operations center

bde brigade

BF battle fatigue

BLDREP blood report

bn battalion

BP blood pressure

br branch

BSA brigade support area

BW biological warfare

C2 command and control

C3 command, control, and communications

CDR commander

CE communications-electronics

CHS combat health support

cmd command

CMO civil-military operations

co company

comm communication

COMMZ communications zone

COMSEC communications security

CONUS continental United States

COSCOM corps support command

CP command post

CPT captain

CS combat support

CSA corps support area

CSC combat stress control

CSH combat support hospital

CSM command sergeant major

CSS combat service support

CSSCS Combat Service Support Control System

CT computer tomography

ctr center

CW chemical warfare

CW2 Chief Warrant Officer, W2

CZ combat zone

DA Department of the Army

DD Department of Defense

DE directed energy

det detachment

DISCOM division support command

DMESS Dynamic Medical Examination Scope Set

DNBI disease and nonbattle injury

DS direct support

DSA division support area

DSB division support battalion

DSMC division support medical company

DSN Defense Switched Network

DTG date-time group

EAC echelons above corps

EEFI essential elements of friendly information

EEI essential elements of information

EMT emergency medical treatment

EPW enemy prisoner(s) of war

evac evacuation

EXT extinguisher

FAX facsimile

1LT first lieutenant

1SG first sergeant

FLOT forward line of own troops

FM field manual (when used with a number); frequency modulation

FMC Field Medical Card

FSMC forward support medical company

FST forward surgical team

ft feet

G1 Assistant Chief of Staff, G1 (Personnel)

G3 Assistant Chief of Staff, G3 (Operations and Plans)

GP/gp general purpose/group

GPS global positioning system

GS general support

HHD headquarters and headquarters detachment

HMMWV high-mobility multipurpose wheeled vehicle

HN host nation

HQ headquarters

HSC headquarters and support company

HSMO health services materiel officer

IHFR improved high-frequency radio

IPB intelligence preparation of the battlefield

ISB intermediate staging base

IV intravenous

kw kilowatt

LAB laboratory

LAN local area network

lbs pounds

LEN large extension node

LOC lines of communication

LT lieutenant

LTC lieutenant colonel

MA mortuary affairs

maint maintenance

MAJ major

MC4 medical communications for combat casualty care

med medical

MEDCOM medical command

MEDLOG medical logistics

MEDSUP medical supply

MES medical equipment set(s)

METT-TC mission, enemy, terrain, troops, time available, and civilian considerations

MH mental health

MOPP mission-oriented protective posture

MOS military occupational specialty

MP military police

MPL mandatory parts list

MRI Medical Reengineering Initiative

MRO medical regulating office(r)

MSB main support battalion

MSE mobile subscriber equipment

MSMC main support medical company

MSR main supply route

MSRT mobile subscriber radiotelephone terminal

MTF medical treatment facility

MTOE modification table(s) of organization and equipment

NATO North Atlantic Treaty Organization

NBC nuclear, biological, and chemical

NC node centers

NCO noncommissioned officer

NCOIC noncommissioned officer in charge

NCS net control station

NDMS National Disaster Medical System

NEO noncombatant evacuation operations

NP neuropsychiatric

NRTD nonreturn to duty

obj objective

OCONUS outside continental United States

OPCON operational control

OPLAN operation plan

OPORD operation order

ops operations

OPSEC operations security

opt optical/optometry

ORF operational readiness float

P pulse

PA physician assistant

PAC Personnel and Administration Center

PDS personnel daily summary

PLL prescribed load list

plt platoon

PMCS preventive maintenance checks and services

PMM preventive medicine measures

pnt patient

POL petroleum, oils, and lubricants

PSYOP psychological operations

Pub publication

PVNTMED preventive medicine

R respiration

RATT radio teletypewriter

RAU radio access unit

RCCS Remote Clinical Consultation System

RMC remote multiplexer combiner

RSO&I reception, staging, onward movement, and integration

RTD return to duty

S1 Adjutant (US Army)

S2 Intelligence Officer (US Army)

S3 Operations and Training Officer (US Army)

S4 Supply Officer (US Army)

SALUTE size, activity, location, unit, time, and equipment

SATCOM satellite communications

SB supply bulletin

SCC system control center

sec section

SEN small extension node

SGT sergeant

SINCGARS Single-Channel Ground and Airborne Radio System

SOF special operations forces

SOI signal operation instructions

SOP standing operating procedures

spt support

sq square

sqd squad

SSN social security number

STANAG standardization agreement

swbd switchboard

TACCS Tactical Army Combat Service Support (CSS) Computer System

TAMMIS Theater Army Medical Management Information System

TB technical bulletin

TCF tactical combat force

TCON teleconsultation

TCON-DNBI teleconsultation-disease and nonbattle injury

TCON-TRAUMA teleconsultation-trauma

TM technical manual

TMDE test, measurement, and diagnostic equipment

TMEN telementoring

TMEN-DNBI telementoring-disease and nonbattle injury

TMEN-TRAUMA telementoring-trauma

TO theater of operations

TOE table(s) of organization and equipment

TPFDD time-phased force deployment data

TPMRC Theater Patient Movement Requirements Center

trmt treatment

TSOP tactical standing operating procedures

TTM triage-trauma management

TTP tactics, techniques, and procedures

US United States

veh vehicle

VTC video teleconferencing

XO executive officer

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