

**ATP 4-02.3**

---

---

**Army Health System Support  
to Maneuver Forces**

---

---

**June 2014**

**DISTRIBUTION RESTRICTION:** Approved for public release; distribution is unlimited.

---

---

**Headquarters, Department of the Army**

---

---

This publication is available at Army Knowledge Online  
(<https://armypubs.us.army.mil/doctrine/index.html>).

To receive publishing updates, please subscribe at  
[http://www.apd.army.mil/AdminPubs/new\\_subscribe.asp](http://www.apd.army.mil/AdminPubs/new_subscribe.asp).

# Army Health System Support to Maneuver Forces

## Contents

	Page
<b>PREFACE</b> .....	<b>vi</b>
<b>INTRODUCTION</b> .....	<b>viii</b>
<b>Chapter 1 ARMY HEALTH SYSTEM OVERVIEW</b> .....	<b>1-1</b>
<b>Section I — System of Systems</b> .....	<b>1-1</b>
Health Service Support.....	1-1
Force Health Protection.....	1-1
Principles of Army Health System Support .....	1-2
<b>Section II — Roles of Care</b> .....	<b>1-2</b>
Role 1 Medical Care .....	1-2
Role 2 Medical Care .....	1-3
<b>Section III — Medical Functions</b> .....	<b>1-3</b>
<b>Section IV — The Threat</b> .....	<b>1-3</b>
Health Threat.....	1-4
<b>Chapter 2 MEDICAL RESOURCES OF BRIGADE COMBAT TEAMS AND OTHER MANEUVER FORCES</b> .....	<b>2-1</b>
<b>Section I — Battalion and Brigade Surgeons</b> .....	<b>2-1</b>
Command Surgeons.....	2-1
Comparison of Battalion and Brigade Surgeons' Duties and Responsibilities... 2-2	2-2
Sustainment—S-4/Med (Brigade Surgeon's Section).....	2-5
<b>Section II — Echelons Above Brigade Army Health System Staff Officers and Mission Command Organizations</b> .....	<b>2-6</b>
Division Surgeon .....	2-6
<b>Section III — Maneuver Battalion Medical Platoon</b> .....	<b>2-8</b>
Medical Platoon of the Maneuver Battalion.....	2-8
<b>Section IV — Medical Company (Brigade Support Battalion)</b> .....	<b>2-15</b>
Mission.....	2-16

---

**Distribution Restriction:** Approved for public release; distribution is unlimited.

\*This publication supersedes FM 4-02.4, dated 24 August 2001 (including Change 1, dated 18 December 2003); FM 4-02.6, dated 1 August 2002 (including Change 1, dated 9 April 2004); and FM 4-02.21, dated 15 November 2000.

	Assignment and Dependencies .....	2-16
	Basis of Allocation.....	2-17
	Mobility .....	2-17
	Capabilities.....	2-17
	Organization and Functions.....	2-18
	<b>Section V — Army Health System Assets in Nonmedical Organizations</b> .....	<b>2-25</b>
	Combat Aviation Brigades .....	2-25
	Maneuver Enhancement Brigade .....	2-35
	Fires Brigade.....	2-35
	Battlefield Surveillance Brigade .....	2-38
	Sustainment Brigade.....	2-42
<b>Chapter 3</b>	<b>PLANNING AND EXECUTING ARMY HEALTH SYSTEM OPERATIONS</b> .....	<b>3-1</b>
	<b>Section I — Planning</b> .....	<b>3-1</b>
	Principles.....	3-1
	<b>Section II — Effect on Army Health System Operations by the Operational Environment</b> .....	<b>3-2</b>
	Terrain and Weather .....	3-2
	<b>Section III — Army Health System Support to Decisive Action</b> .....	<b>3-4</b>
	Decisive Action.....	3-5
<b>Chapter 4</b>	<b>MEDICAL COMPANY (AREA SUPPORT)</b> .....	<b>4-1</b>
	<b>Section I — Medical Company (Area Support)</b> .....	<b>4-1</b>
	Mission .....	4-2
	Assignment and Dependencies .....	4-2
	Basis of Allocation.....	4-2
	Mobility .....	4-2
	Capabilities.....	4-2
	Organization and Functions .....	4-3
	<b>Section II — Comparison of Medical Company (Brigade Support Battalion) and Medical Company (Area Support)</b> .....	<b>4-8</b>
<b>Appendix A</b>	<b>MASS CASUALTY OPERATIONS</b> .....	<b>A-1</b>
<b>Appendix B</b>	<b>MANAGEMENT OF DEPLOYED INDIVIDUAL MEDICAL RECORDS</b> .....	<b>B-1</b>
<b>Appendix C</b>	<b>RECORDS, REPORTS, AND PLANNING TOOLS</b> .....	<b>C-1</b>
<b>Appendix D</b>	<b>MEDICAL COMMUNICATIONS FOR COMBAT CASUALTY CARE</b> .....	<b>D-1</b>
<b>Appendix E</b>	<b>MEDICAL SUPPORT SECTION BRIGADE SPECIAL TROOPS BATTALION</b> .....	<b>E-1</b>
	<b>GLOSSARY</b> .....	<b>Glossary-1</b>
	<b>REFERENCES</b> .....	<b>References-1</b>
	<b>INDEX</b> .....	<b>Index-1</b>

## Figures

Figure 2-1. Medical platoon of maneuver forces .....	2-8
Figure 2-2. Infantry brigade combat team medical company (brigade support battalion) .....	2-16
Figure 4-1. Medical company (area support) .....	4-1
Figure A-1. A mass casualty station established outdoors .....	A-5
Figure C-1. Example daily disposition log .....	C-2
Figure C-2. Example of a patient summary report .....	C-3

## Tables

Table 1-1. Health threat.....	1-4
Table 2-1. Comparison of battalion and brigade surgeons' duties and responsibilities .....	2-2
Table 2-2. Sustainment–S-4/medical staff .....	2-6
Table 2-3. Division surgeon's section.....	2-6
Table 2-4. Medical platoon headquarters.....	2-9
Table 2-5. Medical treatment squad .....	2-10
Table 2-6. Ambulance squad (wheeled).....	2-12
Table 2-7. Medical platoon combat medic section .....	2-13
Table 2-8. Company headquarters.....	2-18
Table 2-9. Preventive medicine section .....	2-19
Table 2-10. Mental health section .....	2-19
Table 2-11. Medical treatment platoon headquarters .....	2-20
Table 2-12. Medical treatment squad.....	2-21
Table 2-13. Area support squad.....	2-22
Table 2-14. Medical treatment squad (area) .....	2-22
Table 2-15. Patient holding squad.....	2-23
Table 2-16. Medical evacuation platoon.....	2-24
Table 2-17. Brigade medical supply office .....	2-25
Table 2-18. Combat aviation brigade (light) S-3 section .....	2-26
Table 2-19. Brigade surgeon section .....	2-27
Table 2-20. Medical treatment team, headquarters and headquarters company, combat aviation brigade.....	2-27
Table 2-21. Medical treatment team (assault battalion).....	2-28
Table 2-22. Combat medic section (pathfinder company) .....	2-28
Table 2-23. General support aviation battalion (S-3 section).....	2-28
Table 2-24. Medical treatment team, general support aviation battalion .....	2-29
Table 2-25. Company headquarters.....	2-29
Table 2-26. Forward support medical evacuation platoon .....	2-30
Table 2-27. Medical treatment teams assigned to attack and reconnaissance squadrons, combat aviation brigade.....	2-31

Table 2-28. Sustain 2—network operations, combat service support automation management office .....	2-31
Table 2-29. Medical platoon headquarters, headquarters and support company, aviation support battalion.....	2-32
Table 2-30. Treatment squad, headquarters and support company, aviation support battalion .....	2-32
Table 2-31. Evacuation section, headquarters and support company, aviation support battalion .....	2-33
Table 2-32. Extended range multipurpose unmanned aircraft system company, aviation support battalion.....	2-33
Table 2-33. Medical company (air ambulance) (light utility helicopter) headquarters .....	2-34
Table 2-34. Flight operations section, (air ambulance) (light utility helicopter).....	2-34
Table 2-35. Medical evacuation flight platoon, (air ambulance) (light utility helicopter) .....	2-34
Table 2-36. Brigade surgeon section .....	2-35
Table 2-37. Sustainment/medical treatment team .....	2-35
Table 2-38. Command post-sustainment/protection-surgeon.....	2-36
Table 2-39. Medical treatment team, headquarters and headquarters battery, medical section.....	2-36
Table 2-40. Medical evacuation squad, headquarters and headquarters battery, medical section.....	2-37
Table 2-41. Medical platoon headquarters, headquarters and headquarters battery, fires battalion, multiple launch rocket system.....	2-37
Table 2-42. Medical treatment team, headquarters and headquarters battery, fires battalion, multiple launch rocket system.....	2-38
Table 2-43. Combat medic section, headquarters and headquarters battery, fires battalion, multiple launch rocket system.....	2-38
Table 2-44. Ambulance team, headquarters and headquarters battery, fires battalion, multiple launch rocket system.....	2-38
Table 2-45. Sustainment/brigade surgeon.....	2-39
Table 2-46. Headquarters and headquarters company/treatment team, battlefield surveillance brigade.....	2-40
Table 2-47. Headquarters and headquarters company/evacuation squad, battlefield surveillance brigade.....	2-40
Table 2-48. Medical treatment platoon headquarters, reconnaissance and surveillance squadron.....	2-41
Table 2-49. Medical treatment team, reconnaissance and surveillance squadron .....	2-41
Table 2-50. Ambulance squad, reconnaissance and surveillance squadron .....	2-42
Table 2-51. Combat medic section, reconnaissance and surveillance squadron .....	2-42
Table 2-52. Brigade surgeon section, sustainment brigade .....	2-43
Table 2-53. Treatment platoon headquarters, sustainment brigade.....	2-44
Table 2-54. Medical treatment squad, sustainment brigade.....	2-44
Table 2-55. Medical evacuation squad, sustainment brigade .....	2-44
Table 2-56. Early entry element, surgeon section, sustainment brigade.....	2-45
Table 3-1. Medical considerations for terrain and environmental conditions.....	3-3

Table 3-2. Primary tasks, purposes and key Role 1 and 2 medical considerations for offensive tasks .....	3-5
Table 3-3. Primary defensive tasks, purposes, and key Role 1 and 2 medical considerations for defensive tasks.....	3-7
Table 3-4. Stability tasks .....	3-8
Table 3-5. Defense support of civil authorities tasks.....	3-10
Table 4-1. Company headquarters.....	4-4
Table 4-2. Mental health section .....	4-4
Table 4-3. Medical treatment platoon headquarters, medical company (area support).....	4-5
Table 4-4. Medical treatment squad, medical company (area support).....	4-5
Table 4-5. Area support squad, medical company (area support).....	4-6
Table 4-6. Area support medical treatment squad, medical company (area support) .....	4-6
Table 4-7. Patient holding squad, medical company (area support).....	4-7
Table 4-8. Ambulance platoon headquarters, medical company (area support) .....	4-7
Table 4-9. Ambulance squads (wheeled), medical company (area support).....	4-8
Table C-1. Sample format for a planning matrix (medical functions) .....	C-4
Table C-2. Sample format for an execution matrix.....	C-7
Table C-3. Sample format for a company Army Health System support synchronization matrix .....	C-7
Table C-4. Sample format for a battalion/brigade Army Health System support synchronization matrix .....	C-8
Table C-5. Sample format for an informational display/status chart .....	C-9
Table E-1. Treatment team.....	E-2
Table E-2. Evacuation squad .....	E-2
Table E-3. Engineer company .....	E-2
Table E-4. Combat medic section .....	E-3

## Preface

This publication is a consolidation of currently existing publications which address Army Health System (AHS) support to maneuver forces. The publications being consolidated into this Army Techniques Publication (ATP) include Field Manual (FM) 4-02.4, FM 4-02.6, and FM 4-02.21.

Army Health System resources (personnel and equipment) are organic to a variety of organizations within the brigade combat teams (BCTs). The numbers of personnel, medical equipment, and unit capabilities for providing organic AHS support also varies depending upon the parent formation/organization. It is essential for AHS planners to understand how AHS resources are arrayed across the battlefield and the capabilities and limitations of the various medical assets that are used across the range of military operations in support of the warfighting functions in the conduct of unified land operations and in pursuit of decisive action in any operational environment (OE). To facilitate this understanding, this publication uses the infantry brigade combat team (IBCT) base table of organization and equipment (TOE) for illustrative purposes only. Variances will exist between what is included in this publication and the actual modified TOEs of deployed units. These variances may be due to updates of areas of concentration (AOCs), military occupational specialties (MOSs), and military grades and modifications made to unit's TOE which result in the unit's modified TOE or updates to the base TOEs reflecting Total Army Analysis findings and judgments. Where significant differences exist in the base TOEs of the BCTs, an explanation of these differences is provided.

The principal audience for this publication is all commanders and their staffs, command surgeons, AHS planners, and Army Medical Department (AMEDD) personnel and units.

Commanders, staffs, and subordinates ensure their decisions and actions comply with applicable United States (U.S.), international, and, in some cases, host-nation laws and regulations. Commanders at all levels ensure their Soldiers operate in accordance with the law of war and the rules of engagement. (See FM 27-10.)

This publication implements or is in consonance with the following North Atlantic Treaty Organization (NATO) Standardization Agreements (STANAGs); American, British, Canadian, Australian, and New Zealand (Armies) (ABCA) Standards; and ABCA Publication 256.

TITLE	NATO STANAG	ABCA STANDARD
Blood Supply in the Area of Operations		815
Formats for Orders and Designation of Timings, Locations and Boundaries	2014	
Documentation Relative to Initial Medical Treatment and Evacuation—Allied Medical Publication-8.1	2132	
Requirements for Water Potability During Field Operations and in Emergency Situations—Allied Medical Publication-4.9	2136	
Road Movements and Movement Control—Allied Movement Publication-1(A)	2454	
Emergency Supply of Water in Operations	2885	
Orders for the Camouflage of Protective Medical Emblems on Land in Tactical Operations—Allied Tactical Publication-79	2931	
Minimum Requirements for Blood, Blood Donors and Associated Equipment	2939	
Essential Field Sanitary Requirements	2982	

This publication uses joint terms where applicable. Selected joint and Army terms and definitions appear in both the text and the glossary. Terms for which this publication is the proponent publication are marked with an asterisk (\*) in the glossary.

This publication applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the United States Army Reserve, unless otherwise stated.

The proponent of ATP 4-02.3 is the United States Army Medical Department Center and School. The preparing agency is the Doctrine Literature Division, United States Army Medical Department Center and School. Send comments and recommendations on a Department of the Army (DA) Form 2028 (Recommended Changes to Publications and Blank Forms) to **Commander, United States Army Medical Department Center and School, ATTN: MCCS-FC-DL (ATP 4-02.3), 2377 Greeley Road, Building 4011, Suite D, JBSA Fort Sam Houston, Texas 78234-7731**; by e-mail to [usarmy.jbsa.medcom-ameddcs.mbx.ameddcs-medical-doctrine@mail.mil](mailto:usarmy.jbsa.medcom-ameddcs.mbx.ameddcs-medical-doctrine@mail.mil); or submit an electronic DA Form 2028. All recommended changes should be keyed to the specific page, paragraph, and line number. A rationale for each proposed change is required to aid in the evaluation and adjudication of each comment.

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

# Introduction

Army Techniques Publication 4-02.3 is a consolidation, update, and concise revision of the superseded FMs 4-02.4, 4-02.6, and 4-02.21. In consolidating the publications, information is presented using TOEs that are current at the time of this publication's development. Although TOEs will transform from existent TOEs, the missions and general capabilities remain consistent within mission and operational requirements as assigned and resourced. Updates to TOEs are based on capabilities required, usually as a result of the Total Army Analysis initiatives that are resourced for implementation. The mission of the AHS support to maneuver units will not change; however, the resourcing and capabilities inherent in various organizational constructs may change with resourcing and transformation initiatives.

Chapter 1 provides an overview of the AHS at the maneuver force level as a system of systems. The chapter discusses the roles of care of the maneuver force and how it interfaces with the entirety of the national (military and Army) health care system. The chapter closes out with a short discussion of medical functions and the health threat.

Chapter 2 discusses the organic medical resources at the BCTs and other maneuver forces. It is understood that TOEs are modified and periodically updated; however, missions and capabilities will remain similar based upon resources and the operational construct. Changes or alterations in TOEs, unless significantly altering capabilities, will not render this manual obsolete. Refer to the current TOEs and modified TOEs for scoping down to unique capability enhancement by unit and area of operations (AO).

Chapter 3 gives a short synopsis of the AHS operations, planning, and execution. The chapter provides information concerning the effects of the OE on AHS operations. The chapter concludes with the AHS support for decisive action (offense and defense); support to stability tasks; and lastly, support of defense support of civil authorities tasks.

Chapter 4 describes the Role 2 medical company (area support) (MCAS) that is an echelon above brigade organization. It is included as it is often deployed in conjunction with maneuver forces providing support to organizations without a Role 2 medical company and for units without organic Role 1 AHS support operating in the AO.

Appendix A provides an overview of mass casualty operations. The appendix briefly discusses mass casualty management, triage management, and a way to establish a mass casualty station.

Appendix B briefly discusses the management of deployed individual medical records.

Appendix C gives examples and rationales for the provision of records, reports, and planning tools. As with all AHS support elements, records, reports, and planning tools are subject to modification and revision to increase effectiveness and efficiency.

Appendix D describes the medical communications for combat casualty care (MC4) system, its components, and a short description of the system mission. The medical information system is constantly evolving based on mission/medical requirements and improvements in system capabilities.

Appendix E briefly discusses the brigade special troops battalion medical support section.

## Chapter 1

# Army Health System Overview

Army Health System support to maneuver forces is provided by both organic medical assets and echelons above brigade assets providing direct or general support on an area basis to the BCT. The focus of the medical effort at the BCT-level and below is to rapidly locate, acquire, treat, stabilize, and evacuate patients. Patients who cannot be treated and returned to duty within 72 hours are stabilized to withstand evacuation to a medical treatment facility (MTF) staffed and equipped to provide the required medical treatment. Roles 1 and 2 medical assets also support force health protection (FHP) measures to mitigate the adverse effects of disease and nonbattle injuries (DNBIs) and promote the health of deployed forces.

### SECTION I — SYSTEM OF SYSTEMS

1-1. The *Army Health System* is defined as a component of the Military Health System that is responsible for operational management of the health service support and force health protection missions for training, predeployment, deployment, and postdeployment operations. Army Health System includes all mission support services performed, provided, or arranged by the Army Medical Department to support health service support and force health protection mission requirements for the Army and as directed, for joint, intergovernmental agencies, coalition and multinational forces (FM 4-02).

1-2. Under the Army warfighting construct, the AHS's missions of health service support (HSS) and FHP are aligned under two Army warfighting functions—sustainment warfighting function and the protection warfighting function.

### HEALTH SERVICE SUPPORT

1-3. The Army HSS mission is aligned under the sustainment warfighting function. *Health service support* is defined as all services performed, provided, or arranged to promote, improve, conserve, or restore the mental or physical well-being of personnel. These services include, but are not limited to the management of health service resources, such as manpower, monies, and facilities; preventive and curative health measures; evacuation of the wounded, injured, or sick; selection of the medically fit and disposition of the medically unfit; blood management; medical supply, equipment, and maintenance thereof; combat and operational stress control and medical, dental, veterinary, laboratory, optometry, nutrition therapy, and medical intelligence services (JP 4-02). Health service support encompasses all support and services performed, provided, and arranged by the Army Medical Department to promote, improve, conserve, or restore the mental and physical well-being of personnel in the Army. Additionally, as directed, provide support to other Services, agencies, and organizations. This includes casualty care (encompassing a number of Army Medical Department functions—organic and area medical support, hospitalization, the treatment aspects of dental care and behavioral/neuropsychiatric treatment, clinical laboratory services, and treatment of chemical, biological, radiological, and nuclear patients), medical evacuation, and medical logistics (FM 4-02).

### FORCE HEALTH PROTECTION

1-4. The Army FHP mission is aligned under the protection warfighting function. *Force health protection* is defined as the measures to promote, improve, or conserve the mental and physical well-being of Service members. These measures enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards (JP 4-02). Force health protection encompasses measures to promote,

improve, conserve or restore the mental or physical well-being of Soldiers. These measures enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards. These measures also include the prevention aspects of a number of Army Medical Department functions (preventive medicine, including medical surveillance and occupational and environmental health surveillance; veterinary services, including the food inspection and animal care missions, and the prevention of zoonotic disease transmissible to man; combat and operational stress control; dental services [preventive dentistry]; and laboratory services [area medical laboratory support]) (FM 4-02).

## PRINCIPLES OF ARMY HEALTH SYSTEM SUPPORT

1-5. The principles of AHS support are essential considerations when planning AHS support operations for maneuver forces. These principles constitute the basis upon which medical plans are developed. The principle of *conformity* dictates that AHS plans must conform to the maneuver commander's tactical plan and commander's guidance and intent. Medical plans and operations that are not synchronized and rehearsed with the operational plan and sustainment concept of support will not provide efficient and effective health care support. Especially at Roles 1 and 2, medical units must have the same *mobility*, *survivability*, and *sustainability* as the forces they are supporting, as the only way to increase the mobility of medical units is to evacuate patients being held at the MTF. Army Health System assets must be in *proximity* of the forces they are supporting. Due to the importance of providing lifesaving interventions as close to the time of wounding or injury as possible, medical assets must be employed close to the forces they are supporting but not so close that they impede ongoing operations. Army Health System plans must be *flexible* to enable the medical commander and/or command surgeon to shift scarce medical resources to meet emerging areas of patient density within the operational area. The principle of *continuity* refers to the AHS continuity of care by moving patients through progressive, phased roles of care extending from the point of injury or wounding to the continental U.S.-support base. *Control* of medical resources ensures that the use of scarce medical assets is maximized to provide the greatest good to the greatest number of patients in the OE. Control comes from the continuous synchronization of AHS operations with the tactical commander and within the AMEDD system of systems.

## SECTION II — ROLES OF CARE

1-6. A basic characteristic of organizing modern AHS is the distribution of medical resources and capabilities to facilities at various levels of command, diverse locations, and progressive capabilities, which are referred to as roles of care. As a general rule, no role will be bypassed except on grounds of medical urgency, efficiency, or expediency. The rationale for this rule is to ensure the stabilization/survivability of the patient through tactical combat casualty care (TC3), advanced trauma management (ATM) and far forward resuscitative surgery prior to movement between MTFs (Roles 1 through 3). *Advanced trauma management* is defined as resuscitative and stabilizing medical or surgical treatment provided to patients to save life or limb and to prepare them for further evacuation without jeopardizing their well-being or prolonging the state of their condition (FM 4-02). For an in-depth discussion of the roles of care to include Roles 3 and 4 refer to FM 4-02.

## ROLE 1 MEDICAL CARE

1-7. The first medical care a Soldier receives is provided at Role 1 (also referred to as unit-level medical care). This role of care includes—

- Immediate lifesaving measures.
- Disease and nonbattle injury prevention.
- Combat and operational stress control (COSC) preventive measures.
- Patient location and acquisition (collection).
- Medical evacuation from supported units (point of injury or wounding, company aid posts, or casualty/patient collecting points) to supporting MTFs.
- Treatment provided by designated combat medics or treatment squads. (Major emphasis is placed on those measures necessary for the patient to return to duty or to stabilize him and allow for his evacuation to the next role of care. These measures include maintaining the airway,

stopping bleeding, preventing shock, protecting wounds, immobilizing fractures, and other emergency measures, as indicated.)

1-8. Nonmedical personnel performing first aid procedures assist the combat medic in his duties. First aid is administered by an individual (self-aid/buddy aid) and enhanced first aid is provided by the combat lifesavers.

## ROLE 2 MEDICAL CARE

1-9. At this role, care is rendered at the Role 2 MTFs (medical company [brigade support battalion] [BSMC] and MCAS, which are operated by the treatment platoon of medical companies. Here, the patient is examined and his wounds and general medical condition are evaluated to determine his treatment and evacuation precedence, as a single patient among other patients. Advanced trauma management and TC3 and/or emergency medical treatment including beginning resuscitation is continued, and if necessary, additional emergency measures are instituted, but they do not go beyond the measures dictated by immediate necessities. The Role 2 MTF has the capability to provide packed red blood cells (liquid), limited x-ray, clinical laboratory, dental support, COSC, and preventive medicine (PVNTMED). The Role 2 MTF provides a greater capability and capacity to resuscitate trauma patients than is available at Role 1. Those patients who can return to duty within 72 hours (1 to 3 days) are held for treatment. Patients who are nontransportable due to their medical condition may require resuscitative surgical care from a forward surgical team (FST) collocated with a medical company/troop. This role of care provides medical evacuation from Role 1 MTFs and also provides Role 1 medical treatment on an area support basis for units without organic Role 1 resources.

## SECTION III — MEDICAL FUNCTIONS

1-10. The AHS is comprised of ten medical functions—mission command, medical treatment (organic and area support), hospitalization, medical evacuation, medical logistics (MEDLOG), PVNTMED services, veterinary services, dental services, COSC, and medical laboratory services. Although the ten functions are aligned with specific medical disciplines or support tasks, the execution of the individual functions are interrelated, interconnected, and interdependent and require close coordination and integration to facilitate the effective and efficient provision of AHS support.

1-11. Army Health System planners at all echelons of command must determine the support requirements for each of the medical functions when developing operation plans. Although the focus of medical operations at Roles 1 and 2 is limited to locating, acquiring, treating, stabilizing, and evacuating patients within a 72-hour window, the planner must still determine what support will be required from echelons above brigade medical units to successfully accomplish the AHS support mission. Within the organic medical assets in a BCT there are only limited or no assets in hospitalization, PVNTMED services, COSC, dental services, veterinary services, and area medical laboratory support.

## SECTION IV — THE THREAT

1-12. The AMEDD views the threat from two perspectives—the general threat and the health threat. Although the AMEDD's primary concern is that of the health threat, the general threat must also be fully considered as it influences the—

- Character, types, and severity of wounds and injuries to which our forces may be exposed.
- Enemy's ability and willingness to disrupt AHS operations and to respect the conditions of the Geneva Conventions in regards to the protection of medical personnel while engaged in their humanitarian mission.

1-13. For a discussion of the threat in general to U.S. forces in unified land operations, refer to Army Doctrine Publication (ADP) 3-0 and Army Doctrine Reference Publication (ADRP) 3-0.

## HEALTH THREAT

1-14. The health threat faced by deployed U.S. forces is depicted in Table 1-1. The health threat is a composite of ongoing or potential enemy actions; adverse environmental, occupational, and geographic and meteorological conditions; endemic diseases; and employment of chemical, biological, radiological, and nuclear (CBRN) weapons (to include weapons of mass destruction that have the potential to affect the short- or long-term health [including psychological impact] of personnel).

**Table 1-1. Health threat**

<b><i>Diseases</i></b>	Endemic and epidemic Foodborne Waterborne Arthropodborne Zoonotic Vectors and breeding grounds
<b><i>Occupational and environmental health hazards</i></b>	Climatic (heat, cold, humidity, and significant elevations above sea level) Toxic industrial materials Accidental or deliberate dispersion of radiological and biological material Disruption of sanitation services/facilities (such as sewage and waste disposal) Disruption of industrial operations or industrial noise
<b><i>Poisonous or toxic flora and fauna</i></b>	Toxic poisonous plants and bacteria Poisonous reptiles, amphibians, arthropods, and animals
<b><i>Medical effects of weapons</i></b>	Conventional (to include blast and mild traumatic brain injury/concussion) Improvised (to include improvised explosive devices) Chemical, biological, radiological, and nuclear warfare agents Directed energy Weapons of mass destruction
<b><i>Physiologic and psychological stressors</i></b>	Continuous operations Combat and operational stress reactions Wear of mission-oriented protective posture ensemble Stability tasks Home front issues

## Chapter 2

# Medical Resources of Brigade Combat Teams and Other Maneuver Forces

Maneuver forces have organic medical resources within maneuver unit headquarters (brigade surgeon's section), maneuver units (medical platoons), and the medical company (brigade support). The medical command (deployment support) (MEDCOM [DS]) or the medical brigade (support) (MEDBDE [SPT]) serves as the medical force provider and is responsible for developing medical force packages for augmentation to the BCT, as required, and for the medical forces to support the division headquarters. Medical resources are also found in Army special operations forces organizations.

Slight differences exist between the medical capabilities/resources of the various types of BCTs (IBCT, armored brigade combat team [ABCT], and Stryker brigade combat team [SBCT]). These differences, based upon the type of parent unit, will be noted but not discussed in detail.

## SECTION I — BATTALION AND BRIGADE SURGEONS

### COMMAND SURGEONS

2-1. A command surgeon is designated at all levels of command (battalion and above). This AMEDD officer is a special staff officer charged with planning and monitoring the execution of the AHS mission. The battalion surgeon is dual-hatted as the medical platoon leader (generally, the senior physician assigned to the medical platoon). The brigade surgeon is on the BCT headquarters staff.

2-2. Command surgeons at all echelons of command have similar duties and responsibilities. For a listing and an in-depth discussion of the command surgeon's duties and responsibilities refer to FM 4-02. Based upon the command surgeon's position, the scope and emphasis on which specific duties will require the greatest attention may change based upon the echelon of command. Additionally, as an example, command surgeons coordinate with higher, adjacent, and supported elements such as Army special operations forces that routinely operate in austere, denied, hostile, and immature AO such as early entry operations and other operations well suited for joint, multinational, or interagency environment. See FM 4-02.43 for more information concerning AHS support for Army special operations forces.

2-3. As discussed previously, the focus of AHS support to BCTs and subordinate units is to rapidly locate, acquire, treat, stabilize, and evacuate patients. As patients are only held within the BCT AO for less than 72 hours, the scope of medical procedures that can be performed are limited by not only time but also by the availability of specialized medical material and equipment. The medical care provided at a medical company can be augmented with an FST to provide far forward resuscitation to stabilize nontransportable patients for evacuation to the next role of care. However, the breadth of procedures which can be accomplished at the FST is again limited by time and the availability of medical specialists and specialized medical equipment.

### BATTALION SURGEON

2-4. The battalion surgeon (Captain [CPT]/O3, AOC 62B00) is normally the platoon leader of the maneuver battalion's medical platoon and is responsible for all medical treatment provided by the platoon. Based upon command discretion, the field medical assistant, (First Lieutenant [1LT]/O2, AOC 70B67) may

be designated as the medical platoon leader. Refer to FM 4-02 for a discussion of the AMEDD team. The battalion surgeon is the battalion-level staff officer responsible for AHS support advice to the maneuver battalion commander. He and his staff coordinate with the battalion personnel staff officer (S-1) for AHS support activities in the battalion and those staff elements (the battalion operations staff officer [S-3] and logistics staff officer [S-4] for example) that affect battalion medical operations. The battalion surgeon keeps the battalion commander and his staff informed of the status of AHS support to the battalion and the overall health of the command. The battalion surgeon, the field medical assistant, and the platoon sergeant comprise the medical platoon headquarters.

**BRIGADE SURGEON**

2-5. The brigade surgeon (Major [MAJ]/O4, AOC 62B00) is responsible for the AHS support for the BCT. He is a brigade-level special staff officer that coordinates AHS support activities with the brigade S-1 and other headquarters elements that affect AHS support in the brigade. The brigade surgeon is responsible for the technical supervision of all medical activities in the command. The brigade surgeon is part of the brigade commander’s special staff, and as such, provides advice to the brigade commander on all medical or medically related issues. The brigade surgeon keeps the brigade commander informed on the status of AHS support for the brigade and the health of the command. The brigade surgeon’s staff is comprised of a medical operations officer and a health care noncommissioned officer (NCO) that is battle staff-qualified.

**COMPARISON OF BATTALION AND BRIGADE SURGEONS’ DUTIES AND RESPONSIBILITIES**

2-6. As discussed in paragraph 2-2, command surgeons at all echelons of command have similar common core of duties and responsibilities. Table 2-1 provides a brief overview on some of the duties that the battalion and brigade surgeon will focus on and the difference in their perspective based on assigned duties.

**Table 2-1. Comparison of battalion and brigade surgeons’ duties and responsibilities**

<i>Focus area</i>	<i>Battalion surgeon</i>	<i>Brigade surgeon</i>
Health of the command	<ul style="list-style-type: none"> <li>• Implement health promotion programs (to include the performance triad—activity, nutrition, and sleep) and education within the battalion.</li> <li>• Ensure leaders have developed sleep plans and work/rest cycles for continuous operations.</li> <li>• Establish and conduct medical and occupational and environmental health surveillance.</li> <li>• Ensure health risk communications have command support.</li> <li>• Coordinate and synchronize the combat and operational stress control program with higher, adjacent, and subordinate units.</li> </ul>	<ul style="list-style-type: none"> <li>• Establish guidelines for sleep plans within the brigade.</li> <li>• Ensure subordinate commands are implementing work/rest cycles and have been acclimated to the environmental temperatures.</li> <li>• Monitor surveillance activities throughout the brigade.</li> <li>• Analyze data to determine emerging disease and nonbattle injury patterns.</li> <li>• Ensure health risk communications have command support.</li> <li>• Monitor the planning and implementation of predeployment and postdeployment health assessments.</li> </ul>

**Table 2-1. Comparison of battalion and brigade surgeons' duties and responsibilities (continued)**

<i>Focus area</i>	<i>Battalion surgeon</i>	<i>Brigade surgeon</i>
Health of the command (continued)	<ul style="list-style-type: none"> <li>• Provide advice to the commander concerning reduction and prevention of disease and nonbattle injury, mild traumatic brain injury, and combat and operational stress reaction.</li> <li>• Provide Role 1 medical care from point of injury through the battalion aid station and on to higher roles of care as required. <b>The <i>battalion aid station</i> is defined as the forward-most medically staffed treat-ment location organic to a maneuver battalion.</b></li> <li>• Ensure the highest overall health of the unit possible in the operational environment.</li> </ul>	<ul style="list-style-type: none"> <li>• Analyze data to determine emerging patterns of mild traumatic brain injury in the brigade.</li> <li>• Analyze data to determine patterns of combat and operational stress reaction in the brigade.</li> <li>• Provide advice on methods to eliminate incidents of, or reduce the severity of combat and operational stress reactions, mild traumatic brain injury, and disease and nonbattle injury.</li> <li>• Monitor the progress of brigade personnel when they enter the Army Health System throughout the roles of care and communicate the appropriate information to the commander.</li> <li>• Monitor the elements of the performance triad within brigade units to ensure health promotion activities are occurring.</li> <li>• Ensure the health of the command is a priority and is communicated through the brigade commander and staff.</li> </ul>
Training	<ul style="list-style-type: none"> <li>• Ensure unit field sanitation teams are trained.</li> <li>• Determine sustainment/refresher training requirements for medical personnel.</li> <li>• Provide appropriate training to elements of the command as required such as prevention and first aid for heat or cold injuries.</li> <li>• Train tactical combat casualty care techniques to appropriate personnel, to include medical and casualty evacuation procedures for assigned organic vehicles.</li> <li>• Conduct training for mass casualty operations.</li> <li>• Ensure the Role 1 Army Health System support elements are trained to appropriately respond to the use or suspected use of directed-energy weapons.</li> <li>• Provide Role 1 first responder training such as self-aid/buddy aid and combat lifesaver training for unit personnel.</li> <li>• Track and train medical and clinical skills of assigned medical personnel.</li> <li>• Train assigned medical personnel in the use of medical communications for combat casualty care.</li> <li>• Track and train the utilization of the electronic health record by assigned medical personnel.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure training of appropriate health and medically related subjects are conducted and reported to and with the proper elements within the brigade.</li> <li>• Monitor and analyze training requirements for the medical personnel of the brigade.</li> <li>• Forecast medical training requirements for both clinical and nonclinical medical personnel in the brigade.</li> <li>• Provide oversight of medical training.</li> <li>• Provide advice to the commander concerning training requirements for chemical, biological, radiological, and nuclear decontamination support for the brigade's medical treatment facilities decontamination elements and the requirement for identification and training of nonmedical personnel to perform patient decontamination tasks under the supervision of medical personnel.</li> </ul>

**Table 2-1. Comparison of battalion and brigade surgeons' duties and responsibilities (continued)**

<i>Focus area</i>	<i>Battalion surgeon</i>	<i>Brigade surgeon</i>
Planning	<ul style="list-style-type: none"> <li>• Maintain unit Army Health System support throughout the area of operations and anticipate and respond when medical surge capability is required.</li> <li>• Determine the requirements for every operation conducted in the area of operations such as ensuring adequate and timely ordering and resupply of Class VIII and the provision of an effective medical evacuation plan.</li> <li>• Ensure medical evacuation resources are responsive, flexible, agile and synchronized in order to meet the myriad of operational challenges with the execution of the tactical plan.</li> <li>• Coordinate for Army Health System support resources such as a response to mass casualties with other Army Health System support elements in or in support of the brigade.</li> <li>• Plan and coordinate for mass casualty situations and ensure unit capabilities with support if required, are adequate to meet potential mass casualty situations.</li> <li>• Determine sustainment refresher training requirements for medical personnel.</li> <li>• Ensure unit medical assets are continually and appropriately pre-positioned based upon the operation plan/operation order and amended operation orders as required.</li> </ul>	<ul style="list-style-type: none"> <li>• Communicate to the commander, the Army Health System support plan for the brigade with potential health service support and force health protection challenges identified, coupled with suggested remediation of those challenges.</li> <li>• Monitor and when required, coordinate for Army Health System support for brigade operations with subordinate, adjacent, and higher Army Health System support elements.</li> <li>• Ensure the health threat, general threat, and medical intelligence considerations are communicated and integrated into the Army Health System support plan.</li> <li>• Identify and communicate medically related commander's critical information requirements.</li> <li>• Ensure the Class VIII distribution plan is adequate and that resupply is possible through the combat trains.</li> <li>• Ensure the medical evacuation plan is sufficient for the operation and operational environment.</li> <li>• Monitor contingency plans, such as reaction to mass casualty situations.</li> <li>• Disseminate commander's intent to subordinate Army Health System support elements.</li> <li>• Ensure each subordinate unit in the brigade has an approved mass casualty plan or is integrated into the higher organization's plan.</li> <li>• Communicate and coordinate Army Health System support, with echelons above brigade surgeons and Army Health System support elements.</li> </ul>
Force Health Protection	<ul style="list-style-type: none"> <li>• Identify, assess and report health threats to the brigade surgeon.</li> <li>• Oversee, monitor, and support unit disease and nonbattle injury reduction measures.</li> <li>• Ensure Soldiers employ personal preventive medicine measures.</li> <li>• Ensure units have field sanitation teams and have all required essential supplies and equipment on hand.</li> <li>• Ensure combat and operational stress control support is provided in a timely manner to every affected element in the battalion.</li> </ul>	<ul style="list-style-type: none"> <li>• Identify potential medically related commander's critical information requirements as they pertain to the health threat, ensuring they are incorporated into the command's information requirements.</li> <li>• Advise the commander on the impact of the health threat on brigade combat team elements and provide recommended techniques and procedures to defeat and minimize the health threat.</li> <li>• Analyze disease and nonbattle injury data to evaluate trends and patterns and make recommendations to the commander to reduce or eliminate the health threat.</li> </ul>

**Table 2-1. Comparison of battalion and brigade surgeons' duties and responsibilities (continued)**

<b>Focus area</b>	<b>Battalion surgeon</b>	<b>Brigade surgeon</b>
Force Health Protection (continued)	<ul style="list-style-type: none"> <li>• Anticipate combat and operational stress reaction and intervene with appropriate combat and operational stress control response down to the squad and individual Soldier level.</li> <li>• Provide mild traumatic brain injury reduction measures (screening) to include training to reduce mild traumatic brain injury.</li> <li>• Ensure chemical, biological, radiological, and nuclear force health protection prescription products are on hand.</li> </ul>	<ul style="list-style-type: none"> <li>• Monitor the combat and operational stress reaction level of the brigade, communicate and provide recommendations to the commander concerning responsive combat and operational stress control for brigade elements.</li> <li>• Communicate with brigade and echelons above brigade combat and operational stress control elements, ensuring a proactive response and adequate plan to ameliorate combat and operational stress reaction.</li> <li>• Monitor mild traumatic brain injury rates in the command and make recommendations where advisable to medically or proactively reduce these rates in the brigade.</li> </ul>
Health Service Support	<ul style="list-style-type: none"> <li>• Advise the battalion commander and the brigade surgeon concerning the health of the battalion and of the occupied or friendly territory within the battalion's area of operations.</li> <li>• Task-organize and reconstitutes the battalion's Role 1 Army Health System support elements when required.</li> <li>• Ensure appropriate medical response to the use or suspected use of directed-energy weapons.</li> <li>• Analyze the patient estimate, deploy Role 1 organizational medical assets to support the mission, and if necessary, coordinate through the brigade surgeons' section for additional Role 1 or Role 2 Army Health System support.</li> <li>• Determine and forecast assets based on operations, medical logistics consumption and respond accordingly, reorder, cross level, or transfer Class VIII from one element to another.</li> <li>• Ensure all Role 1 Army Health System support personnel understand <i>eligibility of care</i> of non-United States military personnel.</li> </ul>	<ul style="list-style-type: none"> <li>• Advise the brigade commander on the health status of the command and of the occupied or friendly territory within the commander's area of responsibility.</li> <li>• Maintain situational understanding by coordinating for current Army Health System information with surgeons of the next higher, adjacent, and subordinate headquarters.</li> <li>• Evaluate and interpret medical statistical data.</li> <li>• Provide advice concerning the health effects and response to the use of directed-energy weapons.</li> <li>• Determine the medical workload requirements (patient estimates).</li> <li>• Monitor medical logistics resources of the brigade.</li> <li>• Monitor blood requirements for the brigade.</li> <li>• Provide advice to the brigade commander on policy regarding eligibility of care of non-United States military personnel.</li> </ul>

### **SUSTAINMENT–S-4/MED (BRIGADE SURGEON'S SECTION)**

2-7. The three medical personnel (see Table 2-2 on page 2-6) assigned to the headquarters and headquarters company (HHC) sustainment–S-4/med (IBCT, ABCT, and SBCT) are referred to as the brigade surgeon's section. The brigade surgeon's section is responsible for assisting the brigade surgeon in planning, coordinating, and synchronizing AHS support operations throughout the BCT's AO as discussed in Table 2-1. For augmentation of AHS assets, the brigade surgeon's section coordinates through the division surgeon's section with the medical force provider in the AO.

**Table 2-2. Sustainment–S-4/medical staff**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Sustainment– S-4/Medical	62B00	O4	Field Surgeon	MC	1
	70H67	O3	Medical Operations Officer	MS	1
	68W4O2S	E7	Health Care NCO	NC	1
<b>LEGEND:</b>					
2S	battle staff operations		MS	Medical Service Corps	
AOC	area of concentration		NC	noncommissioned	
MC	Medical Corps		NCO	noncommissioned officer	
MOS	military occupational specialty		S-4	logistics staff officer	

## SECTION II — ECHELONS ABOVE BRIGADE ARMY HEALTH SYSTEM STAFF OFFICERS AND MISSION COMMAND ORGANIZATIONS

### DIVISION SURGEON

2-8. The division surgeon (Lieutenant Colonel [LTC]/O5, AOC 60A00) is responsible for the AHS support for the division. The division surgeon is a division-level staff officer that coordinates AHS support under the sustainment warfighting function with the division assistant chief of staff, logistics, the division chief of staff, and other headquarters elements that affect AHS support in the division. The division surgeon coordinates with the medical force provider (MEDCOM [DS] or MEDBDE [SPT]) for support of medical requirements. The division surgeon is responsible for the technical supervision of all medical activities in the command. The division surgeon is part of the division commander's special staff, and as such, provides advice to the division commander on all medical or medically related issues. The division surgeon keeps the division commander informed on the status of AHS support for the division and the health of the command.

2-9. The specific duties of the division surgeon are mirrored to a great extent by the brigade and battalion surgeons, the main differences are the complexities and scope of planning, professional duties, and responsibility for coordinating and synchronizing the myriad of elements and organizations affecting AHS support in the AO.

### DIVISION SURGEON'S SECTION

2-10. The division surgeon's section mission is to plan, coordinate, and synchronize the division's AHS support under the supervision of the division surgeon. The division surgeon's section staffing is depicted in Table 2-3 and is based on the IBCT. (Slight differences may exist based upon the parent organization and/or a specific unit's modified TOE.)

**Table 2-3. Division surgeon's section**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Division Surgeon's Section	60A00	O5	Surgeon	MC	1
	70H67	O5	Medical Operations Officer	MS	1
	60W00	O4	Psychiatrist	MC	1
	65D00	O4	Physician Assistant	SP	1
	67J00	O4	Aeromedical Evacuation Officer	MS	1
	70E67	O4	Patient Administration Officer	MS	1
	70H67	O4	Medical Plans Officer	MS	1
	70K67	O4	Health Service Material Officer	MS	1
72D67	O4	Environmental Science Officer	MS	1	

**Table 2-3. Division surgeon's section (continued)**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Division Surgeon's Section (continued)	68Z5O	E9	Chief Medical Noncommissioned Officer	NC	1
	68W5O	E8	Operations Noncommissioned Officer	NC	1
	68W4O	E7	Operations Sergeant	NC	1
	68J3O	E6	Medical Logistics Sergeant	NC	1
	68W3O	E6	Medical Noncommissioned Officer	NC	1
<b>LEGEND:</b>					
AOC	area of concentration		MS	Medical Service Corps	
MC	Medical Corps		NC	noncommissioned	
MOS	military occupational specialty		SP	Army Medical Specialist Corps	

### **MEDICAL COMMAND (DEPLOYMENT SUPPORT)**

2-11. The MEDCOM (DS) provides mission command, administrative assistance, and technical supervision of assigned and attached units. These units provide AHS support within the joint, interagency, intergovernmental, and multinational framework of unified land operations. The MEDCOM (DS) is the medical force provider for all echelons above brigade medical units. The MEDCOM [DS] task-organizes AHS support packages to support both division and corps headquarters and provides units in direct support or general support of the BCTs. For an in-depth discussion of the MEDCOM (DS) and AHS mission command organizations refer to FM 4-02.

### **MEDICAL BRIGADE**

2-12. The mission of the MEDBDE (SPT) is to organize, resource, train, sustain, deploy, and provide mission command to assigned and attached AHS support units in order to provide flexible, responsive, and effective HSS and FHP to supported forces conducting unified land operations. The MEDBDE (SPT) may have organizations/elements under its control operating in the BCT AO; however, the MEDBDE's (SPT) AHS support elements under its command (such as combat support hospitals [CSHs], FSTs, medical company [dental services], and other hospital augmentation teams), operate in support of BCT (and other organizations) operations.

### **MEDICAL BATTALION (MULTIFUNCTIONAL)**

2-13. The mission of the medical battalion (multifunctional) (MMB) is to provide scalable, flexible, technical supervision, and modular mission command for assigned and attached medical functional organizations; task-organized for support of BCTs and echelons above brigade organizations; and attached elements. Task-organizing echelons above brigade health care assets enables the AHS support system to meet requirements for providing AHS support for the projected patient workload. Examples of additive capabilities provided by the MMB, may include additional MEDLOG, PVNTMED resources, and enhanced medical planning capabilities. A partial list of additional capabilities in the way of organizational units include—

- Medical company (ground ambulance).
- Medical detachment (blood support).
- Medical logistics (MEDLOG) company.
- Medical team (optometry).
- Medical detachment (veterinary service support).
- Medical detachment (PVNTMED).
- Medical detachment (COSC).
- Medical company (area support).

2-14. Other AHS support organizations/elements may be task-organized dependent upon mission requirements and the OE.

## SECTION III — MANEUVER BATTALION MEDICAL PLATOON

2-15. All maneuver elements (ABCT and the SBCT) are configured similarly as the IBCT; however, differences in types and quantities of vehicles and numbers of personnel assigned exist between the IBCT, ABCT, and SBCT.

2-16. The IBCT TOE is used as the basis for this section and Section IV. Differences in the information provided here may exist based upon the parent organization and/or the modified TOE.

### MEDICAL PLATOON OF THE MANEUVER BATTALION

2-17. The medical platoon is organic to the maneuver battalion. The mission of the medical platoon is to provide Role 1 AHS support to the maneuver element. Medical platoons within the various BCTs are configured with a headquarters section, medical treatment squad, ambulance squad, and combat medic section (Figure 2-1) with differences between the BCTs being in the quantity and types of vehicles, configuration of medical equipment sets, and number of personnel assigned. The medical platoon is dependent upon the maneuver elements to which it is assigned for all logistic support (with the exception of Class VIII supplies), such as communication, administration, petroleum, oil, and lubricants, and life support such as food and water. The maneuver force Class VIII will continue to be distributed through the combat trains for the internal distribution of Class VIII to the maneuver force's medical platoon and its elements (company combat medics, medical treatment team, and medical evacuation squad).

2-18. Other brigades, such as the fires brigade (FIB), the maneuver enhancement brigade, and the combat aviation brigades' (CABs) organic medical platoons have the same Role 1 mission, and are similar in design of the medical platoons in the BCTs; however, they are configured to meet the requirements of the specific design of the supported brigades. This statement applies to the Role 2 elements of the brigades as well.

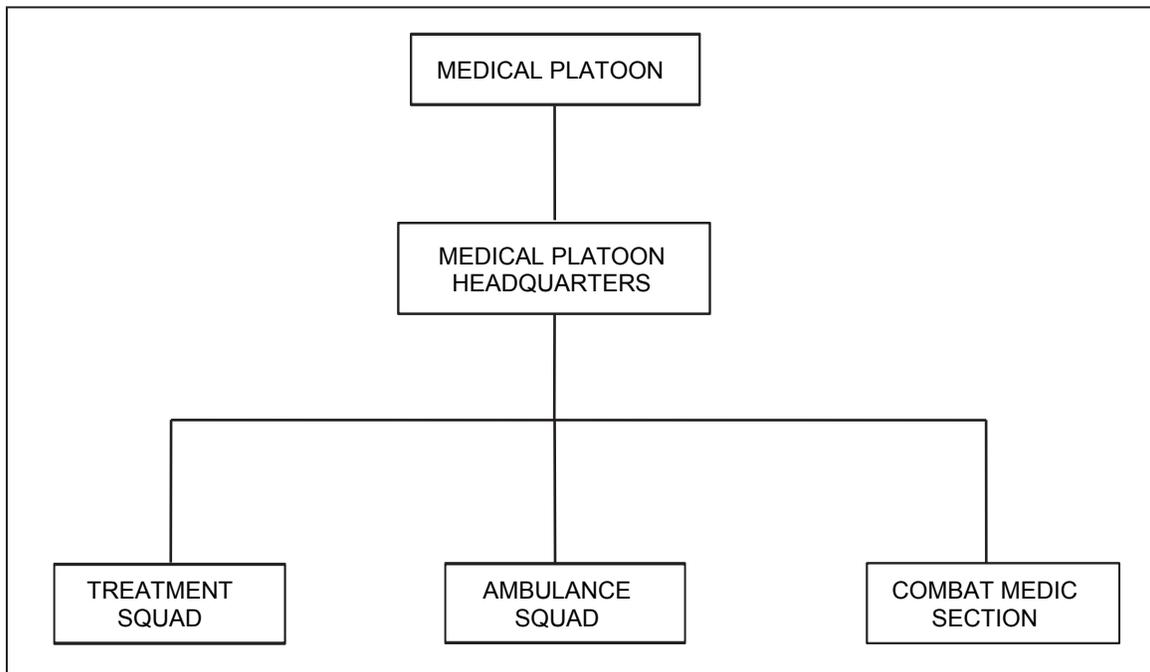


Figure 2-1. Medical platoon of maneuver forces

**HEADQUARTERS ELEMENT**

2-19. The medical platoon headquarters and the treatment squads are normally collocated forming the battalion aid station (BAS). The medical platoon has access to the battalion communications network providing access with all major elements of the battalion and with other supporting/supported units, with the medical platoon headquarters serving as the net control station for the platoon. The medical platoon headquarters personnel are identified at Table 2-4.

**Table 2-4. Medical platoon headquarters**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Platoon Headquarters	62B00	O3	Platoon Leader	MC	0*
	70B67	O2	Field Medical Assistant	MS	1
	68W4O	E7	Platoon Sergeant	NC	1
<b>LEGEND:</b>					
* Platoon Leader is accounted for in the Treatment Squad (code 50)					
AOC	area of concentration		MS	Medical Service Corps	
MC	Medical Corps		NC	noncommissioned	
MOS	military occupational specialty				

**Platoon Leader**

2-20. The platoon leader is generally the battalion surgeon, (CPT/O3, AOC 62B00). (Based upon command discretion, the medical operations officer [field medical assistant, 1LT/O2, AOC 70B67] may be designated as the medical platoon leader.) As platoon leader, he is responsible for both operational and clinical activities conducted by the medical platoon. He plans and executes BAS operations and advises the commander on issues concerning the health of the command.

**Field Medical Assistant**

2-21. The field medical assistant more commonly referred to as the medical operations officer is the primary medical planner for the platoon. The medical platoon headquarters under the direction of the battalion surgeon provides mission command and Class VIII and logistical resupply of the platoon. The platoon headquarters is operated by the medical operations officer and the platoon sergeant.

2-22. The platoon headquarters, includes the AHS support planning and operations functions primarily performed by the medical operations officer of the platoon. The medical operations officer plans, coordinates, and oversees the AHS support operations for the battalion. He works primarily with the platoon leader and platoon sergeant; however, the medical operations officer also works with the battalion surgeon and the battalion physician assistant (PA) to ensure effective and efficient Role 1 AHS support for the maneuver battalion. The medical operations officer is the principal assistant to the platoon leader/battalion surgeon and the primary leader for medical platoon operations, administration, and logistics.

**Platoon Sergeant**

2-23. The medical platoon sergeant assists the medical operations officer and supervises the operations of the platoon. The platoon sergeant plans and supervises the maintenance of platoon equipment. The platoon sergeant serves as the ambulance squad sergeant, supervising the activities and functions of the ambulance squad to include maintenance of ambulances and associated equipment. Requests for both general categories of supplies and Class VIII supplies falls under the purview of the medical platoon sergeant, including supply economy procedures and maintenance of authorized stockage of expendable supplies. The platoon sergeant is responsible for the training of the Soldiers of the medical platoon and provides training and supervision of operational security procedures. The platoon sergeant uses, or, directs the use of the Defense Medical Logistics Standard Support (DMLSS) Customer Assistance Module (DCAM) application for routine requisitions; however, the requests for fill to the supporting brigade medical supply office (BMSO) are accomplished by any means available. The medical platoon sergeant prepares reports of platoon activities and functions with the appropriate officer, the battalion surgeon, or the medical operations officer (field medical assistant).

## TREATMENT SQUAD

2-24. The treatment squad consists of two teams (treatment team alpha and team bravo) (Table 2-5). The treatment squad operates the BAS and provides Role 1 medical care and treatment (to include sick call, TC3, and ATM). Team alpha is clinically staffed with the field/battalion surgeon while team bravo is clinically staffed with the PA. Health care sergeants and specialists are trained to provide TC3 and perform or assist with ATM procedures, commensurate with their training, education, and MOS. Physicians, PAs, and other clinical specialties, when available, perform ATM procedures, commensurate with their training, education, credentialing, and AOCs. The treatment teams can operate for a limited time in split-based operations for close in support of the maneuver battalion. The teams can also operate in split-based operations when the BAS must move to a new location. For example, in one scenario, one team remains at the current location and continues to treat patients, while the other team moves to a new location. Once the jump team has established a treatment capability at the new location, the other team evacuates or returns to duty all patients, and then moves to the new location.

**Table 2-5. Medical treatment squad**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Treatment Team <i>Alpha</i>	62B00	O3	Field Surgeon	MC	1*
	68W3O	E6	Health Care SGT	NC	1
	68W2O	E5	Health Care SGT	NC	1
	68W1O	E3	Health Care SPC		1
Treatment Team <i>Bravo</i>	65D00	O3	Physician Assistant	SP	1
	68W2O	E5	Health Care SGT	NC	1
	68W1O	E3	Health Care SPC		2
<b>LEGEND:</b>					
* Field Surgeon also serves as the Platoon Leader (code 50).					
AOC	area of concentration		SGT	sergeant	
MC	Medical Corps		SP	Army Medical Specialist Corps	
MOS	military occupational specialty		SPC	specialist	
NC	noncommissioned				

**Note.** The ABCT combined arms battalion medical treatment squad is equipped with two M577A3 tracked vehicles forming the base of the BAS with the medical platoon headquarters.

### Field Surgeon

2-25. The field surgeon is normally the platoon leader. For a discussion of his duties and responsibilities as the platoon leader, refer to paragraph 2-20. The field surgeon is the senior physician assigned and is responsible for the clinical operations of the BAS. He provides ATM to combat casualties and examines patients, supervises sick call activities, and diagnoses diseases and injuries of unit personnel. The field surgeon also provides guidance on the necessity for PVNTMED measures and provides advice and assistance on matters such as COSC, identification of combat and operational stress reactions (COSRs), and mild traumatic brain injury.

### Physician Assistant

2-26. The PA is the clinical professional for team bravo. The PA is ATM qualified and works under the clinical supervision of the field surgeon. The PA—

- Establishes and conducts treatment team operations when deployed in split-based operations.
- Provides medical treatment within his scope of practice and abilities for sick and injured patients, referring those patients requiring treatment beyond the PA's capability to the supervising physician or to a higher role of care.
- Provides ATM for wounded patients.

- Conducts training for battalion personnel in first aid procedures (self-aid, buddy aid, and combat lifesaver), field sanitation, evacuation of the sick and wounded, and the medical aspects of injury prevention.
- Provides Soldier and leader training on the prevention of negative COSR and other stress-related reactions.
- Provides training to battalion medical personnel in TC3 principles and procedures.
- Provides training and support for the biannual recertification of the MOS 68W battalion medical personnel.
- Ensures field medical records and/or electronic medical records (if available) are maintained on each Soldier at the BAS according to Army Regulation (AR) 40-66.

### AMBULANCE SQUAD (WHEELED)

2-27. Medical platoon ambulances (see Table 2-6 on page 2-12), provide medical evacuation and en route care from the Soldier's point of injury, the casualty collection point (CCP), or an ambulance exchange point (AXP) to the BAS. *Collection point(s) (patient or casualty)* is a specific location where casualties are assembled to be transported to a medical treatment facility. It is usually predesignated and may or may not be staffed (FM 4-02). Medical evacuation is always mission, enemy, terrain and weather, troops and support available, time available, and civil considerations-driven. The AXP may be placed forward of the BAS when both tracked and wheeled vehicles are being used or when the distance to the BAS is extended. In this way, the ambulance drivers who are most familiar with the array of forces in the fight remain in the forward areas, and if tracked vehicles are being used, it shortens the distance they must travel. Casualty collection points are often located near major traffic routes and along the base of terrain features, reducing the difficulties for ambulatory casualties to reach assistance.

2-28. The ambulance squad is comprised of the emergency care sergeants and ambulance aide/drivers supporting the maneuver force company. The ambulance squad is divided into four teams of two ambulances composed of one emergency care sergeant and two ambulance aide/drivers assigned to each ambulance. The ambulance squad coordinates with the supported combat medics and unit leadership to facilitate responsive support in fluid conditions. Ambulances are equipped with global positioning system equipment; however, strip maps with familiar landmarks/terrain features may also be useful.

2-29. In mass casualty (MASCAL) situations, nonmedical vehicles may be used to assist in casualty evacuation as directed by the commander. Plans for the use of nonmedical vehicles to perform casualty evacuation should be included in the battalion's standard operating procedure. When possible, a combat lifesaver should accompany the casualties to monitor their medical condition during the evacuation.

#### WARNING

**Casualties transported in nonmedical vehicles may not receive proper en route medical care or be transported to the appropriate MTF to address the patient's medical condition. If the casualty's medical condition deteriorates during transport, or the casualty is not transported to the appropriate MTF, an adverse impact on his prognosis and long-term disability or death may result.**

2-30. Ambulance platoon members may serve as messengers within medical channels and may conduct backhaul of medical supplies to supported units when required.

Table 2-6. Ambulance squad (wheeled)

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Ambulance Squad (Wheeled)	68W2O	E5	Emergency Care Sergeant	NC	4
	68W1O	E4	Ambulance Aide/Driver		12
	68W1O	E3	Ambulance Aide/Driver		8
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MOS	military occupational specialty				

*Note.* The IBCT infantry battalion ambulance squad has eight M997A2 wheeled ambulances.

The SBCT infantry battalion medical evacuation squad has four, M1133 (wheeled) medical evacuation vehicles assigned, with four (MOS 68W2O/E5) emergency care sergeants, four (MOS 68W1O/E4) ambulance aide/drivers, and four (MOS 68W1O/E3) ambulance aide/drivers assigned (total of 12 personnel).

The ABCT combined arms battalion ambulance squad has eight, M113A3 (tracked) medical evacuation vehicles with eight (MOS 68W2O/E5) emergency care sergeants, eight (MOS 68W1O/E4) ambulance aide/drivers, and eight (MOS 68W1O/E3) ambulance aide/drivers assigned (total of 24 personnel).

## COMBAT MEDIC SECTION

2-31. Combat medics are normally allocated to the supported maneuver companies on a basis of one emergency care sergeant (MOS 68W2O/E5) per company plus one combat medic (MOS 68W1O/E4) per platoon. The medical platoon's emergency care sergeants normally locate with, or near, the maneuver company commander or first sergeant to provide guidance and direction to the subordinate platoon combat medics. The platoon's combat medic locates with, or near, his assigned platoon leader or platoon sergeant. The staffing of the combat medic section is depicted in Table 2-7.

2-32. To foster good interpersonal relations and morale of supported Soldiers, every effort should be made to attach the same combat medic to the same unit supported each time the unit deploys. However, during lulls in operations, the combat medic should return to the medical platoon for consultation and proficiency training. Functions of combat medic are to—

- Perform triage and TC3 for the sick and wounded.
- Arrange medical evacuation for litter patients and direct ambulatory patients to the CCP or to the BAS.
- Initiate a DA Form 7656 (Tactical Combat Casualty Care [TCCC] Card) preferably by electronic means or Department of Defense (DD) Form 1380 (U.S. Field Medical Card) for the sick and wounded and, as time permits, prepares a DD Form 1380 on deceased personnel.
- Screen, evaluate, and treat within his capabilities those patients suffering minor illnesses and injuries.
- Keep the company commander and the battalion surgeon/medical platoon leader informed on matters pertaining to the health and welfare of the troops.
- Manage Class VIII resupply for the unit's combat lifesavers, vehicle first aid kits, and warrior aid and litter kits.
- Maintain sufficient quantities of medical supplies to support the tactical situation.
- Serve as a member of the unit field sanitation team. In this capacity, he advises the commander and supervises unit personnel on matters of personal hygiene and field sanitation.
- Develop and maintain Soldier and combat medic skills in the context of the tactical and OE.
- Maintain TC3 skills for a broad range of emergencies.

**Table 2-7. Medical platoon combat medic section**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Combat Medic Section	68W2O	E5	Emergency Care Sergeant	NC	3
	68W1O	E4	Combat Medic		12
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MOS	military occupational specialty				

*Note.* The SBCT infantry battalion combat medic section has one emergency care sergeant (MOS 68W2O/E5), assigned to each infantry company (total of three emergency care sergeants [section sergeants]). Each platoon in the infantry company has one combat medic (MOS 68W1O/E4) assigned to it (for a total of nine combat medics). The mobile gun system platoon and the mortar platoon each have one combat medic (MOS 68W1O/E4) assigned (total of two combat medics). The SBCT combat medic section has a total of 12 personnel assigned.

The ABCT combined arms battalion has one emergency care sergeant (MOS 68W2O/E5), assigned to each armor company (total of two emergency care sergeants). The infantry companies of the combined arms battalion have four combat medics (MOS 68W1O/E4) assigned to each company that are normally attached, one to the company headquarters and one to each of the maneuver platoons. The ABCT combat medic section has a total of ten personnel assigned.

The reconnaissance squadrons and fires battalions' medical platoons are similarly configured and employed in the IBCT, ABCT, and SBCT, with some variation. Their missions are the same. The SBCT adds the antiarmor company with three combat medics (MOS 68W1O/E4) and one section NCO (MOS 68W3O/E6) assigned in the combat medic section (total of four Soldiers). The engineer company of the SBCT has four (MOS 68W1O/E4) and one section NCO (MOS 68W3O/E6), assigned to the combat medic section (total of five Soldiers).

**EMPLOYMENT OF THE MEDICAL PLATOON**

2-33. The BAS is under the tactical control of the battalion S-4. To reduce ambulance turnaround time in providing ATM to patients, the BAS may split and place its treatment teams as close to maneuvering companies as tactically feasible. The battalion S-4 closely coordinates locations for forward positioning sustainment elements (including medical treatment elements) with the battalion S-3. This ensures that the location of these elements is known by commanders of the maneuvering forces. Coordination ensures that sustainment elements are not placed in the way of friendly maneuvering forces, in line of fires, or in areas subject to be overrun by rapidly advancing enemy forces. Treatment teams situated close to (within 1,000 meters of) maneuvering companies in contact must be prepared to withdraw to preplanned, alternate positions on short notice.

2-34. When maneuvering companies anticipate large numbers of casualties, augmentation of the medical platoon with one or more treatment teams from the BSMC should be coordinated for and arranged. Augmenting treatment teams are under the tactical control of the battalion S-4; but are under the operational control of the battalion surgeon/medical platoon leader. A suggested scheme of employment is to place a team in close support of each maneuvering company while locating one treatment team in the combat trains. Medical treatment facilities should not be placed near targets of opportunity such as ammunition, petroleum, oils and lubricants, distribution points, or other targets that may be considered lucrative by the opposing force. Considerations for the location of the BAS should include—

- Tactical situation/commander's plan.
- Expected areas of high casualty density.
- Security.
- Protection afforded by defilade.
- Convergence of lines of drift.
- Evacuation time and distance.
- Accessible evacuation routes.

- Avoidance of likely target areas such as bridges, fording locations, road junctions, and firing positions.
- Solid ground with good drainage.
- Near an open area suitable for helicopter landing.
- Available communication means.
- Additional space near this site for establishing a patient decontamination site if required.

2-35. At the BAS, patients requiring further evacuation to the appropriate MTFs or AXP are stabilized for movement. Constant efforts are made to prevent unnecessary evacuation; patients with minor wounds or illnesses are treated and returned to duty as soon as possible. Other functions of the BAS include—

- Receiving and recording patients.
- Notifying the S-1 of all patients processed through the BAS, giving identification and disposition of patients.
- Documenting patient encounters and treatment provided in the electronic medical record (if available) on the DA Form 7656, or on the DD Form 1380, or other appropriate form such as the Standard Form (SF) 600 (Medical Record, Chronological Record of Medical Care).
- Verifying information contained on the DD Form 1380 or DA Form 7656 of each patient evacuated to the BAS.
- Requesting and monitoring the medical evacuation of patients.
- Monitoring personnel, when necessary, for CBRN contamination prior to medical treatment.
- Supervising patient decontamination and treating CBRN patients.

---

*Note.* Patient decontamination is performed by nonmedical personnel. The team is composed of eight nonmedical personnel from supported units working under the supervision of medical personnel. Patient decontamination teams perform best when they train and exercise their skills with the supporting BAS.

---

2-36. Medical evacuation from the BAS is performed by ground ambulances from the BSMC and by air ambulance teams of the supporting general support aviation battalion (GSAB).

2-37. Patient holding and food service are not available at the BAS. Therefore, only procedures necessary to preserve life or limb, or enable a patient to be moved safely, are performed at the BAS.

2-38. Ammunition and individual weapons belonging to patients evacuated from the BAS are accounted for and managed as directed by command standard operating procedures/policy. All excess equipment collected at the BAS is managed by the battalion S-4 or as directed by command guidance.

---

*Note.* Patients will always retain their protective mask when evacuated to the next role of care, as long as they are in the combat zone. Based on the threat, they may retain the protective mask until evacuated out of the theater.

---

2-39. Patients requiring dental treatment are provided relief for dental pain, and, if required, evacuated to the supporting medical company where operational dental care (emergency and essential dental treatment) is provided.

### Class VIII

2-40. The medical platoon sergeant is the key to sustaining medical support through the timely and accurate Class VIII supply/resupply of the medical elements of the maneuver battalion. The platoon sergeant must understand what assets the platoon has available and determine what the organization will need for future operations and for all elements of the medical platoon above the baseline medical equipment sets, and coordinate for the push/pull of medical resupply sets.

2-41. Accurate Class VIII asset inventory is the essential baseline for ensuring the medical platoon has the ability to function in any given scenario. From that baseline, Class VIII resupply estimates are established for current and future operations. Class VIII materiel is packed and configured for distribution to the

requesting unit through available distribution channels to include a backhaul ambulance returning to the Role 1 MTF within the brigade's AO.

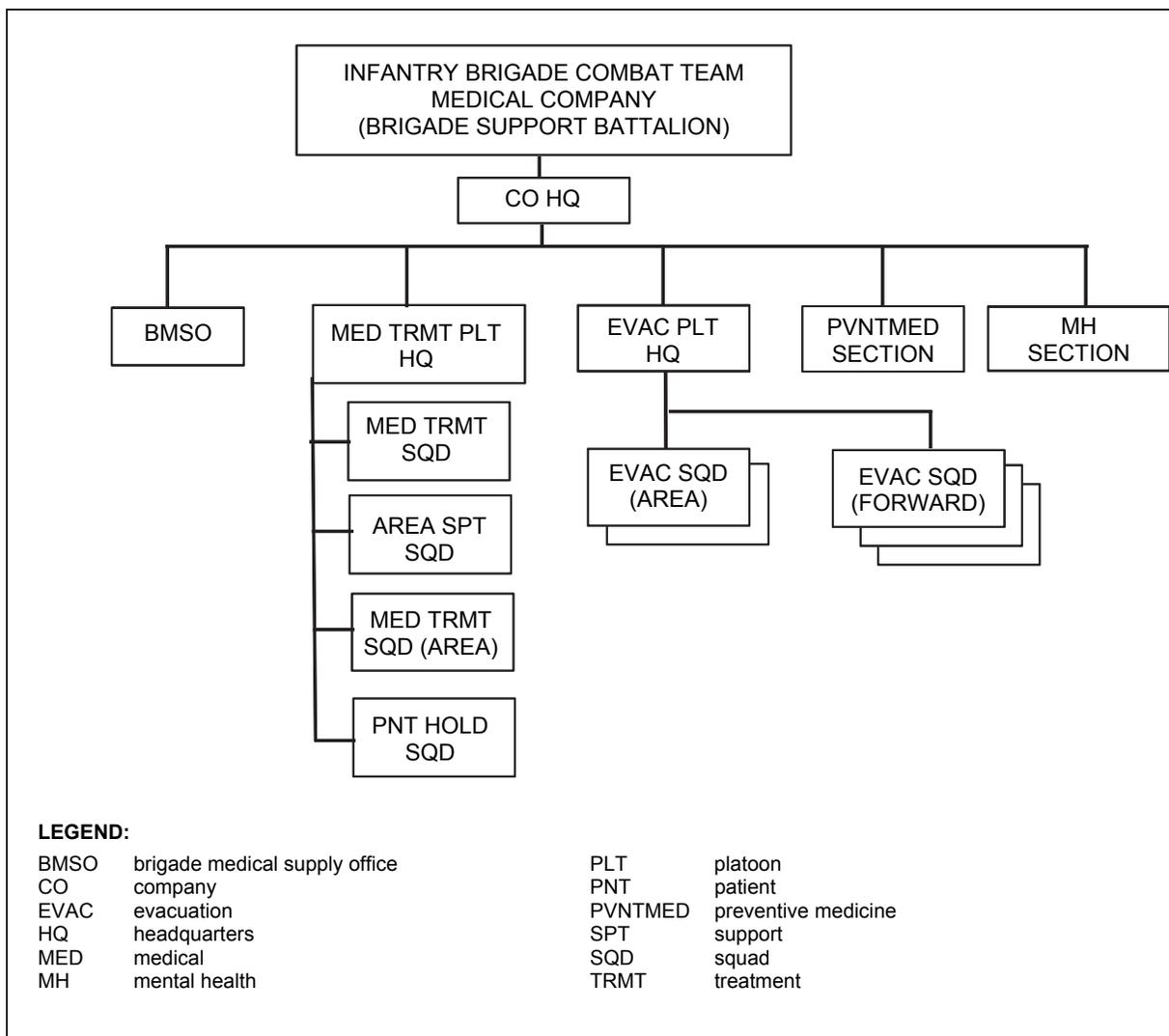
2-42. The medical platoons/sections of the BCTs Role 1 MTFs operations request their Class VIII supplies from the BMSO established by the BSMC. The medical platoons have limited capacity and capability for internal MEDLOG management and are primarily customers of the BMSO. Routine requisitions are sent by the Role 1 MTFs via DCAM over the MC4 system. Emergency requisitions of Class VIII supplies for the BCT are completed according to the unit tactical standard operating procedures.

### **Medical Maintenance**

2-43. At Role 1 MTFs, the platoon leader with the support of the platoon sergeant is responsible for ensuring operator maintenance is performed on assigned equipment and that a medical maintenance support plan is in place and coordinated with the BSMC, BMSO, and supporting organizations. The keys to Class VIII medical maintenance are user/operator preventive maintenance checks and services with coordination between supporting organizations for the required system maintenance, calibration, and repairs. A contact repair team from the MEDLOG company may be available for medical equipment repair and maintenance when conditions and commitments allow the contact repair team to travel to the unit's location; otherwise, retrograde of the medical equipment is required. The BMSO must provide medical equipment support services for the medical platoon when support from a MEDLOG company is not available.

## **SECTION IV — MEDICAL COMPANY (BRIGADE SUPPORT BATTALION)**

2-44. For illustrative purposes, this section is based upon the BSMC (IBCT) depicted in Figure 2-2 on page 2-16. There may be differences (of personnel, equipment, and vehicles), based upon the parent unit, with the medical companies in the ABCT and SBCT, however, the mission remains the same for all AHS support units/elements and they execute their mission in a similar fashion. Significant differences will be highlighted.



**Figure 2-2. Infantry brigade combat team medical company (brigade support battalion)**

*Note.* The SBCT currently does not have a BMSO.

## MISSION

2-45. The mission of the BSMC is to provide Role 2 AHS support to supported maneuver battalions with organic medical platoons. This company provides both Roles 1 and 2 medical treatment on an area basis to those units without organic medical assets operating in the BCT AO.

## ASSIGNMENT AND DEPENDENCIES

2-46. Medical companies are organic to BCTs. They are dependent upon organizations organic to the BCTs and elements outside of the BCT, such as supporting theater organizations, the MEDBDE (SPT), the MEDCOM (DS), the MMB, and other appropriate elements according to the mission, operations, and the OE.

## ASSIGNMENT

2-47. The medical company is organic to the brigade support battalion (BSB), IBCT and/or BSB with forward support company, IBCT.

---

*Note.* In the ABCT the medical company is organic to the BSB, ABCT. In the SBCT it is assigned to the BSB, SBCT.

---

## DEPENDENCIES

2-48. The medical company is dependent upon—

- Appropriate elements within the theater Army for religious, legal, finance, and personnel and administrative services.
- Headquarters and headquarters company, BSB for food service support, religious support, unit administration, and petroleum, oils and lubricants.
- Field maintenance company, BSB for unit maintenance of all organic equipment (less medical).
- Forward surgical team for surgical augmentation.
- Medical company (air ambulance) for rotary-wing air ambulance support.

---

*Note.* The medical company (SBCT) TOE also states it is dependent upon the MEDLOG company for optometry, medical resupply, and medical equipment maintenance and repair. Further, it is dependent upon the blood support detachment for blood support and the headquarters and distribution company, BSB for food service support following initial sustainment periods, religious support, and communications-electronics and communications security equipment maintenance.

---

## BASIS OF ALLOCATION

2-49. The medical company is allocated on a basis of one per BCT.

## MOBILITY

2-50. This unit requires 100 percent mobility of its TOE equipment to be transported in a single lift using organic vehicles.

## CAPABILITIES

2-51. This unit provides—

- Mission command of attached units which include medical planning and coordination of patient movement within and outside of the brigade.
- Treatment of patients with DNBI, COSR, triage of MASCAL, ATM, initial resuscitation and stabilization, and preparation for further evacuation of patients incapable of returning to duty.
- Ground evacuation for patients from the BAS and designated CCPs to the BSMC.
- Operational dental care that consists of emergency and essential dental care designed to circumvent potential dental emergencies.
- Class VIII supply support to units in the brigade AO.
- Unit-level medical equipment maintenance.
- Medical laboratory and radiology services commensurate with Role 2 MTFs.
- Outpatient consultation services for patients referred from Role 1 MTFs.
- Patient holding for up to 20 patients able to return to duty within 72 hours.
- Limited reinforcement and augmentation to supported maneuver battalion medical platoons.
- Regeneration of severely attrited BASs.

- Treatment squads that are capable of breaking down into two treatment teams, which can also operate independently for limited periods of time.
- Preventive medicine support.

---

**Note.** The TOE, Section I, of the SBCT medical company also includes—providing current information concerning the medical aspects of the AHS situation to higher command elements; developing, preparing, and coordinating with the brigade surgeon’s section on the medical portion of the BCT’s plans and policies; allocating medical resources (personnel and equipment) to ensure adequacy of medical treatment to all units operating in the BCT’s AO; providing consultation and advice in the areas of environmental sanitation, epidemiology, sanitary engineering, and pest management services; providing COSC programs for the prevention, triage, and treatment of COSR to maximize rapid return to duty and prevent posttraumatic stress disorders; and provides MEDLOG support to include medical equipment maintenance and blood support to the BCT on an area support basis. (The medical supply section maintains an authorized stockage level of Class VIII medical materiel.)

---

2-52. Individuals of this organization are provided weapons for personal defense and protection of the patients under their care.

2-53. This unit does not perform field maintenance on organic communications security equipment.

## ORGANIZATION AND FUNCTIONS

2-54. The BSMC is composed of six main subelements contributing its role as a Role 2 MTF with functions running the gamut from mission command to the BMSO.

### COMPANY HEADQUARTERS

2-55. The company headquarters provides mission command for the company and attached units. It provides unit-level administration, general supply, and CBRN defense support. The company headquarters is organized into a command element, a supply element, and CBRN operations element consisting of unit decontamination and CBRN defense. The command element conducts BSMC operations within its AO. The command element is responsible for the provision of billeting, security, training, administration, and discipline of assigned personnel. Table 2-8 displays the composition of the BSMC headquarters.

**Table 2-8. Company headquarters**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Company Headquarters	05A00	O4	Commander	IMM	1
	70B67	O3	Executive Officer	MS	1
	68W5M	E8	First Sergeant	NC	1
	92Y2O	E5	Supply NCO	NC	1
	92Y1O	E4	Supply SPC		1
	74D1O	E4	CBRN SPC		1
	74D1O	E4	CBRN Decontamination SPC		2
<b>LEGEND:</b>					
AOC	area of concentration		MS	Medical Service Corps	
CBRN	chemical, biological, radiological, and nuclear		NC	noncommissioned	
IMM	immaterial		NCO	noncommissioned officer	
MOS	military occupational specialty		SPC	specialist	

*Note.* The SBCT medical company was not originally organized with a separate BMSO structure as were the medical companies in the IBCT and ABCT. Therefore, the personnel who perform the MEDLOG functions are assigned to the company headquarters. These personnel include: health services materiel officer (AOC 70K67, CPT/O3); medical logistics sergeant (MOS 68J3O/E6); medical logistics sergeant (MOS 68J2O/E5); pharmacy sergeant (MOS 68Q2O/E5); medical equipment repairer (MOS 68A2O/E5); and medical logistics specialist (MOS 68J1O/E4). In the future, SBCT TOE Class VIII support structure may change within the organization to include a BMSO. The ABCT based on the TOE, currently has one less CBRN decontamination specialist (MOS 74D1O/E4) than the IBCT. Based on the Total Army Analysis 15-19, the IBCT may lose one CBRN decontamination specialist (MOS 74D1O/E4) when the analysis results in change to the base TOE.

**PREVENTIVE MEDICINE SECTION**

2-56. The PVNTMED section provides advice and consultation in the area of health threat assessment, FHP, environmental sanitation, epidemiology, sanitary engineering, and pest management. Through routine surveillance, inspection of potable water supplies, inspection of field feeding facilities, and the application of pest management practices, they identify actual and potential health hazards, recommend corrective measures, and assist in training BCT Soldiers in DNBI prevention programs. The PVNTMED section provides unit field sanitation team training and is a valuable resource for the promotion of health in the unit. Table 2-9 depicts the PVNTMED section personnel.

**Table 2-9. Preventive medicine section**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Preventive Medicine Section	72D67	O2	Environmental Science Officer	MS	1
	68S2O	E5	Preventive Medicine NCO	NC	1
<b>LEGEND:</b>					
AOC	area of concentration		MS	Medical Service Corps	
MOS	military occupational specialty		NC	noncommissioned	
			NCO	noncommissioned officer	

**MENTAL HEALTH SECTION**

2-57. The mission of the mental health section is to support commanders in the prevention and control of COSR through the brigade’s behavioral health activities by the provision of advice and assistance in the areas of behavioral health and COSC. The section collects and records social and psychological data and counsels personnel with personal, behavioral, or psychological problems. The concept of behavioral health support is to provide care at the Soldier’s location to the greatest extent possible as this expedites treatment and minimizes both lost time and evacuation of Soldiers out of the brigade AO. General duties for personnel assigned to this section include assisting in a wide variety of psychological and social services such as providing classes in stress control, compiling caseload data, and providing counseling to Soldiers experiencing emotional or social problems. In addition, personnel of the behavioral health section refer Soldiers to higher roles of care, when indicated, and provide individual case consultation to commanders, NCOs, chaplains, command surgeons, and PAs within the supported AO. The mental health section is staffed as depicted in Table 2-10. For an in-depth discussion of COSC operations refer to ATP 4-02.5.

**Table 2-10. Mental health section**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Mental Health Section	67D00	O3	Behavioral Science Officer	MS	2
	68X2O	E5	Behavioral Health NCO	NC	1
	68X1O	E4	Behavioral Health SPC		1
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MOS	military occupational specialty		NCO	noncommissioned officer	
MS	Medical Service Corps		SPC	specialist	

## MEDICAL TREATMENT PLATOON

2-58. The medical treatment platoon receives, triages, treats, and determines the disposition of patients in the brigade AO. The platoon provides for ATM, TC3, general medicine, general dentistry, and physical therapy. In addition, the medical treatment platoon has limited radiology, medical laboratory, and patient holding capabilities. The medical treatment platoon is organized with a headquarters, a medical treatment squad, a medical treatment squad (area), and patient holding squad.

---

*Note.* In the SBCT, the medical treatment squad is referred to as the medical section (paragraph 2-59).

---

## MEDICAL TREATMENT PLATOON HEADQUARTERS

2-59. The medical platoon headquarters (Table 2-11) determines the general set-up and security of the medical treatment platoon AO, and in consultation with the BSMC commander and appropriate medical leadership, determine when, where, and how long (not more than 72 hours) the medical treatment squad conducts split-based operations. The medical treatment platoon headquarters directs, coordinates, and supervises platoon operations based on the BCT AHS support plan. The headquarters element directs the activities of the BSMC's Role 2 MTF and monitors Class VIII and blood requirements. The medical treatment platoon headquarters element is responsible for overseeing platoon operations, operational security, communications, administration, organizational training, supply, transportation, patient accountability, statistical reporting, and maintenance of medical records functions.

2-60. For medical treatment, the platoon has the capability to maintain communication with superior, adjacent, and subordinate units/elements through secure and nonsecure communications and is part of the BSMC command net and wire communications. The medical treatment platoon headquarters maintains MC4 capability for patient care, accounting, and reporting. See Appendix D for more information concerning MC4.

**Table 2-11. Medical treatment platoon headquarters**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Platoon Headquarters	62B00	O4	Platoon Leader	MC	0*
	70B67	O2	Field Medical Assistant	MS	1
	68W4O	E7	Platoon Sergeant	NC	1
	68G1O	E4	Patient Administration SPC		1
<b>LEGEND:</b>					
* Platoon Leader is accounted for in the medical treatment squad (area) (code 50)					
AOC	area of concentration	MS	Medical Service Corps		
MC	Medical Corps	NC	noncommissioned		
MOS	military occupational specialty	SPC	specialist		

## Medical Treatment Squad

2-61. The medical treatment squad (Table 2-12) provides routine medical care and ATM for Soldiers assigned to supported units. This squad supports brigade elements without organic medical support. It is identical to the medical treatment squad in the maneuver battalion's medical platoon. When positioned with the BSMC, the medical treatment squad personnel work in the Role 2 MTF. The medical treatment squad/teams must be prepared for short-notice operational deployment; therefore, personnel, medical equipment sets, and vehicles must be in a constant state of readiness for immediate employment. The medical treatment squad has the ability to split and operate as separate treatment teams (team alpha and team bravo) for limited periods of time. While operating as separate teams, they may operate up to two aid stations. The medical treatment team composition may be adjusted based upon the professional discretion of AHS leadership.

*Note.* In the SBCT, the medical treatment squad is referred to as a medical section, because it is staffed with an additional medical treatment team consisting of a PA (AOC 65D00, CPT/O3), health care sergeant (MOS 68W3O/E6), health care specialist (MOS 68W1O/E4), and health care specialist (MOS 68W1O/E3).

**Table 2-12. Medical treatment squad**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Treatment Squad	62B00	O3	Field Surgeon	MC	1
	65D00	O3	Physician Assistant	SP	1
	68W3O	E6	Health Care Sergeant	NC	1
	68W2O	E5	Health Care Sergeant	NC	2
	68W1O	E4	Health Care Specialist		1
	68W1O	E3	Health Care Specialist		2
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MC	Medical Corps		SP	Army Medical Specialist Corps	
MOS	military occupational specialty				

*Note.* The ABCT medical treatment squad has two M577A3 tracked vehicles forming the base of the BAS. The IBCT and SBCT medical treatment squad/section vehicles are wheeled.

### Area Support Squad

2-62. The area support squad (Table 2-13 on page 2-22) provides essential and emergency dental services, laboratory services, blood support, and radiological services. This squad is located with and supports the area support treatment squad and provides services for the medical treatment squads deployed forward. When operating with or collocated with an FST, it provides augmentation for the FST's laboratory and blood storage capabilities and also provides radiological services to support the FST.

- The dental personnel provide operational dental care consisting of emergency and essential dental care. Emergency dental care is the care given for the relief of pain, elimination of acute infection, control of life threatening oral conditions (hemorrhage, cellulitis, or respiratory difficulty); treatment of trauma to teeth, jaws, and associated facial structures is considered to be emergency care. It is the most austere type of dental care and is available to Soldiers engaged operationally. Common examples of emergency dental care are simple extractions, antibiotics, administration of pain medication, and temporary fillings. Essential care includes dental treatment necessary for the prevention of lost duty time and preservation of the fighting strength. Soldiers in Class 3 (potential dental emergencies) should be provided essential care as the tactical situation permits. Refer to ATP 4-02.5 for more information on dental services.
- The physical therapy personnel assist in strengthening the Soldiers' physical resiliency, assist in the prevention of neuromusculoskeletal injuries, and provide for the prompt treatment of Soldiers with neuromusculoskeletal injuries returning them to duty as soon as possible. Soldiers are treated as close to their unit of assignment as feasible.
- The medical laboratory personnel perform clinical laboratory and blood banking to aid physicians and PAs in the diagnosis, treatment, and prevention of diseases. Laboratory functions include performing laboratory procedures consistent with Role 2 treatment capabilities. Blood banking procedures are accomplished according to Technical Manual (TM) 8-227-11/NAVMED P-5123/AFI 44-118. This element is responsible for storing and issuing blood (liquid red blood cells).
- The radiology element provides clinical radiological procedures to aid physicians and PAs in the diagnosis and treatment of patients. The radiology element operates x-ray equipment consistent with Role 2 treatment capabilities. Examples of functions performed by this element include interpreting physicians' orders, applying radiation and electrical protective measures, operating and maintaining x-ray equipment, and taking x-rays of extremities, chest, trunk, and skull.

**Table 2-13. Area support squad**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Area Support Squad	63A00	O3	General Dental Officer	DC	1
	65B00	O3	Physical Therapist	SP	1
	68F2O	E5	Physical Therapy Sergeant	NC	1
	68K2O	E5	Medical Laboratory Sergeant	NC	1
	68P2O	E5	Radiology Sergeant	NC	1
	68E1O	E4	Dental Specialist		1
	68K1O	E4	Medical Laboratory Specialist		1
	68P1O	E4	Radiology Specialist		1
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
DC	Dental Corps		SP	Army Medical Specialist Corps	
MOS	military occupational specialty				

### Medical Treatment Squad (Area)

2-63. The medical treatment squad (area) (Table 2-14) is the base medical treatment element of the BSMC. It provides troop clinic-type services and ATM. The medical treatment squad (area) along with the area support squad and the patient-holding squad form the Role 2 MTF. The physician in this squad is also the medical treatment platoon leader.

**Table 2-14. Medical treatment squad (area)**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Treatment Squad (Area)	62B00	O4	Field Surgeon	MC	1*
	65D00	O4	Senior Physician Assistant	SP	1
	68W3O	E6	Health Care Sergeant	NC	1
	68W2O	E5	Health Care Sergeant	NC	2
	68W1O	E4	Health Care Specialist		1
	68W1O	E3	Health Care Specialist		2
<b>LEGEND:</b>					
* Field surgeon is the medical treatment platoon leader and is also depicted in Table 2-11 as (code 50).					
AOC	area of concentration		NC	noncommissioned	
MC	Medical Corps		SP	Army Medical Specialist Corps	
MOS	military occupational specialty				

### Patient Holding Squad

2-64. The patient holding squad (Table 2-15) operates the patient holding facility of the BSMC Role 2 MTF. The mission of the patient holding squad is to provide nursing care of patients awaiting evacuation and/or DNBI patients who are expected to return to duty within 72 hours. The patient holding squad provides care with up to 20 holding cots. (Cots are not staffed and equipped to the level of hospital beds and are therefore not counted as beds within the theater hospital structure.) The patient holding squad does not have a patient feeding capability and DNBI patients must be capable of obtaining their meals at the supporting field feeding facility. In addition, the patient holding capability of the patient holding squad may serve as an overflow recovery area for the patients awaiting medical evacuation from the collocated FST.

**Table 2-15. Patient holding squad**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Patient Holding Squad	66H00	O3	Medical Surgical Nurse	AN	1
	68W2O	E5	Health Care Sergeant	NC	2
	68W1O	E4	Health Care Specialist		1
	68W1O	E3	Health Care Specialist		1
<b>LEGEND:</b>					
AN	Army Nurse Corps		MOS	military occupational specialty	
AOC	area of concentration		NC	noncommissioned	

**EVACUATION PLATOON**

2-65. The evacuation platoon (see Table 2-16 on page 2-24) performs ground evacuation and en route patient care for supported units. The evacuation platoon headquarters provides mission command for the evacuation squad (forward) and the evacuation squad (area). The platoon employs ten evacuation teams, utilizing the M997A2, wheeled ambulance. The evacuation platoon provides ground medical evacuation support for the maneuver battalions of the BCTs. In addition, it provides ground medical evacuation support to units receiving area medical support from the BSMC.

2-66. Medical evacuation to Role 3 hospitals is provided by the higher role of care (coordination of medical evacuation to higher roles of care is the responsibility of the appropriate mission command elements), to include ground and air ambulance. In early entry operations, organic evacuation resources are relied on until echelons above brigade ambulances arrive. See *note* below Table 2-16 on page 2-24 for differences in the SBCT and ABCT evacuation squads.

**Evacuation Platoon Headquarters**

2-67. The medical evacuation team headquarters provides mission command for evacuation platoon operations. It maintains communications to direct ground evacuation of patients and maintains situational understanding of the OE within its AO. The platoon headquarters directs and coordinates ground medical evacuation of patients and synchronizes evacuation platoon operations with supported units and the BSMC. The evacuation platoon headquarters element establishes and maintains contact with supported units and forward deployed treatment squads/teams of the BSMC. The evacuation platoon headquarters performs route reconnaissance (by map; aerial reconnaissance; coordination with the intelligence staff officer [S-2] and S-3; and vehicular route reconnaissance), and develops and issues all necessary route and navigational information. If possible, the information is provided via the Force XXI Battle Command Brigade and Below System to all ambulance teams. The evacuation platoon headquarters coordinates and establishes AXPs for both air and ground ambulances as required. The evacuation platoon is employed in the company command net and establishes a net control station for its evacuation teams.

**Evacuation Squads**

2-68. The evacuation squads (three forward [six teams], two area [four teams]), provide ground evacuation of patients from supported units to the BSMC. Evacuation squad emergency care sergeants and ambulance aides/drivers perform TC3, prepare patients for medical evacuation, and provide en route care for the patients they evacuate. They operate and maintain assigned ambulances, communications equipment, and medical equipment sets. They ensure that appropriate property exchange of medical items (such as litters and blankets) is made at the originating and receiving MTFs (Army only). Evacuation teams maintain situational understanding and use all available navigational tools to ensure quick and secure evacuation of patients. For communications, each evacuation squad/team is employed in the company command net.

**Evacuation Platoon Employment**

2-69. The medical equipment set on each ambulance is designed for medical emergencies and en route patient care. Ambulances deploy forward to support maneuver battalions, other Role 1 MTFs, BSMC treatment squads/teams, CCPs, patient collecting points and/or AXPs supporting medical evacuation

operations. The evacuation platoon leader and platoon sergeant maintain situational understanding of operational requirements for medical evacuation, establish primary and alternate evacuation routes, verify locations of supported units, and assist evacuation teams as necessary. The platoon leader and platoon sergeant coordinate support requirements with supported units for evacuation squads/teams placed in direct support. They synchronize medical evacuation requirements for support of organizations without organic medical support on an area support basis, predicated on the situational understanding of the OE. Evacuation platoon personnel obtain appropriate dispatch and road clearances prior to departing the company or supported unit areas. The platoon leader ensures that maps and all relevant available information is provided to platoon personnel. The platoon sergeant ensures evacuation personnel are trained, equipment is maintained, and that evacuation personnel use information as required to respond to evacuation requests expeditiously and appropriately. If time and fuel permit, the platoon leader or platoon sergeant may take personnel of the evacuation platoon on rehearsal of the evacuation routes.

**Table 2-16. Medical evacuation platoon**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Evacuation Platoon Headquarters	70B67	O2	Platoon Leader	MS	1
	68W4O	E7	Platoon Sergeant	NC	1
Evacuation Squad Forward	68W2O	E5	Emergency Care Sergeant	NC	3
	68W1O	E4	Ambulance Aide/Driver		3
	68W1O	E3	Ambulance Aide/Driver		6
Evacuation Squad (Area)	68W2O	E5	Emergency Care Sergeant	NC	2
	68W1O	E4	Ambulance Aide/Driver		2
	68W1O	E3	Ambulance Aide/Driver		4
<b>LEGEND:</b>					
AOC	area of concentration		MS	Medical Service Corps	
MOS	military occupational specialty		NC	noncommissioned	

*Note.* The SBCT evacuation squad (forward) adds six additional ambulance aide/drivers (MOS 68W1O/E4).

The SBCT and ABCT evacuation squad (area) adds four ambulance aide/drivers (MOS 68W1O/E4); numbers of vehicles assigned does not change from that of the IBCT evacuation squad (area).

The ABCT evacuation squad (forward) consists of six M113A3 tracked ambulances with six emergency care sergeants (MOS 68W2O/E5), six ambulance aide/drivers (MOS 68W1O/E4) and six ambulance aide/drivers (MOS 68W1O/E3).

With the additional personnel, the ABCT and SBCT ambulances are crewed with three medical personnel per ambulance.

## BRIGADE MEDICAL SUPPLY OFFICE

2-70. The BSMC's medical supply element is the BMSO. This office provides brigade level, Role 2, Class VIII coordination, synchronization, and execution of MEDLOG support for the BSMC and supported BCT.

2-71. Operational Class VIII organizational assets in the BCT are fixed and deploy with assigned AHS support units. Operational MEDLOG support relies on the application of a Class VIII supply chain that is agile, responsive, and swift and that possesses situational understanding of the supported organizations, the OE, mission, and the AO. During the initial deployment phase, the BSMC receives medical resupply mainly through preconfigured push packages, medical resupply sets from the supporting MEDLOG company, or a higher logistics support activity. The composition of the BMSO is displayed in Table 2-17.

*Note.* The SBCT MEDLOG personnel are described in paragraph 2-55, page 2-19 (*note*); the SBCT was not organized with a separate BMSO structure. Due to Total Army Analysis SBCT TOEs, it is envisioned that SBCT structure will change to add a BMSO.

**Table 2-17. Brigade medical supply office**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Brigade Medical Supply Office	70K67	O2	Health Services Material Officer	MS	1
	68J3O	E6	Medical Logistics Sergeant	NC	1
	68A2O	E5	Biomedical Equipment Sergeant	NC	1
	68J2O	E5	Medical Logistics Sergeant	NC	1
	68Q2O	E5	Pharmacy Sergeant	NC	1
	68J1O	E4	Medical Logistics Specialist		1
<b>LEGEND:</b>					
AOC area of concentration			MS Medical Service Corps		
MOS military occupational specialty			NC noncommissioned		

## SECTION V — ARMY HEALTH SYSTEM ASSETS IN NONMEDICAL ORGANIZATIONS

2-72. In addition to the AHS assets in the maneuver battalions, the BCT, and division headquarters, AHS assets are organic to a variety of nonmedical units and staffs. This section describes these assets based upon the mission of the parent organization.

### COMBAT AVIATION BRIGADES

2-73. Combat aviation brigades support Army decisive operations, as well as unified action partners in the conduct of unified land operations. The role of the aviation brigade is to conduct and/or support ground maneuver through aviation operations. The aviation brigades are modular and tailorable, which permits task organization based upon the mission. Refer to Army aviation doctrine for more information concerning aviation brigades.

#### TYPES OF COMBAT AVIATION BRIGADES

2-74. Listed below are the four types of CABs described in FM 3-04.111. Medical capabilities as expressed in TOEs are described in the paragraphs that follow. The types of CABs are—

- Light.
- Medium.
- Heavy.
- Expeditionary.

2-75. The heavy, medium, and light CABs are organized in a similar construct, predominately varying in the number and type of attack and reconnaissance aircraft of the attack and reconnaissance battalions. The expeditionary CAB is designed primarily to focus on homeland security operations. Elements of the expeditionary CAB can be task-organized for operations outside of the U.S.

#### COMBAT AVIATION BRIGADE STRUCTURE

2-76. Combat aviation brigades are organized along a similar construct. The heavy and medium CABs have more robust firepower, while the light CAB requires smaller sized U.S. Air Force lift (C-130) to deploy the attack reconnaissance squadron aircraft.

## Army Health System Support Organizations of the Combat Aviation Brigade

2-77. Army Health System support across the CABs is provided by organizations described in paragraphs 2-77 through 2-112. As with the BCTs (IBCT TOE tables), the light CAB TOE is used, significant differences between the CABs are noted as required.

### Medical Operations Cell

2-78. The medical operations cell of the light CAB provides assistance in planning and coordination for air ambulance employment and utilization. The medical operations cell consists of a Medical Service Corps officer and medical operations NCO (Table 2-18) that provide assistance with the synchronization of the air and ground medical evacuation plan. The medical operations officer and operations sergeant also manage MTF information from AHS support commands and surgeon cells from higher roles of care including CSH locations and status (beds by type and number available), evacuation routes, CCPs, and AXP. The medical operations cell performs the following partial list of functions:

- Establishes flight procedures specific to medical evacuation by air ambulance missions within the CAB's AO. This may include special routes or corridors, as well as procedures for escort aircraft link-up.
- Ensures lines of communication to supported units and higher echelons of medical command are available. The medical operations cell also ensures supported units understand medical evacuation by air ambulance procedures and capabilities.
- Establishes medical evacuation by air ambulance briefing and launch procedures. Ensures 24-hour access to those with ability to launch high and very-high risk missions.
- Maintains situational understanding of the tactical and medical situation.
- Coordinates with medical regulators at Role 3 and above to efficiently conduct area support medical evacuation by air ambulance missions.
- Assists the air ambulance medical company, the GSAB, and CAB staffs in the conduct of medical evacuation by air ambulance operations.

**Table 2-18. Combat aviation brigade (light) S-3 section**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
S-3 Section	67J00	O4	Medical Operations Officer	MS	1
	68W4O	E7	Operations Sergeant	NC	1
<b>LEGEND:</b>					
AOC area of concentration			MS	Medical Service Corps	
MOS military occupational specialty			NC	noncommissioned	
There are other nonmedical personnel in the paragraph.					

### BRIGADE SURGEON SECTION

2-79. The brigade surgeon section (Table 2-19) supports the brigade flight surgeon in the role of special staff officer responsible for AHS support in the CAB. The brigade flight surgeon, (MAJ/O4, AOC 61N00), provides physician-directed ATM support for operational casualties and routine sick call service. The brigade flight surgeon is uniquely qualified to serve in the aviation brigade as the AHS support advisor and special staff officer to the CAB commander. The CAB's flight surgeon exercises technical supervision over the medical activities in the CAB. He provides AHS support and oversight of AHS issues of the unmanned aircraft system company operations and products. The flight surgeon keeps the CAB commander informed of HSS and FHP issues.

2-80. The brigade surgeon section ensures timely planning, integration, and synchronization of AHS support with the CAB's operational plan. The CAB coordinates with other organizations and staff elements to ensure personnel receive complete and comprehensive medical support.

**Table 2-19. Brigade surgeon section**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Brigade Surgeon Section	61N00	O4	Flight Surgeon	MC	1
	70H67	O3	Medical Operations Officer	MS	1
	68W40	E7	Operations NCO	NC	1
<b>LEGEND:</b>					
AOC	area of concentration		MS	Medical Service Corps	
MC	Medical Corps		NC	noncommissioned	
MOS	military occupational specialty		NCO	noncommissioned officer	

*Note.* The heavy CAB changes the operations NCO to a master sergeant.

**MEDICAL TREATMENT TEAM**

2-81. The medical treatment team (Table 2-20) in the headquarters and headquarters company, CAB, receives, triages, and determines the disposition of patients. It provides Role 1, TC3, ATM, and behavioral health support for the company. The medical treatment team establishes the Role 1 MTF. The CAB medical treatment team is dependent upon the MCAS or supported BSMC for Role 2 support.

**Table 2-20. Medical treatment team, headquarters and headquarters company, combat aviation brigade**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Treatment Team	65D00	O3	Physician Assistant	SP	1
	67D00	O3	Behavioral Health Officer	MS	2
	68W30	E6	Health Care Sergeant	NC	1
	68X2O	E5	Behavioral Health NCO	NC	1
	68W1O	E4	Health Care Specialist		1
	68W1O	E3	Health Care Specialist		1
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MOS	military occupational specialty		NCO	noncommissioned officer	
MS	Medical Service Corps		SP	Army Medical Specialist Corps	

*Note.* The heavy CAB adds one behavioral health specialist (MOS 68X1O/E4).

**ASSAULT BATTALION**

2-82. The light CAB assault battalion is composed of three medium assault companies with ten UH-60 helicopters each.

2-83. The medical treatment team (Table 2-21 on page 2-28) operates a Role 1 MTF providing AHS support for the assault battalion. Capabilities include routine medical care, TC3, and ATM for Soldiers assigned to the assault battalion. The flight surgeon and aviation medicine PA provide the unit with aviation medicine support the organization requires. The assault battalion’s medical treatment team does not possess behavioral health personnel on its TOE.

**Table 2-21. Medical treatment team (assault battalion)**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Treatment Team	61N00	O3	Flight Surgeon	MC	1
	65D00	O3	Physician Assistant	SP	1
	68W3O	E6	Health Care Sergeant	NC	1
	68W1O	E4	Health Care Specialist		1
	68W1O	E3	Health Care Specialist		1
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MC	Medical Corps		SP	Army Medical Specialist Corps	
MOS	military occupational specialty				

**PATHFINDER COMPANY**

2-84. Elements of the pathfinder company establish landing zones; and determine approach and departure routes for CAB operations.

2-85. Combat medics support the mission of the pathfinder company by the provision of TC3 and are normally allocated within the pathfinder company on a basis of one section NCO (MOS 68W3O/E6) with the company and one (MOS 68W1O/E4) per platoon. Functions of the combat medic can be found at paragraphs 2-31 and 2-32. The combat medic section of the pathfinder company is depicted in Table 2-22.

**Table 2-22. Combat medic section (pathfinder company)**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Combat Medic Section	68W3O	E6	Section NCO	NC	1
	68W1O	E4	Combat Medic		4
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MOS	military occupational specialty		NCO	noncommissioned officer	

**GENERAL SUPPORT AVIATION BATTALION**

2-86. All CABs have a GSAB assigned to them; GSAB assets participate in all brigade operations. The medical company (air ambulance) is assigned to the GSAB and provides medical evacuation by air ambulance. The GSAB is part of the light CAB's medical assets and is described in Tables 2-23 and 2-24.

**Medical Operations Cell**

2-87. The GSAB S-3 section (Table 2-23) medical operations cell provides the same functions as the CAB's medical operations cell described in paragraph 2-76. This medical operations cell is focused on the GSAB air ambulance operations.

**Table 2-23. General support aviation battalion (S-3 section)**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
S-3 Section	67J00	O3	Operations Officer	MS	1
	68W4O	E7	Operations Sergeant	NC	1
<b>LEGEND:</b>					
AOC	area of concentration		MS	Medical Service Corps	
MOS	military occupational specialty		NC	noncommissioned	
There are other nonmedical personnel in this paragraph.					

**Medical Treatment Team**

2-88. The medical treatment team of the GSAB (Table 2-24) operates a Role 1 MTF which provides AHS support to the GSAB. It possesses the same capabilities as the medical treatment team assigned to the assault battalion CAB described in paragraph 2-83.

**Table 2-24. Medical treatment team, general support aviation battalion**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Treatment Team	61N00	O3	Flight Surgeon	MC	1
	65D00	O3	Physician Assistant	SP	1
	68W3O	E6	Health Care Sergeant	NC	1
	68W1O	E4	Health Care Specialist		1
	68W1O	E3	Health Care Specialist		1
<b>LEGEND:</b>					
AOC area of concentration		NC noncommissioned			
MC Medical Corps		SP Army Medical Specialist Corps			
MOS military occupational specialty					

**MEDICAL COMPANY (AIR AMBULANCE) (HH-60)**

2-89. The medical company (air ambulance) has a company headquarters and four forward support medical evacuation platoons (FSMPs) or forward support medical evacuation teams. Whether deployed individually, or as a unit, air ambulance medical company assets are dependent upon the supported unit for food, fuel, security, intelligence, communications, wheeled vehicle maintenance, and all classes of supply except Class IX (air).

**Company Headquarters**

2-90. The medical company (air ambulance) headquarters provides mission command. It provides support to air ambulance operations within the AO assigned it by higher command. The company headquarters provides unit-level administration and general supply. The command element is responsible for the provision of billeting, security, training, and administration and discipline of assigned personnel.

2-91. The medical company (air ambulance) assets can collocate with AHS support organizations, the aviation task force, the supported BCT, or higher to provide air ambulance support throughout the AO. Air ambulance aircraft are equipped with medical personnel and equipment enabling the provision of en route care of patients.

2-92. The air ambulance company with the area support medical evacuation platoon (see Table 2-25) has the same mission as the air ambulance company with area support medical evacuation team; however, the platoon brings increased organizational capacity and capability.

**Table 2-25. Company headquarters**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Company Headquarters/ Area Support Medical Evacuation Platoon	67J00	O4	Commander	MS	1
	67J00	O3	Platoon Leader	MS	1
	67J00	O3	Operations Officer	MS	1
	68W5M	E8	First Sergeant	NC	1
	68W3F	E6	Air Ambulance NCO	NC	1
	68W2F	E5	Flight Medic	NC	3
<b>LEGEND:</b>					
AOC area of concentration		MS Medical Service Corps			
MOS military occupational specialty		NC noncommissioned			
		NCO noncommissioned officer			
There are other nonmedical personnel in this paragraph.					

### Forward Support Medical Evacuation Platoon

2-93. The FSMP (see Table 2-26) is composed of three HH-60 aircraft and associated personnel that support 24-hour operations. The FSMP's assets and efforts should not be rigidly tied to any area or supported unit. The FSMP must remain agile and flexible in employment to effectively support unified land operations throughout the AO. Air ambulance assets are a limited resource and are located where they are most needed.

2-94. The primary mission of the FSMP is medical evacuation by air ambulance. In addition, the FSMP provides the following:

- Patient movement between MTFs.
- Class VIII resupply.
- Joint blood program support.
- Medical mission command transport.
- Movement of medical personnel and equipment.
- Air crash rescue support.

2-95. The forward support and area support medical evacuation platoons have the same mission sets as the forward support and area support medical evacuation teams. See *note* at Table 2-26.

**Table 2-26. Forward support medical evacuation platoon**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Forward Support Medical Evacuation Platoon X 4	67J00	O3	Platoon Leader	MS	1
	67J00	O2	Aeromedical Evacuation Officer	MS	1
	68W4F	E7	Platoon Sergeant	NC	1
	68W34F	E6	Air Ambulance NCO	NC	1
	68W2F	E5	Flight Medic	NC	3
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MOS	military occupational specialty		NCO	noncommissioned officer	
MS	Medical Service Corps				

*Note.* One forward support medical evacuation team legacy organization remains in the Army inventory. The forward support and area support medical evacuation platoons have replaced the remainder of the forward and area support medical evacuation teams.

### ATTACK RECONNAISSANCE SQUADRON (OH-58D)

2-96. There are two attack and reconnaissance squadrons of the light CAB, the light CAB differs from the medium and heavy CABs primarily in the construct of the respective TOEs regarding different models of aircraft, the supporting support and maintenance elements for the airframes, and capabilities of the aircraft assigned. The light CAB attack and reconnaissance squadron requirement for lift results from smaller airframes requiring smaller-sized U.S. Air Force lift from C-130 and up. Unlike the medium and heavy attack and reconnaissance battalions, the light CABs attack and reconnaissance squadron is not capable of long range self-deployment with extended range fuel tanks.

### MEDICAL TREATMENT TEAM

2-97. The medical treatment teams (Table 2-27) assigned to the attack and reconnaissance squadrons of the light CAB have similar capabilities (Role 1 care with flight surgeon and aviation medicine PA) of the medical treatment team assigned to the assault and GSABs (paragraphs 2-82, 2-83, and 2-86 through 2-88). A medical treatment team is assigned to each attack reconnaissance squadron of the light CAB.

**Table 2-27. Medical treatment teams assigned to attack and reconnaissance squadrons, combat aviation brigade**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Treatment Team X 2	61N00	O3	Flight Surgeon	MC	1
	65D00	O3	Physician Assistant	SP	1
	68W3O	E6	Health Care Sergeant	NC	1
	68W1O	E4	Health Care Specialist		1
	68W1O	E3	Health Care Specialist		1
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MC	Medical Corps		SP	Army Medical Specialist Corps	
MOS	military occupational specialty				

*Note.* Although the mix of airframes (OH-58D/AH-64) varies between the light, medium, and heavy CABs, the medical treatment team composition and mission is identical. The light CAB has two squadrons of OH-58Ds. The medium CAB has one squadron of OH-58Ds and one squadron of AH -64s. The heavy CAB has two battalions of AH-64s.

**AVIATION SUPPORT BATTALION**

2-98. The aviation support battalion is organic to all aviation brigades; it is the primary aviation logistics organization above the aviation battalion. The aviation support battalion of the light CAB provides all logistics functions necessary to sustain the aviation brigade throughout the range of military operations. It consists of four companies, the headquarters and support company (with medical platoon), distribution company, net control station, and the aviation support company. All aviation AHS support units assigned to the CAB have similar TOEs and missions.

2-99. The aviation support battalion medical platoon provides Role 1 AHS support for the battalion and distributes Class VIII for the brigade. It has limited Class VIII storage capability.

**Headquarters and Support Company (Sustain 2—Network Operations, Combat Service Support, Automation Management Officer)**

2-100. This element, the Sustain 2-network operations, combat service support automation management office (Table 2-28) is responsible for providing Class VIII support for the brigade.

**Table 2-28. Sustain 2—network operations, combat service support automation management office**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Sustain 2-Network Operations, CSSAMO	68J2O	E5	Medical Logistics Sergeant	NC	1
<b>LEGEND:</b>					
CSSAMO	combat service support automation management office				
AOC	area of concentration		NC	noncommissioned	
MOS	military occupational specialty				

**Medical Platoon**

2-101. The medical platoon is organic to the aviation support battalion. The mission of the medical platoon is to provide Role 1 AHS support to the battalion. The platoon has the same mission in principle as the maneuver battalions’ medical platoons (paragraphs 2-17 and 2-18) with differences driven by the organizational mission, TOE, and parent unit operational employment. The medical platoon is configured with a platoon headquarters, a medical treatment squad, and an evacuation section.

**Headquarters Element**

2-102. The medical platoon headquarters (Table 2-29) and treatment squad are normally collocated together, forming the Role 1 MTF. The medical platoon headquarters serves as the net control station for the platoon and has access to the battalion communications network. The medical platoon headquarters is responsible for planning, logistical (to include Class VIII) resupply of the platoon, maintenance, training, and communications. The medical operations officer (field medical assistant) and the platoon sergeant are responsible for medical platoon operations.

**Table 2-29. Medical platoon headquarters, headquarters and support company, aviation support battalion**

<b>Paragraph title</b>	<b>AOC/MOS</b>	<b>Grade</b>	<b>Title</b>	<b>Branch</b>	<b>Quantity</b>
Medical Platoon Headquarters	70B67	O3	Field Medical Assistant	MS	1
	68W4O	E7	Platoon Sergeant	NC	1
<b>LEGEND:</b>					
AOC	area of concentration		MS	Medical Service Corps	
MOS	military occupational specialty		NC	noncommissioned	

**Treatment Squad**

2-103. The treatment squad (Table 2-30) consists of two teams. They operate the Role 1 MTF and provide Role 1 medical care and treatment (see paragraph 2-24) in support of the aviation support battalion. The CAB medical treatment squads/teams are uniquely suited for the mission of AHS support to aviation elements with the inclusion of the flight surgeon and aviation medicine PA in the TOE.

**Table 2-30. Treatment squad, headquarters and support company, aviation support battalion**

<b>Paragraph title</b>	<b>AOC/MOS</b>	<b>Grade</b>	<b>Title</b>	<b>Branch</b>	<b>Quantity</b>
Medical Treatment Teams	61N00	O3	Flight Surgeon	MC	1
	65D00	O3	Physician Assistant	SP	1
	68W3O	E6	Health Care Sergeant	NC	1
	68W2O	E5	Health Care Sergeant	NC	2
	68W1O	E4	Health Care Specialist		1
	68W1O	E3	Health Care Specialist		2
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MC	Medical Corps		SP	Army Medical Specialist Corps	
MOS	military occupational specialty				

**Evacuation Section**

2-104. The evacuation section provides TC3, medical evacuation, and en route care on an area basis from the Soldiers point of injury, CCP, or AXP to the aviation support battalion treatment squad or appropriate treatment squad/team of the CAB within the unit's AO. The evacuation section is comprised of emergency care sergeants and ambulance aides/drivers (Table 2-31).

**Table 2-31. Evacuation section, headquarters and support company, aviation support battalion**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Evacuation Section	68W2O	E5	Emergency Care Sergeant	NC	2
	68W1O	E3	Ambulance Aide/Driver		2
<b>LEGEND:</b>					
AOC area of concentration				NC	noncommissioned
MOS military occupational specialty					

**EXTENDED RANGE MULTIPURPOSE UNMANNED AIRCRAFT SYSTEM COMPANY**

2-105. The extended range multipurpose unmanned aircraft system company, provides information collection capability for the CAB. Unmanned aircraft systems support commanders and their staffs in the planning, coordination, and execution of operations through an increase of aerial surveillance in the AO.

2-106. The health care specialist (Table 2-32) assigned to the extended range multipurpose unmanned aircraft system company provides TC3 and is supported by the evacuation section and treatment squad of the aviation support battalion. Technical supervision is provided by the clinicians with mentoring provided by the medical platoon sergeant.

**Table 2-32. Extended range multipurpose unmanned aircraft system company, aviation support battalion**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Extended Range Multipurpose Unmanned Aerial Vehicle Company	68W1O	E4	Health Care Specialist		1
<b>LEGEND:</b>					
AOC area of concentration				MOS	military occupational specialty

**MEDICAL COMPANY (AIR AMBULANCE) (LIGHT UTILITY HELICOPTER)**

2-107. The medical company (air ambulance) (light utility helicopter) is assigned to the expeditionary CAB. The light utility helicopter air ambulance company has a company headquarters, a flight operations section, and two medical evacuation flight platoons.

2-108. Each medical evacuation flight platoon consists of four UH-72A aircraft with flight crews that support 24-hour operations. Whether deployed from home station individually, or as a unit, air ambulance company assets are dependent upon the supported organization for food, fuel, security, information, communications, vehicle maintenance, and all classes of supply except Class IX (air). The company deploys within the U.S. in support of defense support of civil authorities and other tasks as assigned by higher command/authority.

**Company Headquarters**

2-109. The medical company (air ambulance) headquarters (see Table 2-33 on page 2-34) provides mission command, unit-level administration, and general supply. The command element is responsible for the provision of billeting (when deployed from home station), security, training, administration, and discipline of assigned personnel.

**Table 2-33. Medical company (air ambulance) (light utility helicopter) headquarters**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Company Headquarters	67J00	O4	Commander	MS	1
	68W5M	E8	First Sergeant	NC	1
	68W1O	E3	Vehicle Driver		1
<b>LEGEND:</b>					
AOC area of concentration		MS Medical Service Corps			
MOS military occupational specialty		NC noncommissioned			

### Flight Operations Section

2-110. The flight operations section (Table 2-34) provides coordination, synchronization, and planning for air ambulance operations. The flight operations officer ensures lines of communications to supported elements is established and maintained. The flight operations section establishes prompt and safe medical evacuation by air ambulance briefings and launch procedures, maintains situational understanding of the AO, and ensures the supported elements understand medical evacuation by air ambulance procedures and capabilities. The flight operations section performs those functions required to ensure the prompt and safe launch of air ambulance assets as required in the AO. This section also maintains situational understanding of MTFs capacities and capabilities as they consider air ambulance operations in the AO.

**Table 2-34. Flight operations section, (air ambulance) (light utility helicopter)**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Flight Operations Section	67J00B4	O3	Flight Operations Officer	MS	1
<b>LEGEND:</b>					
AOC area of concentration		MS Medical Service Corps			
MOS military occupational specialty					

### Medical Evacuation Flight Platoon

2-111. The medical evacuation flight platoon (Table 2-35) has four UH-72A aircraft and crews to support 24-hour operations in the assigned AO. The medical evacuation flight platoon remains flexible and agile in employment to effectively respond to short notice deployment (normally internal to the U.S.) to anticipated or unanticipated events. Air ambulance assets are a limited resource and are located where they are most needed.

2-112. The primary mission of the medical evacuation flight platoon is medical evacuation by air ambulance. The platoon may provide additional support predominantly with AHS support in the AO (see paragraph 2-94).

**Table 2-35. Medical evacuation flight platoon, (air ambulance) (light utility helicopter)**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Forward Support Medical Evacuation Platoon X 2	67J00	O3	Platoon Leader	MS	1
	67J00	O2	Aeromedical Evacuation Officer	MS	1
	68W4O	E7	Platoon Sergeant	NC	1
	68W3O	E6	Air Ambulance Sergeant	NC	1
	68W2O	E5	Flight Medic	NC	3
<b>LEGEND:</b>					
AOC area of concentration		MS Medical Service Corps			
MOS military occupational specialty		NC noncommissioned			

## MANEUVER ENHANCEMENT BRIGADE

2-113. The maneuver enhancement brigade (MEB) provides mission command for forces from multiple branches but especially those that conduct maneuver support operations for the force (FM 3-81). The MEB has limited organic structure and depends on other organizations for additional capabilities. The MEB is comprised of a headquarters and support company, a network support company, and the BSB. Maneuver enhancement brigades are task-organized based upon identified mission requirements for the echelon it is supporting. An MEB typically includes a mix of several types of battalions and separate companies based upon the mission profile, echelon the MEB is supporting, and the OE.

### SUSTAINMENT/BRIGADE SURGEON SECTION

2-114. The MEB surgeon is a special staff officer that advises the MEB commander on all matters that pertain to the health of the command. The MEB surgeon and the brigade surgeon's staff coordinate (Table 2-36) AHS support for the brigade and attachments. The MEB surgeon coordinates with the supported division surgeon and MEDBDE (SPT) commander and establishes medical guidelines for the MEB. The brigade surgeon's section provides medical planning to ensure adequate AHS support is available for the MEB and attached organizations. More information concerning the brigade surgeon and brigade surgeon section is found in paragraphs 2-5 and 2-6, and Table 2-1.

**Table 2-36. Brigade surgeon section**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Brigade Surgeon Section	62B00	O4	Brigade Surgeon	MC	1
	70H67	O3	Medical Operations Officer	MS	1
	68W4O	E7	Health Care NCO	NC	1
<b>LEGEND:</b>					
AOC	area of concentration		MS	Medical Service Corps	
MC	Medical Corps		NC	noncommissioned	
MOS	military occupational specialty		NCO	noncommissioned officer	

### Sustainment/Medical Treatment Team

2-115. The medical treatment team (Table 2-37) assigned to the brigade surgeon's section supports the MEB headquarters. The medical treatment team provides Role 1 AHS support for MEB headquarters and attached personnel. Capabilities include routine medical care, TC3, and ATM for Soldiers assigned to the MEB. The MEB medical treatment team has medical evacuation capabilities with the two wheeled ambulances assigned to the treatment team.

**Table 2-37. Sustainment/medical treatment team**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Sustainment/Medical Treatment Team	65D00	O3	Physician Assistant	SP	1
	68W3O	E6	Health Care Sergeant	NC	1
	68W1O	E4	Health Care Specialist		1
	68W1O	E3	Health Care Specialist/Driver		1
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MOS	military occupational specialty		SP	Army Medical Specialist Corps	

## FIRES BRIGADE

2-116. The FIB's primary task is conducting strike operations (refer to FM 3-09). The FIB is not organic to any Army organization or echelon, nor is it focused on any specific region. The FIB is the only Army field artillery organization above the BCT and can be directed to execute tasks for any joint, Service, or functional headquarters. Unlike BCTs, FIBs do not have an organic medical company. Army Health

System support for the FIB is found in the headquarters and headquarters battery’s medical section. The MCAS from the supporting MMB provides Role 2 AHS support for the FIB.

**COMMAND POST-SUSTAINMENT/PROTECTION–SURGEON**

2-117. The brigade surgeon and the medical sustainment protection command post provide AHS support and planning for the FIB. The brigade surgeon and staff responsibilities are found in paragraphs 2-5 and 2-6, and Table 2-1. Table 2-38 illustrates the brigade surgeon and staff.

**Table 2-38. Command post-sustainment/protection-surgeon**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Command Post-Sustainment/Protection-Surgeon	62B00	O4	Field Surgeon	MC	1
	70H67	O3	Medical Operations Officer	MS	1
	68W4O	E7	Operations Sergeant	NC	1
<b>LEGEND:</b>					
AOC	area of concentration		MS	Medical Service Corps	
MC	Medical Corps		NC	noncommissioned	
MOS	military occupational specialty				

**HEADQUARTERS AND HEADQUARTERS BATTERY, MEDICAL SECTION**

2-118. The headquarters and headquarters battery brigade medical section consists of a medical treatment team (Table 2-39) and medical evacuation squad (Table 2-40).

**Medical Treatment Team**

2-119. The medical treatment team provides Role 1 AHS support to the FIB. It provides routine sick call, TC3, and ATM to wounded or ill Soldiers.

2-120. The FIB’s medical treatment team has enhanced COSC capabilities with the provision of the behavioral health personnel assigned to the medical treatment team.

**Table 2-39. Medical treatment team, headquarters and headquarters battery, medical section**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Treatment Team	65D00	O3	Physician Assistant	SP	1
	67D00	O3	Behavioral Science Officer	MS	2
	68W3O	E6	Health Care Sergeant	NC	1
	68X2O	E5	Behavioral Health NCO	NC	1
	68W1O	E4	Health Care Specialist		1
	68X1O	E4	Behavioral Health Specialist		1
	68W1O	E3	Health Care Specialist		1
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MOS	military occupational specialty		NCO	noncommissioned officer	
MS	Medical Service Corps		SP	Army Medical Specialist Corps	

**Medical Evacuation Squad**

2-121. The medical evacuation squad provides TC3, medical evacuation, and en route care from the Soldier’s point of injury, the CCP, or the AXP to the Role 1 medical treatment team of the FIB. See paragraph 2-65 through 2-66 for more information concerning wheeled ambulance squad/platoon medical evacuation operations.

**Table 2-40. Medical evacuation squad, headquarters and headquarters battery, medical section**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Evacuation Squad	68W2O	E5	Emergency Care Sergeant	NC	2
	68W1O	E3	Ambulance Aide/Driver		2
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MOS	military occupational specialty				

**HEADQUARTERS AND HEADQUARTERS BATTERY, FIRES BATTALION, MULTIPLE LAUNCH ROCKET SYSTEM MEDICAL PLATOON**

2-122. The headquarters and headquarters battery, multiple launch rocket system medical platoon provides Role 1 AHS support to the multiple launch rocket system fires battalion. The medical platoon is a scaled down version of the medical platoon of the maneuver battalions (in the BCTs). It provides the same AHS support on an appropriate scale for the multiple launch rocket system battalion. The multiple launch rocket system battalions' medical platoon is comprised of the same basic elements (platoon headquarters, treatment, evacuation, and combat medic elements) of the BCT maneuver battalions; however, medical treatment teams and the medical evacuation team replace squads in the BCT maneuver battalions. See paragraphs 2-17 through 2-43 for information concerning the employment of a maneuver element medical platoon.

**Medical Platoon Headquarters**

2-123. The medical platoon headquarters (Table 2-41) and medical treatment team (see Table 2-42 on page 2-38) are normally collocated forming the BAS. As in the BCT, and with the exception of Class VIII, the medical platoon is dependent upon the fires battalion to which it is assigned for all logistic support. The platoon leader (CPT/O3, AOC 65D00) has the same responsibilities as delineated in paragraph 2-20. The field medical assistant (medical operations officer) and the section NCO (platoon sergeant) responsibilities are described in paragraphs 2-21 through 2-23.

**Table 2-41. Medical platoon headquarters, headquarters and headquarters battery, fires battalion, multiple launch rocket system**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Platoon Headquarters	65D00	O3	Platoon Leader	MC	0*
	70B67	O2	Field Medical Assistant	MS	1
	68W3O	E6	Section Noncommissioned Officer	NC	1
<b>LEGEND:</b>					
* Platoon leader is accounted for in the medical treatment team (paragraph 18) (Code 50)					
AOC	area of concentration		MOS	military occupational specialty	
MC	Medical Corps		MS	Medical Service Corps	
			NC	noncommissioned	

**Medical Treatment Team**

2-124. The medical treatment team operates the BAS and provides Role 1 medical care and treatment. It does not have split-based operations capability. The medical treatment team provides sick call, TC3, and ATM for the supported battalion.

**Table 2-42. Medical treatment team, headquarters and headquarters battery, fires battalion, multiple launch rocket system**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Treatment Team	65D00	O3	Physician Assistant	SP	1
	68W3O	E6	Health Care Sergeant	NC	1
	68W1O	E4	Health Care Specialist		1
	68W1O	E3	Health Care Specialist		1
<b>LEGEND:</b>					
AOC area of concentration		NC noncommissioned			
MOS military occupational specialty		SP Army Medical Specialist Corps			

### Combat Medic Section

2-125. Combat medics (Table 2-43) are normally distributed to the supported fires batteries on the basis of one per battery, where they provide TC3. Combat medics are supported by the medical treatment team and the ambulance team in the treatment and evacuation of patients from the battery to the BAS. Assignment and functions of the combat medic are found at paragraphs 2-31 and 2-32.

**Table 2-43. Combat medic section, headquarters and headquarters battery, fires battalion, multiple launch rocket system**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Combat Medic Section	68W1O	E4	Combat Medic		4
<b>LEGEND:</b>					
AOC area of concentration		MOS military occupational specialty			

### Ambulance Team

2-126. The ambulance team (Table 2-44) is employed similarly as the evacuation squads (paragraph 2-68) however with fewer ambulances and personnel. It supports the multiple launch rocket system fires battalion with TC3, medical evacuation, and en route care as do the ambulance squads/teams of BCT maneuver units.

**Table 2-44. Ambulance team, headquarters and headquarters battery, fires battalion, multiple launch rocket system**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Ambulance Team	68W2O	E5	Emergency Care Sergeant	NC	1
	68W1O	E3	Ambulance Aide/Driver		1
<b>LEGEND:</b>					
AOC area of concentration		NC noncommissioned			
MOS military occupational specialty					

## BATTLEFIELD SURVEILLANCE BRIGADE

2-127. The battlefield surveillance brigade (BFSB), provides echelon above brigade and higher echelon commanders with long-duration intelligence collection capability with a variety of technical and human intelligence collection enablers that assist in the development of intelligence. The BFSB also provides assets to enhance the intelligence collection capability of other brigades, including BCTs, and when directed, produces intelligence for its supported higher headquarters.

2-128. The BFSB has limited organic AHS medical support capability. The reconnaissance squadron has an organic medical platoon with medical treatment, ground medical evacuation, and combat medic capabilities. The BFSB HHC contains an appropriately sized treatment and evacuation section that can provide Role 1 AHS support to the remaining elements of the BFSB.

2-129. The BFSB differs from BCTs in that it does not contain a medical company with Role 2 medical treatment capability. It also lacks robust ground evacuation (wheeled) assets normally associated with a Role 2 MTF. Instead, the BFSB contains two Role 1 MTFs (these are the aid stations in the brigade HHC and the reconnaissance squadron) and ambulances to medically evacuate Soldiers from the point of injury or CCP to the organic aid stations. The medical treatment team in the HHC will normally support the brigade HHC, the military intelligence battalion headquarters and its elements that are not detached, plus the network support company, and the brigade support company. The treatment capability in the HHC and the reconnaissance squadron's headquarters and headquarters troop is not that of a maneuver force BAS in a BCT. The treatment teams have an assigned PA and staff that will stabilize and prepare patients for further medical evacuation. The BFSB relies heavily on air ambulance support provided by aviation medical assets of the CAB and coordinated by the brigade surgeon section. In most situations, medical evacuation by air ambulance is the normal evacuation means because of the distances at which elements of the BFSB operate.

2-130. The BFSB requires augmentation with medical evacuation assets to move patients from the aid station to the nearest Role 2 (probably by the supporting MCAS, or nearby BSMC) or Role 3 MTF (CSH). Close coordination and synchronization of the operation plans/orders is necessary to ensure that the medical treatment and evacuation systems planning and execution provide Soldiers with the best prospect for rapid treatment at the appropriate role of care. The OE and situation will determine the course of action regarding medical evacuation.

2-131. The S-4 section coordinates Class VIII supply with the BFSB surgeon. Requisitions are transmitted through MEDLOG channels using DCAM. The S-4 and surgeon have access to this data. Movement of Class VIII materiel into the BFSB and internally within the BFSB is coordinated by the S-4 and the BFSB surgeon section.

**SUSTAINMENT/BRIGADE SURGEON**

2-132. The brigade surgeon (Table 2-45) is a special staff officer to the BFSB commander. As such, he keeps the commander informed of all AHS support issues affecting the brigade. As a part of the BFSB sustainment cell, the brigade surgeon with the brigade surgeon section plans and coordinates brigade AHS support. This is accomplished in conjunction with the brigade S-4 through the brigade S-3 which provides AHS support planning input and obtains information to facilitate medical planning. Specific duties of the brigade surgeon are found at paragraphs 2-5 through 2-7, and Table 2-1 on pages 2-2 through 2-5.

**Table 2-45. Sustainment/brigade surgeon**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Brigade Surgeon Section	62B00	O4	Brigade Surgeon	MC	1
	70H67	O3	Medical Operations Officer	MS	1
	68W40	E7	Health Care NCO	NC	1
<b>LEGEND:</b>					
AOC	area of concentration		MS	Medical Service Corps	
MC	Medical Corps		NC	noncommissioned	
MOS	military occupational specialty		NCO	noncommissioned officer	

**Medical Section**

2-133. The BFSB medical section is comprised of the treatment team and evacuation squad. The medical section is not capable of split-based operations. The medical section is assigned to the HHC of the BFSB where it provides Role 1 AHS support to the brigade.

**Headquarters an Headquarters Company Treatment Team**

2-134. The HHC treatment team (see Table 2-46 on page 2-40) provides Role 1 AHS support with routine sick call, TC3, and ATM. The treatment team of the BFSB provides Role 1 AHS support services as common to other medical treatment teams with the exception of a split-based operation capability.

**Table 2-46. Headquarters and headquarters company/treatment team, battlefield surveillance brigade**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Treatment Team	65D00	O3	Physician Assistant	SP	1
	68W3O	E6	Health Care SGT	NC	1
	68W1O	E4	Health Care SPC		1
	68W1O	E3	Health Care SPC		1
<b>LEGEND:</b>					
AOC	area of concentration		SGT	sergeant	
MOS	military occupational specialty		SP	Army Medical Specialist Corps	
NC	noncommissioned		SPC	Specialist	

### Headquarters and Headquarters Company Evacuation Squad

2-135. The evacuation squad (see Table 2-47) provides ground medical evacuation from supported units to the treatment team of the BFSB. Evacuation squad emergency care sergeants and ambulance aide/drivers perform TC3, prepare patients for medical evacuation, and provide en route care. The evacuation squad operates and maintains assigned ambulances (M997A2 wheeled ambulances), communications equipment, related equipment, and medical equipment sets. Evacuation teams maintain situational understanding and use all available navigational tools to ensure rapid and secure evacuation of patients. The medical evacuation squad is composed of two teams equipped with two ground ambulances and associated equipment.

**Table 2-47. Headquarters and headquarters company/evacuation squad, battlefield surveillance brigade**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
HHC/Evacuation Team	68W2O	E5	Emergency Care SGT	NC	2
	68W1O	E3	Ambulance Aide/Driver		2
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
HHC	headquarters and headquarters company		SGT	sergeant	
MOS	military occupational specialty				

### RECONNAISSANCE AND SURVEILLANCE SQUADRON

2-136. The reconnaissance squadron is a multifunctional, task-organized unit. The squadron's primary mission is information collection. Information collection is conducted to answer the supported higher unit's priority information requirements. Using the squadron's organic assets enables the unit to conduct reconnaissance and surveillance operations.

2-137. The headquarters and headquarters troop includes the command group, the troop headquarters section, staff sections, an insertion and extraction section, a fires cell, a fire support platoon, and a medical platoon. The reconnaissance squadron has an organic medical treatment platoon with a medical treatment team, ambulance squad, and a combat medic section.

### Medical Treatment Platoon

2-138. The medical platoon is comprised of a platoon headquarters (see Table 2-48), a medical treatment team (see Table 2-49), an ambulance squad (see Table 2-50 on page 2-42), and a combat medic section (see Table 2-51 on page 2-42). The medical platoon provides AHS support for the squadron and operates a Role 1 MTF. The medical platoon's Role 1 AHS support includes TC3, ATM, and routine sick call services. It includes casualty collection and medical evacuation from the supported companies/troops/elements to the squadron aid station.

**Medical Treatment Platoon Headquarters**

2-139. The medical platoon leader and the platoon sergeant operate the platoon headquarters. The medical platoon headquarters normally collocates with the medical treatment team to form the Role 1 MTF/squadron aid station. The headquarters provides for mission command and resupply of the platoon. The platoon command post includes the plans and operations functions performed by the field medical assistant. The platoon has access to the squadron's communications network and serves as the net control station for the platoon. See paragraphs 2-17 through 2-43 for more information concerning medical platoons.

**Table 2-48. Medical treatment platoon headquarters, reconnaissance and surveillance squadron**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Platoon Headquarters	65D00	O3	Platoon Leader	SP	0*
	70B67	O2	Field Medical Assistant	MS	1
	68W4O	E7	Platoon Sergeant	NC	1
<b>LEGEND:</b>					
* Platoon leader is accounted for in the medical treatment team (paragraph 14) (code 50).					
AOC	area of concentration	MS	Medical Service Corps		
MOS	military occupational specialty	NC	noncommissioned		
		SP	Army Medical Specialist Corps		

**Medical Treatment Team**

2-140. The medical treatment team operates the squadron aid station and provides Role 1 medical care and treatment, including sick call, TC3, and ATM. The treatment team provides area support for other units and elements operating in the squadron AO.

2-141. Normally, the squadron aid station operates from the squadron combat trains. Squadron ambulances are normally employed by pushing ambulances to supported elements to evacuate casualties from the point of injury, CCP, or AXP to the squadron aid station. If the squadron medical platoon requires augmentation, the BFSB staff may request augmentation from the MEDBDE (SPT) or MMB for additional AHS support. Higher medical mission command units (MEDBDE [SPT] and/or MMB) or Role 2 organization (MCAS) ambulances, will evacuate patients from the squadron aid station to a Role 2 or 3 MTF.

**Table 2-49. Medical treatment team, reconnaissance and surveillance squadron**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Treatment Team	65D00	O3	Physician Assistant	SP	1
	68W3O	E6	Health Care Sergeant	NC	1
	68W1O	E4	Health Care Specialist		1
	68W1O	E3	Health Care Specialist		1
<b>LEGEND:</b>					
*Platoon leader accounted for in the medical treatment team (code 50)					
AOC	area of concentration	NC	noncommissioned		
MOS	military occupational specialty	SP	Army Medical Specialist Corps		

**Ambulance Squad**

2-142. The ambulance squad provides medical evacuation, TC3, and en route medical care from the point of injury, CCPs, and/or AXPs to the Role 1 squadron aid station. It is composed of two teams which may be pushed to supported units or ambulances may be dispatched from the squadron aid station. The ambulance teams support the reconnaissance troops or the long-range surveillance company detachments and work with the combat medics supporting them.

2-143. Medical evacuation to higher roles of care is the responsibility of that higher role of care or that of another higher role/medical evacuation capability such as an air ambulance unit/element or medical company (ground ambulance).

**Table 2-50. Ambulance squad, reconnaissance and surveillance squadron**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Ambulance Squad	68W2O	E5	Emergency Care Sergeant	NC	1
	68W1O	E4	Ambulance Aide/Driver		2
	68W1O	E3	Ambulance Aide/Driver		1
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MOS	military occupational specialty				

### Combat Medic Section

2-144. The combat medic section (Table 2-51) provides TC3 and other functions identified in paragraphs 2-31 and 2-32. It has nine combat medics and one section NCO. The combat medics are assigned either to the headquarters of each (two) reconnaissance troop or to the long-range surveillance company in support of the company's detachments and teams. The section NCO and the appropriately trained and equipped combat medics accompany the reconnaissance and surveillance elements to which assigned or attached (MOS 68W3O/E6 [MOS 68W1O/E4]).

**Table 2-51. Combat medic section, reconnaissance and surveillance squadron**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Table</i>	<i>Branch</i>	<i>Quantity</i>
Combat Medic Section	68W3O	E6	Section NCO	NC	1
	68W1O	E4	Combat Medic		4
	68W1O	E4	Combat Medic		5
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MOS	military occupational specialty		NCO	noncommissioned officer	

## SUSTAINMENT BRIGADE

2-145. The major missions performed by the sustainment brigade are theater opening, theater distribution, and sustainment. A sustainment brigade will likely perform more than one of these interrelated functions and subtasks such as movement control, terminal operation, distribution management, transportation, cargo transfer, and more sustainment activities simultaneously throughout the course of an operation. The sustainment brigade provides brigade-level sustainment support at echelons above brigade.

2-146. The sustainment brigade is a multifunctional, flexible, task-organized, and tailorable organization. All sustainment brigade headquarters are identical in organizational structure and capabilities. Organic to the sustainment brigade are the brigade headquarters and a special troops battalion.

2-147. The sustainment brigade headquarters and special troops battalion consists of two subordinate elements, the sustainment brigade (main) and the early entry element. The early entry element has minimal personnel and equipment to establish sustainment brigade operations. The early entry element is employed in conjunction with the sustainment brigade (main) and provides a rapidly deployable and employable headquarters element to synchronize sustainment operations. The early entry element is dependent on the main for augmentation as needed in all support functions.

### BRIGADE SURGEON

2-148. The brigade surgeon keeps the sustainment brigade commander informed of all matters regarding the health of the command. The brigade surgeon is part of the brigade commander's special staff. The sustainment brigade surgeon ensures all AHS support functions are considered and included in operations

plans and orders. Information concerning the brigade surgeon is found in paragraphs 2-5 and 2-6, and Table 2-1 on pages 2-2 through 2-5.

**BRIGADE SURGEON SECTION**

2-149. The sustainment brigade surgeon section assists the sustainment brigade surgeon with the AHS support coordination, synchronization, and planning for the sustainment brigade and attached units. The sustainment brigade surgeon section is described in Table 2-52. See paragraphs 2-5 through 2-7 and Table 2-1 on pages 2-2 through 2-5 for information concerning the brigade surgeon section. The brigade surgeon section consists of two cells, the medical plans and operations cell and the MEDLOG and sustainment cell described below. Also, the medical treatment team and medical evacuation squad are under the technical supervision of the surgeon.

**Medical Plans and Operations Cell**

2-150. The medical plans and operations cell is normally staffed with a medical operations officer (MAJ/O4, AOC 70H67), and a medical operations NCO (Master sergeant [E8], MOS 68W50). The primary function of this cell is medical planning to ensure adequate AHS support is available in a timely and efficient manner for the sustainment brigade and its attached units. This cell coordinates with the division surgeon section and, as authorized, the MEDBDE (SPT) for the placement of and support requirements of medical units and elements located in the sustainment brigade AO.

**Medical Logistics and Sustainment Cell**

2-151. The MEDLOG and sustainment cell is normally staffed with a MEDLOG officer (MAJ/O4, AOC 70K67). This cell receives daily updates on the status of Class VIII within the brigade and from attached medical units/elements. The MEDLOG and sustainment cell coordinates shortfalls in throughput distribution with the supporting MEDLOG company. This cell may update priorities with the supporting MEDLOG activity to correct deficiencies in the delivery system. The supporting MEDLOG company will forward information to the MEDLOG and sustainment cell on items filled and shipped and on those requisitions that were not filled. The goal of the MEDLOG and sustainment cell is to reduce shortfalls as much as possible and to prioritize Class VIII fill. This cell provides daily updates to the sustainment brigade surgeon and the support operations office chief on the status of Class VIII in the brigade.

**Table 2-52. Brigade surgeon section, sustainment brigade**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Brigade Surgeon Section, Sustainment Brigade	62A00	O5	Surgeon	MC	1
	70K67	O4	Medical Logistics Officer	MS	1
	70H67	O3	Medical Operations Officer	MS	1
	68W50	E8	Operations NCO	NC	1
<b>LEGEND:</b>					
AOC	area of concentration		MS	Medical Service Corps	
MC	Medical Corps		NC	noncommissioned	
MOS	military occupational specialty		NCO	noncommissioned officer	

**BRIGADE MEDICAL SECTION, SUSTAINMENT BRIGADE**

2-152. The brigade medical section is comprised of a treatment platoon headquarters (see Table 2-53 on page 2-44), a medical treatment squad, a medical evacuation squad, and an early entry element (surgeon section).

**Treatment Platoon Headquarters, Sustainment Brigade**

2-153. The treatment platoon headquarters provides mission command, communications, and resupply for the treatment platoon. The platoon headquarters consists of the medical platoon leader (CPT/O3 AOC 62B00) who is assigned as a member of the medical treatment squad and the section NCO (MOS 68W30/E6) who serves as a member of the medical treatment squad. The brigade surgeon section

provides planning, coordination, and synchronization support of HSS/FHP operations for the treatment platoon.

**Table 2-53. Treatment platoon headquarters, sustainment brigade**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Treatment Platoon Headquarters	62B00	O3	Platoon Leader	MC	0*
	68W3O	E6	Section NCO	NC	1
<b>LEGEND:</b>					
* Platoon leader is accounted for in the medical treatment squad (code 50).					
AOC	area of concentration	NC	noncommissioned		
MC	Medical Corps	NCO	noncommissioned officer		
MOS	military occupational specialist				

### Medical Treatment Squad, Sustainment Brigade

2-154. The medical treatment squad (see Table 2-54) provides Role 1 AHS support for the sustainment brigade. The treatment platoon headquarters and the medical treatment squad together form the Role 1 MTF for the sustainment brigade. The medical treatment squad consists of two medical treatment teams; Alpha and Bravo. While operating as separate teams, one team may operate a separate aid station for up to 72 hours. See paragraph 2-24 for more information concerning medical treatment squad operations.

**Table 2-54. Medical treatment squad, sustainment brigade**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Treatment Squad	62B00	O3	Field Surgeon	MC	1
	65D00	O2	Physician Assistant	SP	1
	68W3O	E6	Health Care SGT	NC	1
	68W2O	E5	Health Care SGT	NC	2
	68W1O	E4	Health Care SPC		1
	68W1O	E3	Health Care SPC		2
<b>LEGEND:</b>					
AOC	area of concentration	SGT	sergeant		
MC	Medical Corps	SP	Army Medical Specialist Corps		
MOS	military occupational specialty	SPC	specialist		
NC	noncommissioned				

### Medical Evacuation Squad, Sustainment Brigade

2-155. The medical evacuation squad (see Table 2-55) provides TC3, en route medical care, and ground medical evacuation from the point of injury to the Role 1 MTF of the sustainment brigade. Ground medical evacuation is provided by the squad with two teams using two M997A2 wheeled ambulances. Medical evacuation to higher roles of care is the responsibility of the sustainment brigade, higher role of care mission command elements, and medical evacuation assets.

**Table 2-55. Medical evacuation squad, sustainment brigade**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Evacuation Squad	68W2O	E5	Emergency Care Sergeant	NC	1
	68W1O	E4	Ambulance Aide/Driver		1
	68W1O	E3	Ambulance Aide/Driver		2
<b>LEGEND:</b>					
AOC	area of concentration				
MOS	military occupational specialty				
NC	noncommissioned				

**Early Entry Element (Surgeon Section)**

2-156. The early entry element, surgeon section (Table 2-56) provides medical staff planning and supervision of AHS support for early entry operations with AHS support and synchronization for follow-on forces. The early entry element surgeon section is not equipped or manned to provide medical care, it is a planning and AHS support coordinating element. This element is dependent upon AHS support within the AO and supporting higher roles of medical care for AHS support.

2-157. The early entry element surgeon section provides MEDLOG support through Class VIII, and required logistics forecasting with coordination of further distribution as required for assigned and attached units conducting AHS support operations in the AO during early entry operations. Medical logistics for follow-on forces is coordinated with required MEDLOG support.

**Table 2-56. Early entry element, surgeon section, sustainment brigade**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Surgeon Section	70H67	O4	Medical Operations Officer	MS	1
	70K67	O3	Medical Logistics Officer	MS	1
	68W50	E8	Operations NCO	NC	1
<b>LEGEND:</b>					
AOC	area of concentration		NC	noncommissioned	
MOS	military occupational specialty		NCO	noncommissioned officer	
MS	Medical Service Corps				

**This page intentionally left blank.**

## Chapter 3

# Planning and Executing Army Health System Operations

To effectively execute AHS operations to support the tactical commander, comprehensive planning and thorough coordination and rehearsal with all elements participating in the operations is essential. To ensure the continuum of care from the point of injury or wounding through successive roles of care is uninterrupted, medical treatment and medical evacuation must be synchronized with all medical functions considered and planned for within the operations process. The importance of the care rendered at the point of injury and in Role 1 and Role 2 MTFs cannot be overstated as it impacts the Soldier's immediate survivability, enhances the opportunities for a favorable recovery, and may reduce the Soldier's long-term disability.

## SECTION I — PLANNING

### PRINCIPLES

3-1. The AHS Principles of conformity, mobility, proximity, flexibility, continuity, and control form the underpinnings upon which every AHS support plan is developed (see paragraph 1-5).

### ARMY MEDICAL DEPARTMENT BATTLE RHYTHM

3-2. The AHS support plan must conform to the tactical commander's operations plan and the AHS planner must thoroughly understand the commander's intent, concept of operation, and guidance provided. The AMEDD battle rhythm is that of the tactical commander. Casualties begin to occur immediately upon engagement with the enemy or potentially sooner, such as during preparations for operations or movement to the line of departure. Due to the necessity to perform lifesaving interventions for Soldiers suffering combat trauma within minutes of wounding or injury, medical resources must be arrayed in close proximity to the forces supported. This also permits the medical assets to rapidly clear the battlefield of casualties and enhances the tactical commander's ability to quickly take advantage of opportunities which present themselves during the battle.

### MOBILITY, SURVIVABILITY, AND SUSTAINABILITY

3-3. Medical units operate across the battlefield and across all of types of terrain. In order for the medical Soldier and medical units to successfully accomplish their mission, medical personnel, vehicles, and equipment must have the same mobility, survivability, and sustainability of those elements used by the fighting force it is supporting. Without comparable vehicles and equipment, the medical force will be unable to maintain the pace set by the combat forces. This may result in lengthening lines of communications, longer medical evacuation distances, and longer response times to provide initial lifesaving interventions at the point of injury or wounding. Sustainability of vehicles has been an issue in recent operations. Mixed fleets of vehicles require maintenance support for varying vehicles types, different repair parts and their accessibility and availability, and in some cases, equipment repairers with specialized skills and knowledge.

### SCARCE MEDICAL RESOURCES AND TASK ORGANIZATION

3-4. Due to constraints in manpower and a smaller medical footprint within the operational area, care must be taken to ensure scarce medical resources are employed in a manner which optimizes their effectiveness and efficiency and maximizes the numbers of patients treated. To realize this goal, AHS

plans must be flexible to stay abreast with changing situations on the battlefield and the medical commander/command surgeon must be empowered to task-organize medical resources and relocate and reallocate these resources to shifting areas of patient density. In fluid operations, units in contact will normally be experiencing the highest combat trauma rates, which require increased surgical capability to stabilize nontransportable patients to withstand the rigors of a lengthy evacuation. To provide the required surgical capability to the unit in contact, the medical commander may have to move an FST collocated with a medical company that is not in contact with the enemy, to augment the unit in contact.

## **SECTION II — EFFECT ON ARMY HEALTH SYSTEM OPERATIONS BY THE OPERATIONAL ENVIRONMENT**

3-5. One of the most important factors affecting operational planning is the effects of terrain and weather on the execution of the operation. This is particularly true with AHS support operations. In addition to the affects it has on all military units, personnel, and equipment such as disrupting transportation, reducing visibility, or deteriorating equipment/reducing shelf life of parts, these affects can shape the character, frequency, and severity of injuries to patients.

### **TERRAIN AND WEATHER**

3-6. The analysis of the type of terrain (both natural and man-made) upon which an operation is to be conducted is an essential step in planning for the operation. Terrain which is difficult to traverse, has natural barriers and impediments, and which changes with weather conditions, can affect how a force is employed and the types of maneuver that can be conducted. From a medical perspective, different terrain features will influence the types and severity of wounds incurred; the medical equipment and supplies required to treat injured or wounded Soldiers; the manner in which medical evacuation operations can be conducted; and the length of time required to evacuate the wounded or injured Soldiers. Additionally, terrain and weather can complicate the treatment of disease and injuries by providing conditions which foster the spread of diseases and infections and providing breeding grounds for disease carrying vectors. Table 3-1 provides different medical considerations for terrain and environmental conditions.

**Table 3-1. Medical considerations for terrain and environmental conditions**

<i>Type of terrain</i>	<i>Environmental consideration</i>	<i>Medical considerations</i>	<i>Medical equipment and supplies required</i>
<p><b>MOUNTAINOUS</b></p> <ul style="list-style-type: none"> <li>• Rugged</li> <li>• Difficult to traverse</li> </ul>	<ul style="list-style-type: none"> <li>• Extreme cold</li> <li>• Altitude</li> <li>• Winds</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of crush injuries, fractures, and concussive injuries from falls.</li> <li>• Potential for high altitude illnesses (rapid ascent to heights over 7,500 feet).</li> <li>• Potential for dehydration and/or heat exhaustion. Enforce water discipline.</li> <li>• Aggravation of sickle cell anemia.</li> <li>• Increased sunburn and snow blindness.</li> <li>• Evacuation by rotary-wing ambulance may not be possible.</li> <li>• All patients should be considered as litter patients on rugged terrain. All litters should be dressed for both warmth and padding.</li> <li>• Medical evacuation is labor intensive. Litter teams are required. Establish litter shuttle system to provide litter bearers with required rest.</li> <li>• Manual evacuation is time consuming. Plan for overnight stops on the evacuation route. Plan to erect warming stations.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased splinting and casting materials.</li> <li>• Additional litters, litter straps, hypothermia kits, and blankets.</li> <li>• Light-weight shelter or improvised shelters for warming stations.</li> <li>• Additional ropes, pitons, hammers, or other mountain climbing equipment.</li> <li>• Personal protective equipment (sunscreen and sunglasses).</li> </ul>
<p><b>JUNGLE</b></p> <ul style="list-style-type: none"> <li>• Thick undergrowth</li> <li>• Swampy</li> <li>• Difficult to traverse</li> </ul>	<ul style="list-style-type: none"> <li>• Hot</li> <li>• Humid</li> <li>• Disease vectors</li> <li>• Poisonous or toxic flora and fauna</li> </ul>	<ul style="list-style-type: none"> <li>• In swampy areas, all patients should be considered litter patients.</li> <li>• Increased immersion injuries and other dermatological conditions (skin rashes).</li> <li>• The hoist with jungle penetrator may be required for evacuation by rotary-wing ambulance.</li> <li>• Field hygiene and sanitation difficult to maintain.</li> <li>• Increased gastrointestinal disease.</li> <li>• Chemoprophylaxis.</li> <li>• Increased stings and bites.</li> <li>• Increased food-, water-, and vectorborne diseases.</li> <li>• Increased disease and nonbattle injury rates.</li> <li>• Increased combat and operational stress reactions.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased requirement for litters.</li> <li>• Hoist with jungle penetrator.</li> <li>• Increased requirement for potable water.</li> <li>• Chemoprophylaxis, as indicated.</li> <li>• Increased requirement for the use of bed nets, insect repellent, hot weather clothing, sunscreen, and sunglasses.</li> <li>• Increased requirement to ensure perishable and dated medical supplies are stored properly. If medical supplies are improperly stored (such as without refrigeration) they will degrade quickly.</li> </ul>
<p><b>URBAN</b></p> <ul style="list-style-type: none"> <li>• Above, at, and below ground level</li> <li>• Rubble and debris</li> </ul>	<ul style="list-style-type: none"> <li>• All weather conditions</li> <li>• Breakdown or disruption of sanitation</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of crush injuries, fractures, and concussive injuries from falls and explosions within confined spaces.</li> <li>• Evacuation by air ambulance may not be possible.</li> </ul>	<ul style="list-style-type: none"> <li>• Axes, crowbars, and other tools may be required to break through barriers.</li> <li>• When by air ambulance evacuation is possible, the hoist may be required to</li> </ul>

**Table 3-1. Medical considerations for terrain and environmental conditions (continued)**

<i>Type of terrain</i>	<i>Environmental consideration</i>	<i>Medical considerations</i>	<i>Medical equipment and supplies required</i>
URBAN (CONTINUED) <ul style="list-style-type: none"> <li>• Isolating effect</li> </ul>		<ul style="list-style-type: none"> <li>• Increased use of improvised litters; casualty evacuation platforms; and buildings of opportunity for Roles 1 and 2 medical treatment facilities.</li> <li>• Isolating effects of rubble and damaged buildings may make locating and acquiring patients more difficult.</li> <li>• Potential for dehydration. Enforce water discipline.</li> <li>• Field hygiene and sanitation difficult to maintain. Increased gastrointestinal disease.</li> <li>• Disruption of sanitation and rubble effects may increase vector breeding grounds.</li> <li>• Increased risk of exposure to unintentional release of toxic industrial materials (such as, combat damage to gas stations, industrial complexes, or laboratory facilities). Toxic and noxious chemical gases may be heavier than air and settle in low-lying areas (such as basements).</li> </ul>	remove patients from the tops of buildings. <ul style="list-style-type: none"> <li>• Special harnesses; portable block and tackle equipment; grappling hooks; collapsible ladders; heavy gloves; and casualty blankets for shielding. This equipment is used to lower casualties from buildings or move them from one structure to another.</li> <li>• Equipment for the safe and quick retrieval from craters, basements, sewers, and subways. Casualties may have to be extracted from under rubble and debris.</li> <li>• Increased requirement for intravenous fluids.</li> </ul>
EXTREME COLD WEATHER	<ul style="list-style-type: none"> <li>• Extremely cold temperatures (below -40° Fahrenheit)</li> <li>• Gale force winds</li> <li>• Blowing snow</li> </ul>	<ul style="list-style-type: none"> <li>• Exposure to extremely cold temperatures and wind make exposure unsurvivable.</li> <li>• Loss of depth perception in total white out conditions.</li> <li>• Increased disease and nonbattle injuries to include—               <ul style="list-style-type: none"> <li>• Cold injuries (ranging from minor to severe frostbite, especially of exposed areas of the body and feet, to hypothermia).</li> <li>• Dehydration and heat exhaustion.</li> <li>• Increased combat and operational stress reactions.</li> </ul> </li> <li>• Patients must be kept warm as effects of the extreme cold can hasten and/or deepen shock.</li> <li>• Blood and intravenous fluids must be kept from freezing while in use.</li> <li>• Ambulance exchange points are established when evacuation times or distances are lengthy.</li> <li>• Augmentation of evacuation platforms and/or the use of casualty evacuation platforms may be required.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased use of shelters to keep patients warm.</li> <li>• Increased use of blankets to dress litters and hypothermia kits to keep patients warm.</li> <li>• Augmentation of ambulances may be required.</li> <li>• Increased potable water supplies may be carried on ambulance platforms.</li> <li>• Increased requirement to ensure perishable and dated medical supplies are stored properly and kept from freezing.</li> </ul>

## SECTION III — ARMY HEALTH SYSTEM SUPPORT TO DECISIVE ACTION

3-7. The AHS supports unified land operations and decisive action with tailorable, modular, responsive, and agile medical support for operations ranging from predeployment operations, initiation of operations to

close out, postdeployment operations, and reset. *Decisive action* is the continuous, simultaneous combinations of offensive, defensive, and stability or defense support of civil authorities tasks (ADRP 3-0). Army forces employ synchronized action proportionate to the mission and informed by a thorough understanding of all the dimensions in an OE. Army Health System support enables and extends the operational reach with tailored AHS support across the range of military operations.

## DECISIVE ACTION

3-8. Decisive action is the continuous and simultaneous application of the combination of the four primary tasks as stated in paragraph 3-7. Tables 3-2 through 3-5 illustrate examples of various tasks that may be required for the accomplishment of missions in an OE.

## OFFENSIVE TASKS

3-9. An *offensive task* is a task conducted to defeat and destroy enemy forces and seize terrain, resources, and population centers (ADRP 3-0). See Table 3-2.

**Table 3-2. Primary tasks, purposes and key Role 1 and 2 medical considerations for offensive tasks**

<i>Primary task</i>	<i>Purposes</i>	<i>Role 1 and Role 2 key medical considerations</i>
<ul style="list-style-type: none"> <li>• Movement to contact</li> <li>• Attack</li> <li>• Exploitation</li> <li>• Pursuit</li> </ul>	<ul style="list-style-type: none"> <li>• Dislocate, isolate, disrupt, and destroy enemy forces.</li> <li>• Seize key terrain.</li> <li>• Deprive the enemy of resources.</li> <li>• Develop intelligence.</li> <li>• Deceive and divert the enemy.</li> <li>• Create a secure environment for stability tasks.</li> </ul>	<ul style="list-style-type: none"> <li>• All medical functions fully synchronized by medical mission command.</li> <li>• Focus of effort: locate, acquire, treat, stabilize, and evacuate.</li> <li>• First aid administered by nonmedical individuals (self- and buddy aid) and enhanced first aid by combat lifesavers.</li> <li>• Tactical combat casualty care procedures by combat medics.</li> <li>• Advanced trauma management by physician and physician assistant, at battalion aid station and Role 2 medical treatment facility.</li> <li>• Resuscitative (damage control) surgery at collocated forward surgical team.</li> <li>• Prevention of endemic and epidemic diseases.</li> <li>• Emergency resupply of Class VIII equipment and supplies may be required by combat lifesavers, ambulances, and battalion aid stations.</li> <li>• Emergency resupply of Class VIII blood and blood products may be required for Role 2 medical treatment facilities and forward surgical teams.</li> </ul>

### Movement to Contact

3-10. In movement to contact medical evacuation is keyed to the tactical plan. Prior deployment of the BSMC ground ambulances with the maneuver battalion’s organic medical platoons, permits uninterrupted

and effective medical evacuation from the BAS to the medical company. A movement to contact operation is executed when there is little or no threat information available. This tactic is designed to develop threat information and informs the commander on the appropriate response to the information as it develops. The medical company and treatment teams from maneuver BASs in support of these operations must maintain their flexibility and be prepared to adjust the AHS support response once contact is established. More information concerning offensive and defensive tasks is found in ADRP 3-90.

### Attack

3-11. The attack is based on a more detailed knowledge of the threat disposition and likely actions. The BCT's actions in contact may be more predictable than the fluid situation of a movement to contact, exploitation, or pursuit. Specific terrain, routes, and avenues of approach can be selected. Units can at least conduct a map reconnaissance of their planned locations and objectives. While there may be AHS support requirements on the approach, the assault on the objective will produce the greatest number of casualties. Some highlights of the attack include—

- High percentage of casualties.
- Casualties are more concentrated in time and space.
- Once the objective is secured, maneuver force treatment teams can move to the objective instead of evacuating patients from the objective to the treatment teams.
- Use of air ambulances to overcome some obstacles may be required.
- High likelihood of wounded enemy prisoner of war or other detainees.

### Exploitation and Pursuit

3-12. Since exploitation and pursuit operations can rarely be planned in detail, medical evacuation operations must adhere to unit tactical standard operating procedures and innovative mission command. Ambulances are positioned well forward to quickly evacuate 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 the Role 2 MTF by supporting ground ambulances from the medical company. These actions are characterized by—

- Fewer casualties.
- Decentralized operations.
- Unsecured evacuation routes.
- Exceptionally long distances for evacuation.
- Increased reliance on convoys and air ambulances.
- More difficult communications.

### DEFENSIVE TASKS

3-13. A *defensive task* is a task conducted to defeat an enemy attack, gain time, economize forces, and develop conditions favorable for offensive or stability tasks (ADRP 3-0). See Table 3-3.

**Table 3-3. Primary defensive tasks, purposes, and key Role 1 and 2 medical considerations for defensive tasks**

<i>Primary task</i>	<i>Purposes</i>	<i>Role 1 and Role 2 key medical considerations</i>
<ul style="list-style-type: none"> <li>• Mobile defense</li> <li>• Area defense</li> <li>• Retrograde</li> </ul>	<ul style="list-style-type: none"> <li>• Deter or defeat enemy offensive operations.</li> <li>• Gain time.</li> <li>• Achieve economy of force.</li> <li>• Retain key terrain.</li> <li>• Protect the populace, critical assets, and infrastructure.</li> <li>• Develop intelligence.</li> </ul>	<ul style="list-style-type: none"> <li>• All medical functions fully synchronized by medical mission command.</li> <li>• Focus of effort: locate, acquire, treat, stabilize, and evacuate.</li> <li>• First aid administered by nonmedical individuals (self- and buddy aid) and enhanced first aid by combat lifesaver.</li> <li>• Tactical combat casualty care procedures by combat medics.</li> <li>• Advanced trauma management by physician and physician assistant at the battalion aid station and Role 2 medical treatment facility.</li> <li>• Resuscitative (damage control) surgery at collocated forward surgical team.</li> <li>• Prevention of endemic and epidemic diseases.</li> <li>• Emergency resupply of Class VIII equipment and supplies may be required to support combat lifesavers, combat medics, ambulances, and battalion aid stations.</li> <li>• Emergency resupply of Class VIII blood and blood products may be required for Role 2 medical treatment facilities and forward surgical teams.</li> <li>• Stability tasks to support the effected civilian population within the defensive perimeter.</li> </ul>

**Mobile Defense**

3-14. The mobile defense combines elements of offensive tasks and defensive tasks requiring an AO of considerable depth. For AHS support operations, this creates challenges in the allocation of support (limited AHS support assets) brought about by the combination of operations (the fixing and striking force), the increase in the area supported, and the potential for prolonged operations. Mobile defense requires a large maneuver formation, normally at division or corps level.

3-15. The decisive action is a counterattack by the striking force, set-up by the fixing force placing enemy forces into position. The fixing force supplements the combat power of the striking force in the counterattack. Some of the medical considerations for the mobile defense include—

- Fluid lines of communication and medical evacuation.
- Casualties concentrated at decisive points in time and space.
- High likelihood of wounded enemy prisoners of war or other detainees.
- Use of air ambulance to overcome obstacles and movement of URGENT AND URGENT-SURG patients to the appropriate MTF.

**Area Defense**

3-16. The focus of the area defense is to retain terrain with the bulk of the force in mutually supporting prepared positions. As in any type of operation, the key to successful defense is the integration and synchronization of all available assets. In an area defense, the likelihood of a MASCAL situation is increased when the enemy possesses the capacity and capability to employ large quantities of munitions and/or the ability to attack in strength at any point or points of the defensive perimeter. An area defense does not imply fixed; the dynamics of the defensive tasks and enemy offensive operations requires agility of the medical evacuation system in both planning and execution. At any point during the area defense, the defensive task turns to predominantly offensive tasks when the commander determines the conditions to regain the initiative have occurred. Medical treatment teams may receive high volumes of casualties when contact with the opposing forces is made and sustained.

**Retrograde**

3-17. The retrograde is a type of defensive task that involves organized movement away from the enemy. Army Health System support organizations and elements echelon their movements to maintain adequate support to the committed force. By echeloning support, the commander maximizes the support the AHS elements provide for the retrograding forces. It is imperative that the AHS support units maintain proximity and capability when participating in retrograde operations. Medical elements supporting the retrograding force must provide rapid evacuation of patients to MTFs. Medical evacuation requirements are especially demanding in the large AO common to the retrograde.

**STABILITY TASKS**

3-18. Stability is an overarching term encompassing various military missions, tasks, and activities conducted outside the U.S. in coordination with other instruments of national power to maintain or reestablish a safe and secure environment, provide essential government services, emergency infrastructure reconstruction, and humanitarian relief.

3-19. Stability tasks (see Table 3-4) are conducted simultaneously with offensive and defensive tasks. At lower echelons of mission command, stability tasks may be conducted independently as part of the higher echelon mission commander’s overall operation plan/order. Refer to ADRP 3-0 and ADRP 3-07 for additional information.

**Table 3-4. Stability tasks**

<i><b>Primary tasks</b></i>	<i><b>Purposes</b></i>	<i><b>Key medical considerations</b></i>
<ul style="list-style-type: none"> <li>• Establish civil security (including security force assistance).</li> <li>• Establish civil control.</li> <li>• Restore essential services.</li> <li>• Support to governance.</li> <li>• Support to economic and infrastructure development.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide a secure environment.</li> <li>• Secure land areas.</li> <li>• Meet the critical needs of the populace.</li> <li>• Gain support for the host nation government.</li> <li>• Shape the environment for interagency and host nation success.</li> <li>• Shape civil conditions.</li> </ul>	<ul style="list-style-type: none"> <li>• Operationally focused Role 1 and Role 2 medical mission command engaged to promote unity of purpose of all engaged medical assets in support of the stability task.</li> <li>• Medical information management to provide and synchronize health risk communication, coordinate multinational forces health service support and force health protection services, interagency medical interoperability, and to document health encounters.</li> <li>• Traditional Army Health System support to a deployed force engaged in stability tasks.</li> <li>• Medical expertise and consultation services to enhance medical capacity building in the public, private, and military health sectors</li> </ul>

**Table 3-4. Stability tasks (continued)**

<i>Primary tasks</i>	<i>Purposes</i>	<i>Key medical considerations</i>
		within the area of operations of the brigade combat team. <ul style="list-style-type: none"> <li>• Development of operationally focused (medical capabilities and responsibilities in the operational area inherent in Role 1 and Role 2 organizations) AHS support to stability tasks.</li> <li>• Synchronization of Role 1 and Role 2 Army Health System support plans and operations aimed at mitigating or resolving the underlying causes of health issues prevalent within the operational area.</li> <li>• Augmentation of medical equipment sets with pediatric, geriatric, and obstetrics equipment and medical supplies.</li> </ul>

**Establish Civil Security**

3-20. Establishing civil security involves providing for the safety of the host nation and its population, including protection from internal and external threat; it is essential to providing a safe and secure environment.

3-21. The establishment of civil security is the primary task foundational to all of the support to stability tasks; thus, this task requires the greatest expenditure of resources. The enforcement of peace agreements, conducting disarmament, demobilization, and reintegration brings great potential for the need for AHS activities in support of the tasks. Planning and coordination for the required AHS support activities is required prior to commencing this stability task.

**Establish Civil Control**

3-22. Establishing civil security is the first task of military forces in a stability operation; they must also reestablish civil control without the restoration of civil control, civil security cannot be maintained. Combined with governance and civil security, civil control is an essential element of security sector reform.

**Restore Essential Services**

3-23. Efforts to restore essential services ultimately contribute to achieving a stable democracy, a sustainable economy, and the social well-being of the population.

3-24. The AMEDD has historically conducted foreign humanitarian assistance operations when deployed in overseas areas. In some operations, medical forces may be deployed prior to deployment of maneuver forces, as medical forces due to the humanitarian nature of their activities, may be more acceptable to a host nation than the deployment of maneuver forces. In early stages of humanitarian efforts, Role 1 and Role 2 capability may have to stand alone especially in disaster relief, as higher roles of care (Role 3 CSH) are deployed later (if employed) in the humanitarian operation due to mobility concerns (weight and cube) with the Role 3 MTFs.

3-25. Restoration of essential services is based upon the requirement for a baseline of services for a functioning civil society. Medical capabilities are normally required in restoring essential services and are interconnected with effective sewage removal and treatment, the availability of potable water, the functionality and dependability of electricity, trash removal and disposal, and safety.

3-26. Coordination with the appropriate civil affairs staff is essential for effective and efficient implementation of AHS support to stability tasks in an AO. The civil affairs staff is the link between the civil authorities, the local populace, and U.S. support for stability tasks.

**Support to Governance**

3-27. Military efforts combined with the host nation enable the development of an open political process that enables a free press and a functioning civil society operating in concert with legitimate legal and constitutional frameworks. That is the goal of the support to governance stability tasks.

**Support to Economic and Infrastructure Development**

3-28. The military efforts support economic stabilization and infrastructure repair and development. The local efforts support the integration and development of a broad national recovery. This effort must reduce and eliminate as much as possible causing disruptions to the local economy no matter how unintended they may be.

**DEFENSE SUPPORT OF CIVIL AUTHORITIES TASKS**

3-29. Army forces demonstrate the Army’s core competencies by combining offensive, defensive, and stability or defense support of civil authorities tasks. Refer to ADRP 3-28 for further information. In defense support of civil authorities tasks (Table 3-5), Army forces support civil authorities with proper authorization at the local, state, and federal levels. In defense support of civil authorities tasks, Army forces provide essential support, services, or specialized resources to help civil authorities deal with situations beyond their capabilities. The purpose of defense support of civil authorities tasks is to meet the immediate needs of designated groups for a limited time until civil authorities can do so without Army assistance. Unlike support to stability tasks, defense support of civil authorities may be conducted as an independent operation (see ADRP 3-0).

**Table 3-5. Defense support of civil authorities tasks**

<i>Primary tasks</i>	<i>Purposes</i>	<i>Key medical considerations</i>
<ul style="list-style-type: none"> <li>• Provide support for domestic disasters.</li> <li>• Provide support for domestic chemical, biological, radiological, and nuclear incidents.</li> <li>• Provide support for domestic civilian law enforcement agencies.</li> <li>• Provide other designated support.</li> </ul>	<ul style="list-style-type: none"> <li>• Save lives.</li> <li>• Restore essential services.</li> <li>• Maintain or restore law and order.</li> <li>• Protect infrastructure and property.</li> <li>• Maintain and restore local government.</li> <li>• Shape the environment for interagency success.</li> </ul>	<ul style="list-style-type: none"> <li>• Medical mission command to coordinate, integrate, and synchronize Army Health System resources into interagency efforts focused on defense support to civil authorities.</li> <li>• Provide medical expertise to identify and analyze critical emerging medical needs within the operational area.</li> <li>• Medical information management to facilitate medical regulating of victims to medical facilities outside of the disaster/incident area and document medical treatment provided.</li> <li>• Assist the affected medical infrastructure in saving lives and alleviating human suffering.</li> <li>• Assist the local government in conducting rescue, triage, medical treatment, and provide medical evacuation of victims to facilities</li> </ul>

**Table 3-5. Defense support of civil authorities tasks (continued)**

<i>Primary tasks</i>	<i>Purposes</i>	<i>Key medical considerations</i>
		capable of providing the required health care. • Provide preventive medicine measures to respond to and resolve emerging health threats caused by the disaster/incident.

**Provide Support for Domestic Disasters**

3-30. Natural and man-made disasters occur throughout the U.S. and its territories. Some disasters provide advance warning (such as hurricanes, ice storms, or volcanic eruptions). Other disasters such as an earthquake or a chemical spill usually provide no warning.

**Provide Support for Domestic Chemical, Biological, Radiological, or Nuclear Incidents**

3-31. A *chemical, biological, radiological, or nuclear incident* is any occurrence, resulting from the use of chemical, biological, radiological, and nuclear weapons and devices; the emergence of secondary hazards arising from counterforce targeting; or the release of toxic industrial materials into the environment, involving the emergence of chemical, biological, radiological, and nuclear hazards (JP 3-11).

3-32. In the context of homeland security, counterforce targeting is not applicable, but preparation for terrorist attacks is a significant factor.

**PROVIDE SUPPORT FOR DOMESTIC CIVILIAN LAW ENFORCEMENT AGENCIES**

3-33. Providing support for domestic civilian law enforcement agencies applies to the restricted use of military assets to support civilian law enforcement personnel within the U.S. and its territories. Unlike operations outside of the U.S., these operations are significantly different—Army forces support domestic civilian law enforcement agencies under strict constitutional and statutory restrictions, as prescribed by corresponding directives and regulations. For additional information, see Department of Defense Instruction 3025.21.

**PROVIDE OTHER DESIGNATED DOMESTIC SUPPORT**

3-34. Providing other designated domestic support encompasses preplanned, routine, and periodic support not related to disasters or emergencies.

3-35. Army Health System support for defense support of civil authorities will include both medical operating forces (Roles 1, 2, and/or 3) and the generating force. The U.S. Army Medical Command is the mission command headquarters for all table of distribution and allowances MTFs and Army medical research facilities within the U.S.

**This page intentionally left blank.**

## Chapter 4

# Medical Company (Area Support)

The MCAS provides Role 2 AHS support within its assigned AO, as well as unit-level (Role 1) support for assigned and attached units without organic Role 1 capability. Modular in design, the MCAS can task-organize and is tailorable to the OE and mission requirements in support of unified land operations. The MCAS normally is assigned to an MMB.

### SECTION I — MEDICAL COMPANY (AREA SUPPORT)

4-1. For illustrative purposes, this section is based upon the MCAS (see Figure 4-1).

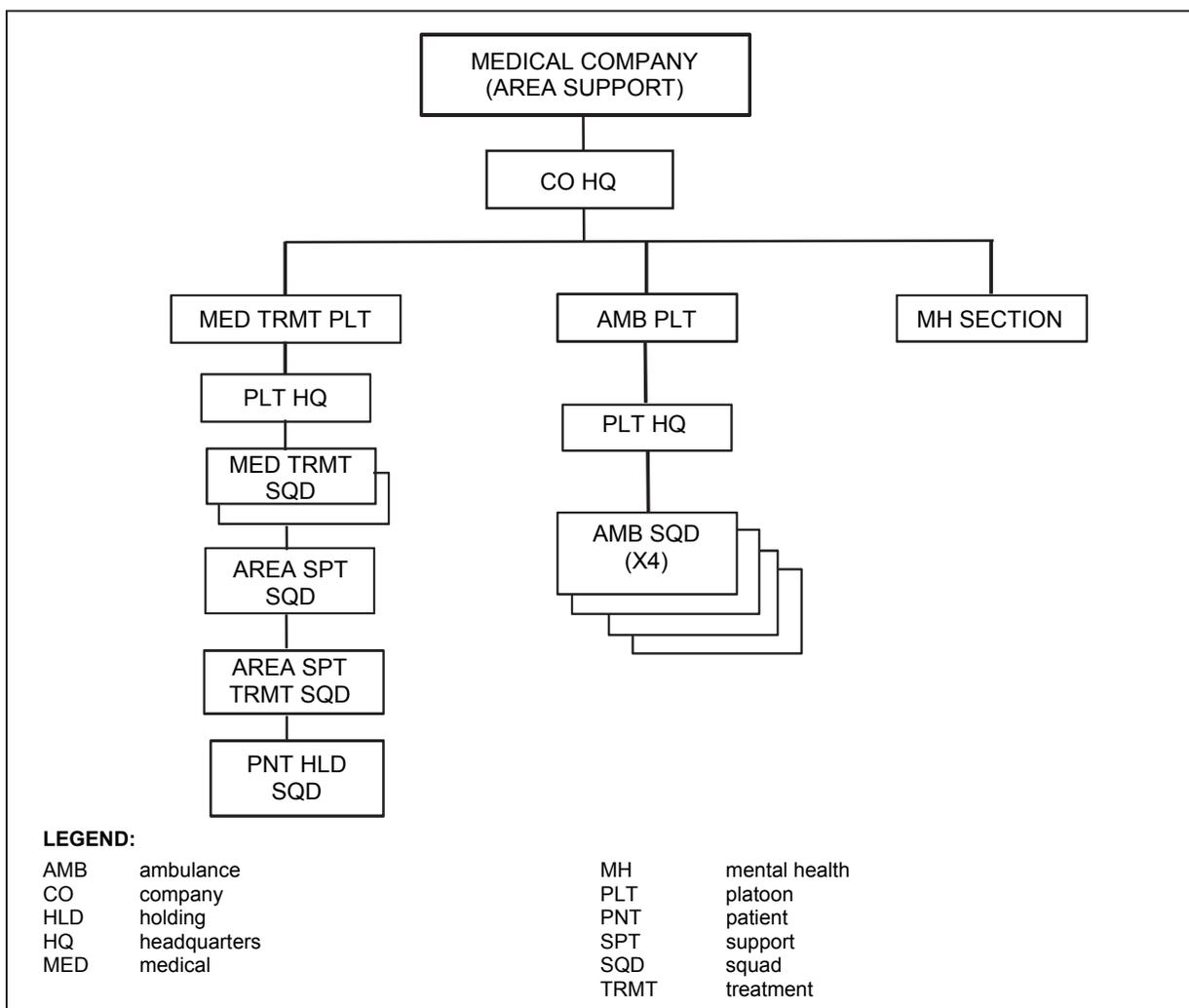


Figure 4-1. Medical company (area support)

## MISSION

4-2. The MCAS provides Role 1 and Role 2 AHS support to units located in its AO. Role 1 AHS support is provided to organizations without organic Role 1 AHS support and the MCAS provides Role 2 AHS support on an area support basis for all assigned and attached organizations.

## ASSIGNMENT AND DEPENDENCIES

### ASSIGNMENT

4-3. The MCAS is assigned to the headquarters and headquarters detachment of the MMB.

### DEPENDENCIES

4-4. The MCAS is dependent upon—

- Appropriate elements of the theater for religious, legal, finance, personnel, and administrative services.
- Forward surgical teams for surgical augmentation of nontransportable patients requiring surgical intervention in preparation for medical evacuation by air ambulance.
- Medical logistics company for Class VIII support and medical equipment maintenance and repair capability.
- Medical company (air ambulance) for rotary-wing air ambulance support.
- Medical (ground ambulance) company for ground medical evacuation.

## BASIS OF ALLOCATION

4-5. The MCAS is allocated on the basis of 1 per 10,000 non-BCT troops supported in the committed brigade headquarters area and/or division and corps headquarters AO.

## MOBILITY

4-6. This unit requires 100 percent mobility of its TOE equipment to be transported in a single lift using organic vehicles.

## CAPABILITIES

4-7. This unit provides—

- Mission command of attached units which include medical planning and coordination of patient movement within and outside of the MCAS's AO.
- Treatment of patients with DNBI, COSR, triage of mass casualties, emergency medical treatment, ATM, initial resuscitation and stabilization, and preparation for further evacuation of patients incapable of returning to duty within 72 hours.
- Treatment squads capable of breaking down into two treatment teams than can operate independently of the MCAS for a limited time.
- Medical evacuation (ground) for patients from units within the MCAS's AO to the treatment squads of the MCAS.
- Operational dental care consisting of emergency and essential dental care designed to circumvent dental emergencies.
- Emergency Class VIII supply/resupply to supported units operating within the AO of the MCAS.
- Unit-level field maintenance on the unit's organic vehicles and power equipment.
- Behavioral health consultation and support, including coordinating operations of COSC elements operating within the AO of the MCAS.
- Medical laboratory and radiology services commensurate with Role 2 MTFs.

- Outpatient consultation services for patients referred from Role 1 MTFs.
- Food service support for staff and patients and other medical elements dependent upon the MCAS for support. See *note* below for additional information.
- Patient holding for up to 40 patients able to return to duty within 72 hours.

4-8. Soldiers assigned to this organization are provided weapons for personal defense and protection of the patients under their care.

4-9. This unit does not possess organic medical maintenance capability.

4-10. Food service personnel are responsible for providing food service support to patients and staff. Advance dietary support is available at Role 3 MTFs. See *note* below concerning food service personnel.

---

*Note.* Food service personnel (MOS 92G) assigned to the Role 2 MCAS are not trained or provisioned to provide special diets. Patients requiring advanced dietary support or special diets are evacuated to Role 3 (CSHs) where both patient rations and personnel trained to support dietary needs are available. In the AO, only CSHs have the trained personnel (dietitians and nutrition care specialists) to provide the dietary support needed. Dietitians (AOC, 65C) and nutrition care specialists (MOS, 68M) are assigned to the CSHs. Food service personnel conduct food service operations according to Army Tactics, Techniques, and Procedures (ATTP) 4-41.

---

## ORGANIZATION AND FUNCTIONS

4-11. The MCAS is composed of four main subelements contributing its role as a Role 2 MTF with functions running the gamut from mission command to the medical treatment platoon.

### COMPANY HEADQUARTERS

4-12. The company headquarters (see Table 4-1 on page 4-4) provides mission command for the company and attached medical units. The company provides for general classes of supply and emergency Class VIII supply/resupply, food services, small arms maintenance, vehicle maintenance, power generator repair, CBRN defense operations, and communications equipment support to organic and attached elements. The command element conducts MCAS operations within its AO. The command element, commander (MAJ/O4, AOC 05A00), field medical assistant, and the first sergeant is responsible for the provision of billeting, security, training, administration, and discipline of assigned personnel.

Table 4-1. Company headquarters

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Company Headquarters	05A00	O4	Commander	IMM	1
	70B67	O3	Field Medical Assistant	MS	1
	68W5M	E8	First Sergeant	NC	1
	68J3O	E6	Medical Logistics Sergeant	NC	1
	92G3O	E6	Food Operations Manager	NC	1
	91B2O	E5	Wheeled Vehicle Mechanic	NC	1
	92G2O	E5	Food Operations NCO	NC	1
	92Y2O	E5	Supply NCO	NC	1
	25U1O	E4	Forward Signal Support Specialist		1
	25U1O	E4	Signal Support System Maintenance		1
	74D1O	E4	CBRN Specialist		1
	91B1O	E4	Wheeled Vehicle Mechanic		1
	91D1O	E4	Power-Generation Equipment Repairer		1
	92G1O	E4	Food Operations Specialist		1
	92Y1O	E4	Supply Specialist		1
	91B1O	E3	Wheeled Vehicle Mechanic		1
92G1O	E3	Food Operations Specialist		1	
<b>LEGEND:</b>					
AOC	area of concentration		MS	Medical Service Corps	
CBRN	chemical, biological, radiological, and nuclear		NC	noncommissioned	
IMM	branch immaterial		NCO	noncommissioned officer	
MOS	military occupational specialty				

## MENTAL HEALTH SECTION

4-13. The mission of the mental health section (see Table 4-2) is to support commanders in the prevention and control of COSR. The section accomplishes this task by providing training and advice in the control of stressors, the promotion of positive combat stress behaviors, and the identification and management of negative COSRs. The mental health section provides care at the Soldier's location as much as possible. Treatment is more efficient and effective in reducing lost time by minimizing the evacuation of a Soldier out of his unit and support chain. It coordinates COSC training for supported units through the MCAS commander and/or the MMB. The mental health section collects and records social and psychological data and counsels personnel with personal, behavioral, or psychological problems. In addition, personnel of the mental health section refer Soldiers to higher roles of care when indicated, and provide individual case consultation to commanders, NCOs, chaplains, command surgeons, and PAs within the supported AO.

Table 4-2. Mental health section

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Mental Health Section	67D00	O3	Behavioral Science Officer	MS	1
	68X1O	E4	Behavioral Health Specialist		1
<b>LEGEND:</b>					
AOC	area of concentration		MS	Medical Service Corps	
MOS	military occupational specialty				

## MEDICAL TREATMENT PLATOON

4-14. The medical treatment platoon receives, triages, treats, and determines the disposition of patients in the MCAS's AO. The medical treatment platoon is composed of the medical treatment platoon headquarters, a medical treatment squad, the area support squad, the area support treatment squad, and the patient holding squad, these elements compose the core of the MCAS's Role 2 MTF.

### Medical Treatment Platoon Headquarters

4-15. The medical treatment platoon headquarters (see Table 4-3) directs, coordinates, and supervises platoon operations. The medical treatment platoon leader assumes command of the company when the commander is absent. The headquarters element directs the activities of the MCAS Role 2 MTF and monitors Class VIII supplies and inventory levels, blood usage, and keeps the commander informed of the status of the platoon AHS support capabilities. The headquarters element is also responsible for operational security, communications, administration, training, patient accountability, statistical reporting functions, and coordination for patient evacuation. The platoon headquarters is responsible for coordinating the movement and Class VIII resupply of treatment squads within the MCAS's AO.

**Table 4-3. Medical treatment platoon headquarters, medical company (area support)**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Medical Treatment Platoon Headquarters	62B00	O4	Platoon Leader	MC	0*
	70B67	O2	Field Medical Assistant	MS	1
	68W4O	E7	Platoon Sergeant	NC	1
	68G1O	E4	Patient Administration Specialist		1
<b>LEGEND:</b>					
* Platoon leader is accounted for in area support treatment squad (code 50)					
AOC area of concentration		MS Medical Service Corps			
MC Medical Corps		NC noncommissioned			
MOS military occupational specialty					

### Medical Treatment Squad

4-16. The medical treatment squad (see Table 4-4) consists of two treatment teams that provide emergency care, ATM, and routine sick call for Soldiers assigned to supported units without organic medical support within the MCAS's AO. When positioned with the MCAS, the medical treatment squad personnel work in the MCAS's Role 2 MTF. The medical treatment squads/teams must be prepared for short-notice deployment away from the MCAS. The squad has the ability to split and operate as two separate teams for limited periods of time, for up to 72 hours. They can be assigned to reinforce or reconstitute similar treatment squads/teams.

**Table 4-4. Medical treatment squad, medical company (area support)**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Treatment Squad	62B00	O3	Field Surgeon	MC	2
	65D00	O3	Physician Assistant	SP	2
	68W3O	E6	Health Care Sergeant	NC	2
	68W2O	E5	Health Care Sergeant	NC	4
	68W1O	E4	Health Care Specialist		2
	68W1O	E3	Health Care Specialist		4
<b>LEGEND:</b>					
AOC area of concentration		NC noncommissioned			
MC Medical Corps		SP Army Medical Specialty Corps			
MOS military occupational specialty					

### Area Support Squad

4-17. The area support squad (see Table 4-5 on page 4-6) includes a dental element, a radiology element with field radiology capabilities, and a medical laboratory element. The area support squad provides basic services commensurate with Role 2 medical treatment.

4-18. The dental element provides emergency dental care (to include treatment of minor maxillofacial injuries), operational dental care (designed to prevent or intercept potential dental emergencies), limited dental preventive dentistry, consultation services, and dental radiology services.

4-19. The radiology element operates radiology equipment consistent with the Role 2 MTF medical equipment set and radiologic personnel capabilities. This element performs routine clinical radiology procedures to aid physicians and PAs in the diagnosis and treatment of patients.

4-20. 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 basic laboratory procedures consistent with the Role 2 MTF laboratory medical equipment set and personnel.

**Table 4-5. Area support squad, medical company (area support)**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Area Support Squad	63A00	O3	General Dental Officer	DC	1
	68E1O	E4	Dental Specialist		1
	68P2O	E5	Radiology Sergeant	NC	1
	68K2O	E5	Medical Laboratory Sergeant	NC	1
	68K1O	E4	Medical Laboratory Specialist		1
	68P1O	E4	Radiology Specialist		1
<b>LEGEND:</b>					
AOC area of concentration		MOS military occupational specialty			
DC Dental Corps		NC noncommissioned			

**Area Support Medical Treatment Squad**

4-21. The area support medical treatment squad (Table 4-6) is the core element of the medical treatment platoon’s MTF. Unlike the medical treatment squad, this element does not deploy from the MCAS Role 2 MTF. It is the base element of the medical treatment platoon. The squad provides routine sick call services and initial resuscitative treatment, emergency medical treatment and ATM for supported units. This squad operates the MCAS’s Role 2 MTF and is not used to reinforce or reconstitute other medical units.

**Table 4-6. Area support medical treatment squad, medical company (area support)**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Area Support Medical Treatment Squad	62B00	O4	Field Surgeon	MC	1*
	65D00	O4	Physician Assistant	SP	1
	68W3O	E6	Health Care Sergeant	NC	1
	68W2O	E5	Health Care Sergeant	NC	2
	68W1O	E4	Health Care Specialist		2
	68W1O	E3	Health Care Specialist		2
<b>LEGEND:</b>					
* Code 50, dual hatted in field surgeon/platoon leader paragraphs					
AOC area of concentration		NC noncommissioned			
MC Medical Corps		SP Army Medical Specialist Corps			
MOS military occupational specialty					

**Patient Holding Squad**

4-22. The patient holding squad (Table 4-7) operates the patient holding facility of the MCAS MTF. The patient holding squad is staffed and equipped to provide care for up to 40 patients for no longer than 72 hours. Normally, only those patients waiting evacuation or those requiring treatment for minor illness or injury are placed in the patient holding area. Neuropsychiatric patients and COSC patients, who are expected to return to duty within 72 hours, may also be placed in the patient holding area.

4-23. The medical-surgical nurse assigned to the patient holding squad provides nursing supervision and is responsible for the operation of the patient holding facility. The medical-surgical nurse is capable of providing and augmenting AHS support by the provision of professional expertise outside of the patient holding squad. Since Role 2 facilities, such as the MCAS patient holding squad, do not have admission

capability, patients may only be held at this facility and are not counted as hospital admissions. If recovery and/or return to duty is not expected in 72 hours, the patients are sent to a Role 3 CSH for admission.

**Table 4-7. Patient holding squad, medical company (area support)**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Patient Holding Squad	66H00	O3	Medical-Surgical Nurse	AN	1
	68W2O	E5	Health Care Sergeant	NC	1
	68W1O	E4	Health Care Specialist		1
	68W1O	E3	Health Care Specialist		1
<b>LEGEND:</b>					
AOC	area of concentration		MOS	military occupational specialty	
AN	Army Nurse Corps		NC	noncommissioned	

## AMBULANCE PLATOON

4-24. The ambulance platoon performs ground medical evacuation and en route patient care for supported units. The ambulance platoon consists of a platoon headquarters and four ambulance squads capable of being split into eight ambulances teams.

### Ambulance Platoon Headquarters

4-25. The ambulance platoon headquarters (Table 4-8) directs and coordinates ground medical evacuation within the MCAS'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 MCAS. The ambulance platoon headquarters element develops ground medical evacuation routes by map or ground reconnaissance and also develops and issues strip maps, as appropriate. The platoon headquarters also coordinates and establishes AXP's for both air and ground medical evacuation as required.

**Table 4-8. Ambulance platoon headquarters, medical company (area support)**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Ambulance Platoon Headquarters	70B67	O2	Platoon Leader	MS	1
	68W4O	E7	Platoon Sergeant	NC	1
<b>LEGEND:</b>					
AOC	area of concentration		MS	Medical Service Corps	
MOS	military occupational specialty		NC	noncommissioned	

### Ambulance Squads (Wheeled)

4-26. The ambulance squads (wheeled) (see Table 4-9 on page 4-8) provide ground medical evacuation of patients from units and organic aid stations within the supported AO of the MCAS. Ambulance squad personnel perform emergency medical treatment, evacuate patients, and provide for continued medical care en route. They operate and maintain assigned equipment. Ambulance squad personnel maintain Class VIII supply levels for the ambulance medical equipment set, as well as maintaining general classes of supply required for the operation of the ambulance squad.

**Table 4-9. Ambulance squads (wheeled), medical company (area support)**

<i>Paragraph title</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Ambulance Squad (Wheeled)	68W20	E5	Emergency Care Sergeant	NC	4
	68W10	E4	Ambulance Aide/Driver		4
	68W10	E3	Ambulance Aide/Driver		8
<b>LEGEND:</b>					
AOC area of concentration		NC noncommissioned			
MOS military occupational specialty					

## **SECTION II — COMPARISON OF MEDICAL COMPANY (BRIGADE SUPPORT BATTALION) AND MEDICAL COMPANY (AREA SUPPORT)**

4-27. The structure of the MCAS has a number of significant differences in capability when compared to the BSMC. The MCAS—

- Does not have organic PVNTMED, physical therapy, or medical equipment maintenance and repair capabilities.
- Has a limited behavioral health capability as it has only one behavioral health officer and one behavioral health specialist.
- Has a limited CBRN defensive capability with only one assigned CBRN specialist in the headquarters.
- Has a smaller medical evacuation capability/capacity than the BSMC as it has three fewer ambulances and assigned crews.
- Has a more robust increase in food service capability with the assignment of four additional food services NCOs and specialists in the headquarters.
- Has an increase in vehicle maintenance capability with the assignment of four additional motor maintenance personnel (NCOs and mechanics).
- Has additional communications support capabilities with the assignment of two additional signal personnel.
- Has a power generation maintenance support capability with the assignment of a power generation equipment repairer.
- The MEDLOG staff that forms the brigade medical supply office (to include the pharmacy specialist). There is one medical supply sergeant in the headquarters of the MCAS.

## **Appendix A**

# **Mass Casualty Operations**

Mass casualty situations occur when the number of casualties exceeds the available medical capability to rapidly treat and evacuate them. Therefore, the actual number of casualties required before a MASCAL situation is declared varies from situation to situation depending upon the availability of AHS resources. This appendix provides a description of how to establish a MASCAL station. Due to the complexity of the MASCAL station and the number of personnel involved, the entire station may not be established at the medical company level. The AHS planner should, therefore, modify the station based on the specific unit's needs. Further, this station is not practical at the BAS. When faced with a MASCAL situation at the BAS, the important aspects for managing a MASCAL situation are establishing control, organizing activities, and sorting of patients (triage). Effective sorting will enhance the physician's ability to maximize the use of his time and resources on those patients who would receive the most benefit from medical intervention.

### **MASS CASUALTY MANAGEMENT**

A-1. Mass casualty situations are normally chaotic and may include the full range of casualties from minor injuries to life-threatening injuries. All casualties will have some degree of pain and will be in distress either physically or emotionally. Casualties may present with a single wound, multiple wounds, or wounds from combined sources such as blast injuries in a nuclear detonation resulting in both traumatic injury and radiation-related conditions. Additionally, there may be some personnel who are dazed and wandering through the area disrupting operations or uninjured Soldiers looking for a buddy.

#### **PLANNING**

A-2. To ensure effective management of MASCAL situations, the AHS planner must develop and rehearse a MASCAL plan for the unit. The MASCAL plan should include considerations for establishing the station in a noncontaminated environment and establishing the station when a patient decontamination station is required to be collocated with the MASCAL station.

#### **REHEARSING**

A-3. The MASCAL plan must be rehearsed on a periodic basis. Rehearsing the plan is essential to ensure that all personnel know their roles and responsibilities during a MASCAL situation. A well-rehearsed plan enables the medical element to quickly gain control of a chaotic situation, establish a well-organized and efficient MASCAL station, and maximize the use of scarce resources. Repeated rehearsals of establishing the MASCAL station ensures that medical personnel can establish the station quickly and effectively with a minimum amount of supervision and instructions.

A-4. Nonmedical personnel assigned to the unit should be trained in the proper techniques for loading, carrying, and unloading litters. This training will enhance their ability to perform the task of transporting patients correctly; using the proper techniques will reduce physical fatigue and the risk of injury to the litter bearers. Nonmedical personnel can also serve as messengers throughout the station and/or provide security and control within the station.

## TRIAGE CATEGORIES

A-5. Triage is the dynamic process of medically sorting patients by the type and seriousness of the injury, the likelihood of survival, priority of treatment and evacuation, the limitations of the current situation, the mission, and available resources (time, equipment, supplies, personnel, and evacuation). This process is accomplished keeping in mind that triage is a dynamic process, in that it continues from initial triage, reassessment, and continued assessment of the patient throughout the medical treatment and medical evacuation system. Triage ensures that medical resources are used to provide care for the greatest benefit to the largest number of casualties, saving the most lives, limbs, and eyesight possible given limited resources and time available.

### TRIAGE OF CONVENTIONAL WOUNDS AND INJURIES

A-6. Triage (sorting) is the process of prioritizing or rank ordering of wounded Soldiers on the basis of the individual needs for surgical intervention. The likely outcome of the individual casualty must be factored into the decision process prior to the commitment of limited medical resources. Casualties are generally sorted into four categories (or priorities). These priority groupings are discussed in decreasing order of surgical urgency.

#### **Triage Category: IMMEDIATE**

A-7. The IMMEDIATE triage category is for the patient whose condition demands immediate, resuscitative treatment. An example of this treatment is the control of hemorrhage from an extremity. Generally, the procedures used are short in duration and economical in terms of medical resources and should concern only those patients with high chances for survival. (Approximately 20 percent of the casualties are normally in this category.)

#### **Triage Category: DELAYED**

A-8. Casualties in the DELAYED category can tolerate delay prior to time-consuming operative intervention without unduly compromising the likelihood of a successful outcome. When surgical/medical resources are overwhelmed, Soldiers in this category are held until the IMMEDIATE cases are treated. (Approximately 20 percent of the casualties are normally in this category.) Sustaining treatment will be required such as stabilizing intravenous fluids, splinting, administration of antibiotics, and relief of pain amongst other medical interventions. An example of this category is a stable abdominal wound with probable visceral injury but no significant hemorrhage. These cases may go unoperated for 8 to 10 hours, after which there is a direct relationship between time lapsed and the advent of complications. Other examples include—

- Soft tissue damage requiring debridement.
- Maxillofacial wounds without airway compromise.
- Vascular injuries with adequate collateral circulation.
- Genitourinary tract disruption.
- Fractures requiring operative manipulation, debridement, and external fixation.
- Eye and central nervous system injuries.
- Large muscle wounds.
- Fractures of major bones.
- Intra-abdominal and/or thoracic wounds.
- Burns less than 50 percent of total body surface area.

#### **Triage Category: MINIMAL**

A-9. These casualties have relatively minor injuries that are so superficial that they require no more than cleansing, minimal debridement, administration of antibiotics or prophylactic vaccines, and first aid type dressings. They must be rapidly directed away from the triage area to uncongested areas where first aid is available. Most of the injured in this category are ambulatory. Medical providers should query casualties

concerning their exposure to a potentially concussive incident and document the event in the Soldier's individual medical record. Examples include—

- Burns of less than 15 percent of total body surface area with the exception of those involving the face, hands, and genitalia.
- Upper extremity fractures.
- Sprains.
- Abrasions.
- Behavioral health issues, such as COSR.

### **Triage Category: EXPECTANT**

A-10. Casualties in the EXPECTANT category have wounds that are so extensive that even if they were the sole casualty and had the benefit of optimal medical resource application, their survival would be unlikely. During a MASCAL situation, this type of casualty would require an unjustifiable expenditure of medical resources depriving other Soldiers with a higher probability of surgical/medical rescue. The EXPECTANT casualties should be segregated from the view of other casualties; however, they must not be abandoned. Above all, one attempts to make them comfortable by whatever appropriate means necessary and provide attendance by a minimal, but competent staff. (Approximately 20 percent of the casualties are normally in this category.) Examples of this category include—

- Unresponsive patients with penetrating head wounds.
- High spinal cord injuries.
- Mutilating explosive wounds involving multiple anatomical sites and organs.
- Second and third degree burns in excess of 60 percent total body surface area.
- Profound shock with multiple injuries.
- Agonal respiration.

### **TRIAGE OF CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR CASUALTIES**

A-11. For an in-depth discussion of sorting casualties exposed to CBRN warfare agents, refer to FM 4-02.7.

### **MASS CASUALTY STATION**

A-12. The MASCAL station is established and organized to rapidly and effectively process incoming casualties during a MASCAL situation. In addition to sorting patients and establishing a priority for medical treatment and/or medical evacuation, the MASCAL station must also finalize patient documentation and other administrative actions required.

### **CONTROL ELEMENT**

A-13. The MTF commander designates the personnel who will staff the control element. This element is responsible for—

- Implementing the plan.
- Establishing security.
- Limiting access to the MASCAL station area.
- Monitoring and regulating ongoing activities.
- Coordinating medical resource augmentation.
- Providing informational updates/briefs, as required.

A-14. Communication with the triage, treatment, and holding areas is absolutely essential to accomplish the coordination and control of ongoing activities. If telephone/radio communications are not available, a messenger system is employed using a number of the nonmedical unit personnel for this function.

## **ESTABLISHING TRIAGE, TREATMENT, AND HOLDING AREAS**

A-15. Depending on the tactical situation or the location of the MASCAL situation, the triage, treatment, and holding areas may be established in the existing MTF, an available shelter, or outdoors.

### **Using the Existing Medical Treatment Facility**

A-16. When the existing MTF is used, the triage area should afford easy access for incoming litter bearer teams, ground and air ambulances, and nonmedical transportation assets. Sufficient space must be allocated for ambulance turnaround to ensure a smooth and efficient flow of traffic. The requirements are normally met with the established layout of the MTF; however, depending on the number of casualties being received, additional space may be required to accommodate the patient flow. Weather could also affect the effectiveness and efficiency of the flow of traffic to the MTF's triage area. Litter stands (both standard and/or improvised) should be established for placing casualties to be triaged. At a minimum, two should be established with a triage officer between the stations. Resuscitation and vascular volume replacement are initiated in the triage area, if required. The flow of wounded/injured into the triage area must be controlled. An increase in the noise level and confusion may result if too many casualties are brought into the triage area at one time. These factors can adversely impact on the ability of the medical personnel to thoroughly evaluate and prioritize each casualty.

A-17. Within the MTF, specific areas are designated for each of the triage categories, personnel pools, and control elements. Additionally, internal traffic routes to the x-ray area, the laboratory area, the preoperative area, recovery area, and holding areas (if augmented by an FST) must be identified. Surgical procedures are limited to those required to save life and stabilize nontransportable patients for medical evacuation.

A-18. Preferably, holding areas for each of the four triage categories should be established; however, the exception is the EXPECTANT category. The EXPECTANT category must be segregated from and out of sight of the other triage categories, if at all possible.

A-19. The various holding areas should be marked. Marking may be accomplished with the use of different color panels or a numbering system. The marking system used should function during good visibility, as well as during periods of poor visibility. Materials used for marking purposes should be prepared when the MASCAL plan is developed and stored until required for use.

A-20. Two personnel pools should be designated, one for medical personnel and one for nonmedical personnel. The MTF commander should designate those individuals who will supervise the management of those pools. As unit personnel complete tasks, shifts, or other duties, they report back to the appropriate personnel pool area. Using this system ensures the efficient use of available resources and permits the reallocation of resources as requirements change. The MINIMAL category of patients can be used as an additional manpower pool while waiting transportation back to their units. They, with minimal training or briefing can act as runners, litter bearers, or guides to free up medical personnel so they can attend to medical tasks.

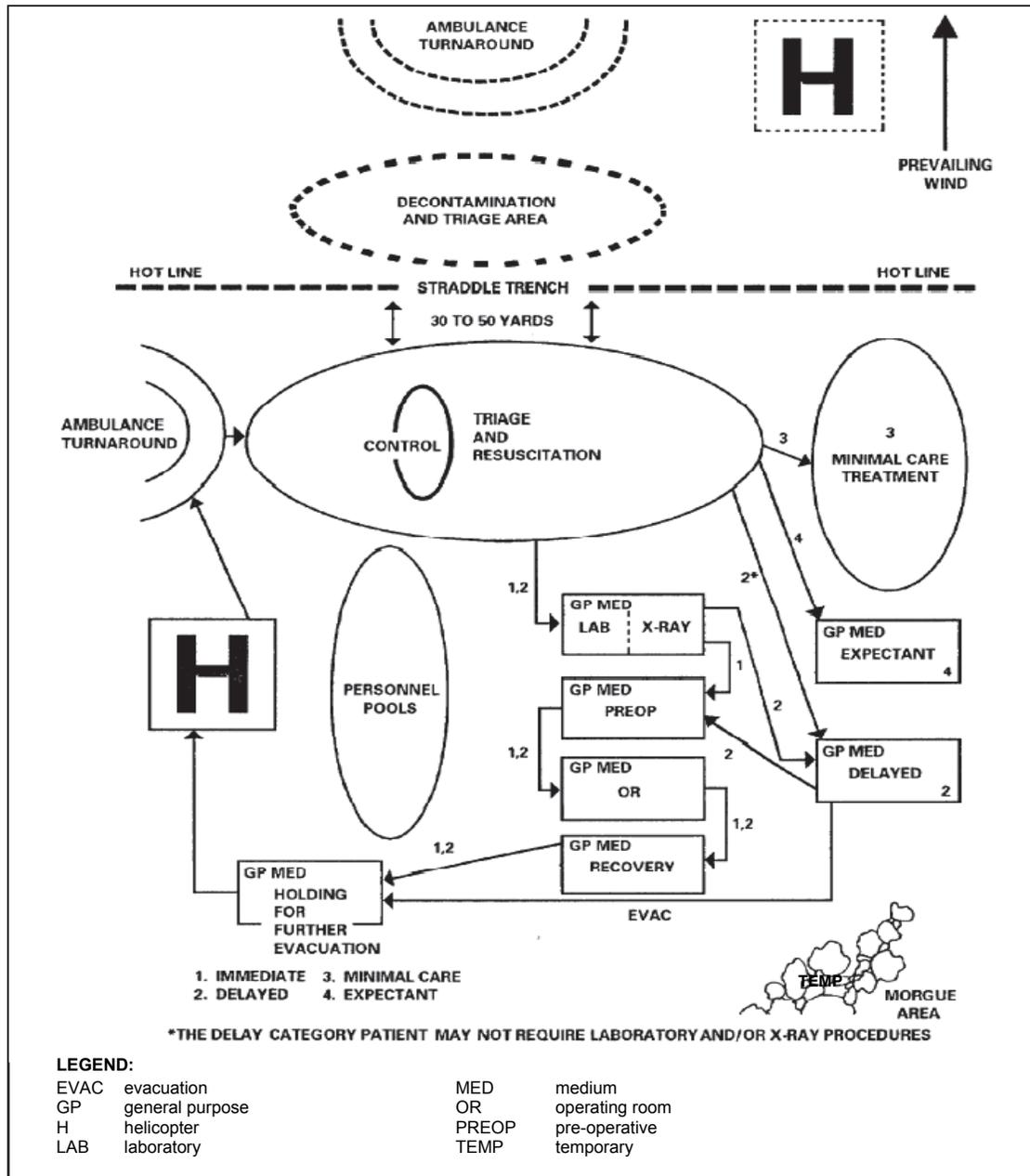
A-21. The control element should have access to all areas as required to proactively solve issues before they become challenges. The internal communications system should be modified as required to provide communications capability to the major areas of the facility. If an adequate communications system does not exist, a messenger system is established.

### **Using an Available Shelter**

A-22. A MASCAL situation may occur in an area away from the MTF. It may not be practical or possible to evacuate or transport the casualties to the MTF location. If a structure not previously used for an MTF is available, it may be used. The requirements for the establishment of the area are the same as when an existing MTF is used; however, the actual layout will differ depending upon the structure used. Caution must be used to develop a traffic plan that will avoid congestion and the crisscrossing of internal paths and will expedite patient flow. If possible, the shelter should be inspected by supporting engineer elements for structural integrity and safety.

**Establishing the Mass Casualty Station Outdoors**

A-23. In some instances, a MASCAL station may be required to be established outdoors. When this occurs, efficient use of overhead cover and available shade is essential. Unless inclement weather occurs, the triage area and the MINIMAL treatment area remain outdoors. The triage area must remain accessible to incoming vehicles and provide sufficient space for the turnaround of vehicles. It should also not be established too far from the treatment areas as the distance will place an additional burden on the litter bearers. Once triaged, patients should be brought inside an improvised shelter as soon as possible. The use of improvised shelters or the use of cover may be required until more appropriate shelters can be obtained or established. Figure A-1 depicts a MASCAL station established outdoors.



**Figure A-1. A mass casualty station established outdoors**

## **PATIENT ACCOUNTABILITY**

A-24. During MASCAL situations, medical personnel do not have the time to fully complete the DD Form 1380 or DA Form 7656. A numbering system can be used to expedite this process. The patient can be identified by a number and this same number is then entered on the DD Form 1380 or DA Form 7656. The card is then attached to the individual's clothing. The card is used to record the treatment and medications that the patient receives. When the MASCAL situation begins to resolve, and as time permits, medical personnel obtain the necessary information to complete the card. If the electronic medical record is available at the MTF conducting the MASCAL operation, the handwritten record of the patient encounter should be entered into the electronic medical record at the earliest possible time.

## **MEDICAL EVACUATION**

A-25. When MASCAL situations occur, the number of casualties will normally overwhelm the available medical evacuation resources. Therefore, the MASCAL plan should include provisions for the use of nonmedical vehicles and aircraft. When at all possible, casualties who have sustained more severe wounds should be evacuated in medical ground or air ambulances. These Soldiers will benefit most from the provision of en route medical care. The lightly wounded and stable casualties and those suffering from COSR can be transported by nonmedical transportation assets without serious risk of worsening their medical condition.

## **DISPOSITION OF REMAINS**

A-26. In a MASCAL situation, there will be casualties who have died before reaching the triage area (dead on arrival) or who die of wounds before they can be stabilized and further evacuated. A temporary morgue area should be established away from and out of sight of the triage and treatment areas. (The temporary morgue area is for use only by the MTF for those patients who have died. It is not a temporary collecting point for deceased personnel from other units.) This area could be established behind a natural barrier, such as a stand of trees or it can be set off with tentage or tarpaulins. This area is not an actual morgue as it has neither the required equipment nor is it staffed; it is only a holding area. The DD Form 1380 or DA Form 7656 must be completed for each deceased personnel and it must be signed by a physician. There remains are held until mortuary affairs support can be obtained.

## Appendix B

# Management of Deployed Individual Medical Records

The purpose of a medical record is to document patient encounters, health assessments, potential exposures to toxic industrial materials or CBRN warfare agents and concussive incidents, treatments received, and medications provided. The longitudinal medical record is initiated when a Soldier joins the Service and continues through the Soldiers' entire military career. It is essential that the individual medical record be comprehensive and captures all required data for medico-legal purposes, research, and education and aids in determining military retention, eligibility for benefits, and readiness for mobilization. Medical records may be handwritten or electronic. The electronic medical record is the preferred method for compiling a health record; however, in some deployed settings it may not be available at all roles of care. When using handwritten documentation, care must be taken to ensure the documentation accompanies the patient through the evacuation process. This appendix provides guidance on the maintenance of the Soldier's individual health record (HREC) (handwritten) and civilian employee medical records (CEMRs) in the field. The governing regulation for health care documentation is AR 40-66.

## MAINTENANCE OF HEALTH RECORDS

B-1. Health records are maintained by the MTF that provides primary care for the Soldier.

B-2. Unit commanders will ensure that HRECs are always available to AMEDD personnel who require such records in the performance of their duties. Unit commanders will also ensure that the information in the HRECs is kept private and confidential in accordance with law and regulations governing patient records administration.

B-3. Health records located at Role 1 MTFs are maintained by unit medical personnel. The AMEDD officer-in-charge serves as the custodian of the HRECs and CEMRs. Army Medical Department officers are in charge of the HRECs and CEMRs for the members of the units and civilian employees for whom they supply primary medical care. They are also in charge of the HRECs, CEMRs, and the records of other individuals that are receiving treatment from the MTF. Health records are important for the conservation and improvement of the patient's health. Therefore, AMEDD officers will ensure that all pertinent information is promptly entered in the HREC/CEMR in their custody. If any such pertinent information has been omitted, the AMEDD officer will take immediate action to obtain such information from the proper authority and include it in the HREC/CEMR.

B-4. The Health Insurance Portability and Accountability Act of 1996 provides for the privacy rights and protection of health information of Soldiers while ensuring necessary and required health/medical information is accessible to medical personnel and other appropriate entities. This applies whether the Soldier is deployed or at home station, whether it is written, verbal, or in digital format.

B-5. Detainees are afforded safeguards to patient confidences and privacy within constraints of U.S. law, whether the information is entered in electronic format, written down, or verbally presented. Medical records for enemy prisoners of war and/or detainees will be identified by the interment serial number. If an interment serial number has not been assigned, the individual will be identified by the capture tag number. Once the individual has been processed by the theater interment facility, he will be assigned his interment serial number and the HREC is annotated appropriately.

## HEALTH RECORDS FOR DEPLOYED SOLDIERS

B-6. The HREC of deployed Soldiers and the CEMR of deployed civilians will not accompany them to the combat area. The supporting MTF will initiate a DD Form 2766 (Adult Preventive and Chronic Care Flowsheet), DD Form 2766C (Adult Prevention and Chronic Care Flowsheet [Continuation Sheet]), DD Form 2795 (Pre-Deployment Health Assessment), and DD Form 2796 (Post-Deployment Health Assessment [PDHA]). If an individual deploys, the DD Form 2766 and DD Form 2766C will be photocopied prior to deployment and the copy will be kept in the individual's medical record. The original DD Form 2766 and any DD Forms 2766C will accompany the individual to the field. The DD Form 2766 serves as the treatment folder for the individual that is deployed; other forms, such as DD Form 2766C, DD Form 2795, DD Form 2796, and SF Form 600 will be filed on the fastener inside DD Form 2766. The photocopies of the DD Form 2766 and DD Form 2766C will be removed and shredded when the originals are placed back into the HREC or CEMR. Forms that had been filed inside the DD Form 2766 folder will be removed and placed in the HREC or CEMR.

B-7. When processing individuals for deployment, the MTF and dental treatment facility will audit each individual's HREC or CEMR and record essential health and dental care information on DD Form 2766. If a HREC or CEMR is not available, DD Form 2766 will be completed based on individual interviews and any other locally available data. A HREC may not be available for most individual ready reserve, individual mobilization augmentees, and retired personnel because these HREC may remain on file at the Human Resources Command or the Department of Veterans Affairs. Upon notification of deployment, all military personnel will complete DD Form 2795. A copy of the form will be filed on the fastener inside the DD Form 2766 folder; one copy will remain in the HREC and the original form will be sent to the Armed Forces Health Surveillance Center.

B-8. If the deployed individual is taking part in a classified operation, the DD Form 2795 is still required, but the form will be maintained only in the personnel folder.

B-9. The completed DD Form 2766 and a copy of any printout from an automated immunization tracking system will be provided to the individual's command or to the individual if he is an individual replacement, and then handed off to the MTF in the AO responsible for providing primary medical care to that individual. That MTF will maintain the DD Form 2766 as an outpatient field file for reference as needed. The MTF will ensure that the blood type from a verified blood bank typing is recorded accurately. The field file will consist of, in part, DD Form 2766, DD Form 2795, and possibly DD Form 2766C, DD Form 2796, SF 600, SF 558 (Medical Record, Emergency Care and Treatment [Patient]), SF 603 (Health Record, Dental), or DD Form 1380 and/or DA Form 7656. These forms will be filed on the fastener inside the DD Form 2766.

B-10. If DD Form 2766 is not available, the Soldier's field file may be managed as a drop file (forms not attached) and integrated into the DD Form 2766 when it is available.

### Use of Field Files

B-11. If a Soldier's primary MTF changes, the field file/DD Form 2766 should be moved to the gaining MTF. If a Soldier requires admission to the hospital, every attempt will be made to forward the field file/DD Form 2766. The file will be returned to the Soldier's primary MTF if disposition is return to duty.

### Storage of Health Records and Civilian Employee Records

B-12. Deployed (Roles 1 and 2) MTFs will secure a field chest or field file containers in quantities sufficient for the troop and civilian employee population supported. They will maintain the DD Form 2766 for each individual receiving primary medical care from their MTF.

### Establishment and Management of the Field File in the Operational Area

B-13. A DD Form 2766 and the medical records identified above will be maintained by medical companies operating a Role 2 MTF or the medical platoon/section that operates an Role 1 MTF, or will be handed off to the MTF providing their primary care.

B-14. Supported units will be required to provide the primary care MTF a battle roster of personnel assigned. This roster should be provided when personnel assignment changes are made or upon request.

B-15. The MTF, when possible, will attempt to ensure that the HREC or CEMR accompanies the medically evacuated individual.

B-16. If a Soldier's primary MTF changes, the HREC or CEMR will be transferred to the gaining MTF.

B-17. If an individual requires hospital admission, every attempt will be made to forward the HREC or CEMR to the admitting hospital.

B-18. When the MTF determines that an individual was evacuated without the DD Form 2766 and other medical records in the file, then the Soldier's DD Form 2766 and other medical records are forwarded to the medical mission command headquarters responsible for regulating patients out of the operational area. The medical mission command headquarters forwards the outpatient field file to the hospital where the patient was evacuated. The hospital patient administration section will attach the file to the inpatient chart and the file is evacuated with the patient out of the operational area or theater. If the Role 3 MTF has an electronic medical record capability, the medical information contained in the handwritten record should be entered into the electronic medical record system at the soonest time possible.

**This page intentionally left blank.**

## Appendix C

# Records, Reports, and Planning Tools

Individuals entering the medical treatment chain must be accounted for at all times. Prompt reporting of patients and their health status to the next higher headquarters is necessary for the maintenance of a responsive personnel replacement system and the Army Casualty System. Patient accountability and status reporting is required to—

- Provide the commander with an accurate account of personnel losses due to medical causes (enemy action and related combat losses and DNBI).
- Verify personnel replacement requirements.
- Assist the command surgeon in the preparation of the AHS estimate and plan.
- Alert PVNTMED personnel to the health threat in a given operational area.

The preferred method of medical record keeping is the electronic medical record. However, the electronic medical record may not be available at all locations in the operational area. This appendix provides sample report formats that can be used if the electronic systems are not available.

### SECTION I — RECORDS

---

**This paragraph implements STANAG 2132.**

---

## UNITED STATES FIELD MEDICAL CARD AND TACTICAL COMBAT CASUALTY CARE CARD

C-1. The DD Form 1380 and the DA Form 7656 are used to record data similar to that recorded on the inpatient treatment record cover sheet and the SF 600. These cards used by combat medics, BASs, Role 2 MTFs, and nonfixed troop or health clinics working overseas, on maneuvers, or attached to commands moving between stations. They may also be used to record an outpatient visit when the health record is not readily available at an MTF. These cards are used in the operational area during times of hostilities. They may also be used to record *carded for record only cases*. The DA Form 7656 is an updated form in consonance with the TC3 protocols and is the preferred card if available. The DD Form 1380 is currently the approved NATO emergency medical record.

C-2. These cards are made so that it can be attached to a casualty.

C-3. Medical treatment facilities initiating the SF 600, having received a patient with an initiated DD Form 1380 and/or DA Form 7656, will attach this form to the SF 600 to remain as a permanent record of the patient.

C-4. For additional information on the preparation and use of these cards and other health care documentation, refer to AR 40-66.

## DAILY DISPOSITION LOG

C-5. The daily disposition log (see Figure C-1 on page C-2) is maintained by Role 2 MTFs. The information from this log is extracted, when required, and provided to the S-1 or supported unit requesting the information. The daily disposition log is also the primary source document for information needed in the preparation of the DA Form 1156 (Casualty Feeder Card), patient summary report, and the patient

evacuation and mortality report. The daily disposition log can be modified to include other information if required by higher headquarters.

C-6. The daily disposition log does not lend itself to transmission. However, the information may be extracted and provided via courier or electronic means to agencies responsible for preparing consolidated reports and/or casualty feeder reports.

<b>Daily Disposition Log</b>				
<b>Date/Time Group: 060200Z MAY 12</b>				
<b>Name</b>	<b>Grade</b>	<b>Unit/nation</b>	<b>Injury/illness status</b>	<b>Disposition time</b>
BANNON, E. J.	O6	D Btry, 3FA/U.S.	GSW, L LEG/WIA	R2MTF/0900Z
PRICE, B. L., Jr.	O3	C Co 3, 6 INF/U.S.	LACERATION L HAND/NBI	R2MTF/1005Z
FRANKLIN, E.	E7	UK.	PUNCTURE WOUND R ANKLE/WIA	R2MTF/1056Z
UNKNOWN		EPW	FRAG WOUND OF HEAD/DOA/KIA	MA/1145Z
SYMTHE, W.	E2	A Co 3, 6 INF/U.S.	COSR/DNBI	R2MTF/1515Z
NAVARRO, D.	E7	C Btry, 3FA/U.S.	CHEMICAL INJURY SYSTEMIC/WIA	15 <sup>th</sup> CSH/1634Z
RICHMOND, A.	E6	B Co 3, 6 INF/U.S.	BURN, 3D DEGREE CHEST/WIA/DOW	MA/1826Z
DRAPER, J.	O2	U.K.	UNCONTROLLED VOMITING/BW/WIA	R2MTF/1958Z

**NOTE:** This log is maintained by all Roles 1 and 2 medical treatment facilities. It does not lend itself to transmission. However, the information may be extracted and provided to agencies responsible for preparing the consolidated feeder report.

**LEGEND:**

BTRY	battery	INF	infantry
BW	biological warfare agent	KIA	killed in action
CO	company	L	left
COSR	combat and operational stress reaction	MA	mortuary affairs
CSH	combat support hospital	MTF	medical treatment facility
DNBI	disease and nonbattle injury	NBI	nonbattle injury
DOA	dead on arrival	R	right
DOW	died of wound	R2	Role 2
EPW	enemy prisoner of war	U.K.	United Kingdom
FA	field artillery	U.S.	United States
FRAG	fragmentation	WIA	wounded in action
GSW	gunshot wound		

Figure C-1. Example daily disposition log

## SECTION II — REPORTS

### PATIENT SUMMARY REPORT

C-7. The patient summary report is a weekly report (Figure C-2) compiled as of 0001 hours, Sunday. It is prepared by Roles 1 and 2 MTFs and is submitted to respective surgeons as required. The command surgeon can, however, dictate the frequency of submission to meet command requirements. Further, the format can be adjusted if additional information is required by higher headquarters.

PATIENT SUMMARY REPORT						
DTG: 060200Z MAY 12						
		(FROM) / (TO)				
PATIENTS		WIA	NBI	DISEASE	*NP	TOTAL
ALPHA	US	3	1	1		5
BRAVO	ALLIED	2				2
CHARLIE	EPW	1				1
DISPOSITION						
DELTA	RETURNED TO DUTY	1				
ECHO	EVACUATED BY AIR					
FOXTROT	EVACUATED BY GROUND	5				
GOLF	EXPIRED EN ROUTE	1				
HOTEL	EXPIRED IN MTF	1				
TOTALS		8				

SAMPLE

**NOTE:** This report, when completed, will be classified in accordance with local command policy—encode/encrypt for transmission.

\*Neuropsychiatric or stress-related patients should be reported in this category.

**LEGEND:**

DTG	date-time group	NB	nonbattle
EPW	enemy prisoner of war	NP	neuropsychiatric
MTF	medical treatment facility	U.S.	United States
		WIA	wounded in action

Figure C-2. Example of a patient summary report

**SECTION III — PLANNING TOOLS**

C-8. This section provides a number of planning tools in the form of matrices for planning and/or controlling AHS operations. They should be modified as required for each specific mission and scenario.

**PLANNING MATRIX**

C-9. This matrix provides the leader with a quick reference to unit locations and supported and supporting units. Whenever planning for AHS missions, all medical functions must be considered, even if the units providing this support are not located in the immediate vicinity. Table C-1 on page C-4 provides a sample format for a planning matrix inclusive of all medical functions.

**Table C-1. Sample format for a planning matrix (medical functions)**

	<i>Units</i>	<i>Location</i>	<i>Supported units</i>	<i>Location</i>	<i>Remarks</i>
<b>MISSION COMMAND</b>	2 <sup>d</sup> Brigade Combat Team Headquarters	Vicinity of NT 413874 near the brigade support area.	2d Brigade Combat Team and attached units in the area of operations.	On a line from NT 380920 to NT 460902 to NT 460830 to NT 380830 back to NT 380920 inclusive. This area encompasses the brigade's area of operations.	The brigade command headquarters and planning elements coordinate and direct operations and security throughout the brigade's area of operations as directed by the brigade's command and higher command authorities guidance and planning.
<b>EVACUATION</b>  <ul style="list-style-type: none"> <li>• Casualty collection points</li> <li>• Patient collection points</li> <li>• Role 2 ground (evacuation squad forward) ambulances</li> <li>• Air ambulances</li> </ul>	1-8 <sup>th</sup> Infantry	Vicinity of NT 402842	1-8 <sup>th</sup> Infantry and attachments.	Vicinity of NT 402837	Casualty collection point located under cover and concealment near the engagement area to the rear of engaged friendly element. Treatment is continued or initiated, medical evacuation or casualty evacuation to the battalion aid station or higher roles of care dependent on operations, severity of wounds, and availability of transport assets.
	1-8 <sup>th</sup> Infantry	Vicinity of NT 405851	1-8 <sup>th</sup> Infantry and attachments	Vicinity of NT 402837	Patient collection point collocated with the battalion aid station for patient waiting for medical evacuation to higher roles of care or waiting transport back to their units.
	204 <sup>th</sup> Medical Company Brigade Support Battalion	Vicinity of NT 419875	1-8 Infantry and attachments.	Vicinity of NT402837.	Role 2 (evacuation squad forward) ground ambulances located at 1-8 <sup>th</sup> battalion aid station to transport appropriate patients to higher roles (Role 2) of care.
	2-4 <sup>th</sup> General Support Aviation Battalion	Vicinity of NT 419875	2d Brigade Combat Team with attachments with priority given to engaged brigade units	Inclusive of the brigade's area of operations.	Medical evacuation by air ambulance support is provided from the brigade support area with forward employment of assets dependent upon operational requirements.
<b>HOSPITALIZATION</b>	28 <sup>th</sup> Combat Support Hospital	Vicinity of NT 442904	Brigade units and attachments to include joint and multinational partners.	Inclusive of the brigade's area of operations.	Provides Role 3 Army Health System support for all entitled elements within the brigade's area of operations.

SAMPLE

Table C-1. Sample format for a planning matrix (medical functions) (continued)

	<i>Units</i>	<i>Location</i>	<i>Supported units</i>	<i>Location</i>	<i>Remarks</i>
<b>MEDICAL TREATMENT (AREA SUPPORT)</b> • Role 1  • Role 2	1-8 <sup>th</sup> Infantry Battalion Aid Station.	Vicinity of NT 405851.	1-8 <sup>th</sup> Infantry and attachments.	Vicinity of NT 402842	Organic Role 1 medical care provided at or near the point of injury or illness by combat medics of 1-8 <sup>th</sup> Infantry.
	204 <sup>th</sup> Medical Company Brigade Support Battalion.	Vicinity of NT 419875.	2 <sup>d</sup> Brigade Combat Team and attachments.	Inclusive of the brigade's area of operations.	Organic Role 2 medical care for the brigade is provided as well as Role 1 care for units without organic Army Health System support. Provides Army Health System area support throughout the brigade's area of operations.
<b>PREVENTIVE MEDICINE</b>	204 <sup>TH</sup> Medical Company Brigade Support Battalion	Vicinity of NT 410975	2 <sup>d</sup> Brigade Combat Team and attachments.	Inclusive of the brigade's area of operations.	Provides Role 2 preventive medicine services on an area support basis. Additional support provided by the Role 3 combat support hospitals such as medical laboratory support if required. Army Health System support for all entitled elements within the brigade's area of operations.
<b>COMBAT AND OPERATIONAL STRESS CONTROL</b>	204 <sup>TH</sup> Medical Company Brigade Support Battalion	Vicinity of NT 410975	2 <sup>d</sup> Brigade Combat Team and attachments.	Inclusive of the brigade's area of operations.	Provides systematic support on an area basis to all organizations within the brigade. Additional support provided by the Role 3 combat support hospitals if required.
<b>DENTAL</b>	204 <sup>TH</sup> Medical Company Brigade Support Battalion	Vicinity of NT 410975	2d Brigade Combat Team and attachments.	Inclusive of the brigade's area of operations.	Provides unit-level dental care to brigade units. Additional hospital-level support is provided by combat support hospitals.
<b>MEDICAL LOGISTICS</b>  • Medical supply and equipment	204TH Medical Company Brigade Support Battalion	Vicinity of NT 410975	2d Brigade Combat Team and attachments.	Inclusive of the brigade's area of operations.	Replenishment of Class VIII supply is the function of the brigade medical supply office primarily by the management of medical equipment sets and basic ordering of replenishment.

SAMPLE

Table C-1. Sample format for a planning matrix (medical functions) (continued)

	<i>Units</i>	<i>Location</i>	<i>Supported units</i>	<i>Location</i>	<i>Remarks</i>
<b>MEDICAL LOGISTICS</b> <i>(continued)</i>  • Blood	204 <sup>th</sup> Medical Company Brigade Support Battalion	Vicinity of NT 410975.	2d Brigade Combat Team and attachments.	Inclusive of the brigade's area of operations.	Minimal blood capability at the medical company. Additional blood bank services are provided by the supporting combat support hospital. When a forward surgical team is attached, blood bank requirements must be adjusted to meet the higher anticipated demand for the product.
<b>VETERINARY</b>  • Animal medicine  • Food Inspection	204 <sup>th</sup> Medical Company Brigade Support Battalion	Vicinity of NT 410975.	2 <sup>d</sup> Brigade Combat Team and attachments.	Inclusive of the brigade's area of operations.	Provides Role 2 veterinary medicine services on an area support basis.
	204 <sup>th</sup> Medical Company Brigade Support Battalion	Vicinity of NT 410975.	2 <sup>d</sup> Brigade Combat Team and attachments.	Inclusive of the brigade's area of operations.	Provides Role 2 food inspection services on an area support basis.
<b>MEDICAL LABORATORY</b>	204 <sup>th</sup> Medical Company Brigade Support Battalion	Vicinity of NT 410975	2 <sup>d</sup> Brigade Combat Team and attachments.	Inclusive of the brigade's area of operations.	Role 2 laboratory capability with enhanced capacity and capability provided by the supporting Role 3 combat support hospital. Higher order capacity is provided by the area medical laboratory such as analytical, investigational, and consultative capabilities.

## EXECUTION MATRIX

C-10. The execution matrix (see Table C-2) provides a simplified format for delineating critical tasks. It is organized by time sequence and permits the leader to see at a glance what events should be taking place. The elements included are—

- Item Number: An item number is assigned to identify the event.
- When: This indicates as closely as possible the date/time group an event should take place.
- Who: This indicates the specific individual/team/squad and equipment required to complete the task.
- What: This identified the specific event that must occur.
- Where: This indicates the location where the event is to occur. It is depicted by grid coordinates.
- Remarks: Additional information is provided, if required.

**Table C-2. Sample format for an execution matrix**

<i>Item</i>	<i>When</i>	<i>Who</i>	<i>What</i>	<i>Where</i>	<i>Remarks</i>
1	Date/time group	Litter teams	2 teams forward sited with C Company	Line of departure/ start point (grid coordinates)	Augmentation support
2	Date/time group	Treatment Team (battalion aid station [-])	Treatment team displaces forward; establishes (battalion aid station [-]).	Phase Line Red (grid coordinates)	Link up with 2LT Bannon

## SYNCHRONIZATION MATRIX

C-11. A synchronization matrix can be used to provide a highly visible, clear method of ensuring that planners address all medical functions when they are developing courses of action. The matrix clearly shows the relationships between activities, units, support functions, and key events. Sample formats for synchronization matrices are provided in Tables C-3 and C-4 on page C-8.

**Table C-3. Sample format for a company Army Health System support synchronization matrix**

<i>Tasks</i>	<i>TAA</i>	<i>LD/SP</i>	<i>PL Red</i>	<i>PL Blue</i>	<i>Objective</i>	<i>Remarks</i>
CBT medic	NR393562 130200Z Mar __	NR503633 130500Z Mar __	NR893743	NS367399	NS479418	Goes forward with assigned maneuver unit
Litter team	NR393562 130200Z Mar __	NR503633 130500Z Mar __	NR789639	NS313897	NS43709	Augmentation support; sited with units in contact
CCP			NR773555	NS360537	NS421665	Unmanned CCP
<b>LEGEND:</b>						
CBT	combat	LD	line of departure	TAA	tactical assembly area	
CCP	casualty collecting point	Z	Zulu			
PL	phase line					
SP	start point					

**Table C-4. Sample format for a battalion/brigade Army Health System support synchronization matrix**

<i>Tasks</i>	<i>TAA</i>	<i>LD/SP</i>	<i>PL Red</i>	<i>PL Blue</i>	<i>Objective</i>	<i>Remarks</i>
AXP			NR703341	NS257308	NS408843	Medical evacuation personnel staff point
MED PLT						Medical platoon establishes BAS (Role 1 MTF); Leap-frog treatment teams, if required.
TM A	NR393562 130200Z Mar __	NR503633 130500Z Mar __	NR753633	NS102654	NS102654	
TM B	NR393562 130200Z Mar __	NR503633 130500Z Mar __	NR753633	NR753633	NS423001	
BSMC	NR393562 130200Z Mar __	NR503633 131105Z Mar __	NR773555	NS360537	NS421665	Establish Role 2 MTF in TAA.
AA	NR393562 130200Z Mar __	NR503633 131105Z Mar __	NR703341	NS257308	NS408843	Forward sited AA at AXP.
FST	NR393562 130200Z Mar __	NR503633	NR773555	NS360537	NS421665	Collocates with BSMC and EPSS.
<b>LEGEND:</b>						
AA	air ambulance		Mar	March		
AXP	ambulance exchange point		MED PLT	medical platoon		
BAS	battalion aid station		MTF	medical treatment facility		
BSMC	brigade support medical company		PL	phase line		
EPSS	en route patient staging system		SP	start point		
FST	forward surgical team		TAA	tactical assembly area		
LD	line of departure		TM	team		
			Z	Zulu		

**INFORMATION DISPLAY/STATUS CHART**

C-12. The commander may want information displayed graphically in order that a quick appraisal of the situation/status of key functions can be made. This information may be displayed using a bubble chart (Table C-5). Each function is color-coded depending upon its readiness status. For example:

- GREEN—80 percent or greater combat capability remains (full strength).
- AMBER—60 to 79 percent combat capability remains—mission capable with only minor deficiencies.
- RED—40 to 59 percent combat capability remains—marginally mission capable with major deficiencies.
- BLACK—less than 40 percent combat capability remains—NOT mission capable.

Table C-5. Sample format for an informational display/status chart

	<i>Pre-engagement</i>	<i>Engagement</i>	<i>Post-engagement</i>	<i>Reconstitution</i>
<i>Mission Command</i>	0	0	0	0
<i>Evacuation</i>	0	0	0	0
<i>Hospitalization</i>	0	0	0	0
<i>Medical Treatment (Area Support)</i>	0	0	0	0
<i>Preventive Medicine</i>	0	0	0	0
<i>Dental</i>	0	0	0	0
<i>Combat and Operational Stress Control</i>	0	0	0	0
<i>Medical Logistics</i>	0	0	0	0
<i>Veterinary</i>	0	0	0	0
<i>Medical Laboratory</i>	0	0	0	0

SAMPLE

**This page intentionally left blank.**

## Appendix D

# Medical Communications for Combat Casualty Care

This appendix describes the MC4 system, the Army hardware component program that runs the Defense Health Information Management System (DHIMS) Theater Medical Information Program software in TOE units. The MC4 system operates on the Army communications systems.

## SECTION I — SYSTEM OVERVIEW

### SYSTEM MISSION

D-1. The MC4 system consists of hardware, software, and training support to implement the system at the appropriate echelon of mission command medical organizations. The MC4 system performs the following missions:

- Provides the Army computer infrastructure to enable automated medical data collection and sharing throughout the roles of medical care (from the point of injury [Role 1] to the sustaining base [Role 4]).
- Provides the computer infrastructure for the Army's implementation of the DHIMS software.
- Provides commanders at all roles of care with timely medical information and unit status information.
- Provides medical units with the capability to capture, store, and then transmit high-density medical data to higher roles of care.

D-2. The MC4 system links deployed Army health care providers and diagnostic systems into a seamless AHS diagnostic, treatment, evacuation, and medical understanding capability. The system is designed to support the Warfighting Functions of the Army through the AMEDD's HSS and FHP missions aligned under the Army's sustainment warfighting function and protection warfighting function, respectively.

### CURRENT CAPABILITY

D-3. Current capabilities of the MC4 system are constantly improving with releases of new software and hardware upgrades. Medical communications for combat casualty care is constantly evolving with lessons learned coupled with advances in information technology.

D-4. The MC4 system provides for deployed health care documentation and reporting, reference documents, and medical surveillance capabilities. Also, MC4 provides logistic systems to submit orders and maintain an inventory database for the management of Class VIII supplies.

### Employment of Medical Communications for Combat Casualty Care

D-5. The medical staff such as clinical, ancillary, and medical specialty services officers are medical professionals that provide or support direct patient clinical care. Clear delineation of clinical documentation expectations and responsibilities among medical professionals facilitates the flow of medical information through the MC4 system.

### Continuity of Medical Communications for Combat Casualty Care

D-6. The flow of medical information which includes order entry, order results, and patient documentation is performed by medical professionals and supported by medically trained personnel from the point of injury or illness and delivery to MTFs with professional staff from Role 1 through succeeding roles of care

up to Role 4. This results in a longitudinal comprehensive medical record that reflects the total care given by all medical personnel from the point of injury/illness through all roles of care.

D-7. In Role 1 maneuver force organizations, the first medically trained Soldier to provide medical care to an injured or ill Soldier is the combat medic. It is imperative that documentation is initiated at this point of care. If an electronic means is not available, the combat medic documents care on a DA Form 7656 or DD Form 1380. The paper documentation must be converted with digital entries into the MC4 system at the earliest opportunity. The following should be entered at a minimum on the electronic medical record enabled through MC4—

- Patient treatments and care.
- Patient observations.
- Patient consultations and therapies.
- Prescribed medications.
- Patient records transferred to the correct location within the MC4 application.
- Patient exposure to occupational environment hazards such as toxic industrial materials and CBRN warfare agents.

D-8. The hardware consists of commercial off-the-shelf electronic equipment supporting the MC4/DHIMS Theater Medical Information System capabilities. Examples include, but are not limited to, computers, printers, and networking devices.

## SOFTWARE

D-9. The Department of Defense and the information technology program offices are responsible for most of the medical software application development and acquisition that resides on the MC4 hardware infrastructure. All software on the MC4 system is developed according to the joint technical architecture and is common operating environment compliant as mandated by the Joint Requirements Oversight Council. The MC4 system comprises DHIMS software and Army-specific applications interfacing with the Army infrastructure (hardware and communications). The Theater Medical Data Store (TMDS) and the Medical Situational Awareness in the Theater (MSAT) applications are maintained by DHIMS and provide visibility of patient records, illnesses and injuries incurred in all deployed environments.

## Current Defense Health Information Management Systems Theater Medical Information Program Applications

D-10. The following are descriptions of DHIMS software applications that comprise the MC4 baseline system. Although functionality does not change, the software that DHIMS actually delivers to meet the required functionality may change.

### *Armed Forces Health Longitudinal Technology Application—Mobile*

D-11. The Armed Forces Health Longitudinal Technology Application (AHLTA)-Mobile (AHLTA-M) is the first responders' hand-held application. This application (AHLTA-M) resides on a handheld computer and is designed for rapid data entry by combat medics deployed in the operational area. The application allows for the generation of patient encounters by the combat medic or the health care specialist in the field and health care providers at the Role 1 BAS to the Role 3 CSH. This application interfaces with Service-specific removable media and AHLTA-Theater (AHLTA-T). When available, the AHLTA-M is synchronized with a laptop computer containing AHLTA-T to upload patient encounter information. When communications are available, the information is transmitted to the TMDS and the MSAT systems. Once AHLTA-M encounters are signed and synchronized with the AHLTA-T, information is distributed to the MSAT application for medical surveillance, as well as to the TMDS where the data becomes part of the patient's longitudinal electronic health record.

### *Armed Forces Health Longitudinal Technology Application—Theater*

D-12. The AHLTA-T application resides on a laptop computer configured as a stand-alone server or on a large server with several laptop clients. This application allows deployable medical staff/clinicians to

document encounters. It enables clinicians to document the diagnosis, update provided care, and track illnesses at deployed locations in a standardized format. Medical staffs are enabled to document the same information noted above, with the exception of making and recording a diagnosis. It also handles the recording and reporting of individual and mass immunizations in the theater Army environment. Completed encounters, are stored locally, sent to TMDS imported into the MSAT and forwarded to the clinical data repository where the patient's longitudinal electronic medical record is stored. Regardless of network or Internet connectivity, AHLTA-T supports the documentation of care with its store and forward capability to the TMDS and Department of Defense's clinical data repository which is accessible to authorized personnel regardless of location.

#### ***Armed Forces Health Longitudinal Technology Application Warrior***

D-13. The AHLTA Warrior system enables deployed military professionals to view a Soldier's stateside medical history through read-only, virtual private network access into the clinical data repository. The system allows read-only access to the patient's comprehensive electronic health records from all points of care worldwide.

#### ***Theater Medical Information Program Composite Health Care System Cache***

D-14. The Theater Medical Information Program Composite Health Care System Cache (also known as TC2) application is used to document inpatient healthcare, outpatient order entry, and results retrieval. Completed encounters are stored locally, sent to the TMDS, and imported to MSAT. At this time, Theater Medical Information Program Composite Health Care System Cache data does not move from TMDS to the clinical data repository.

#### ***Defense Medical Logistics Standard Support, Customer Assistance Module***

D-15. Operational units use DCAM to monitor and replenish Class VIII as required. It is the MEDLOG tool at lower roles of care in austere communications environments, particularly at Roles 1 and 2. The DCAM system is designed for use by nonlogisticians to digitally view and order from their suppliers' catalog. The DCAM system automates supply processing and feeds MEDLOG information to the joint medical asset repository.

#### ***Medical Situational Awareness in the Theater***

D-16. The MSAT system is a Web-based application that combines information from multiple communities to provide a common operational picture, as well as decision support. The MSAT system links together information that encompasses DNBI, physical and psychological trauma, patient tracking, chemical and biological warfare agent threats, environmental and occupational health hazards, mission command data, human resources, unit locations, and weather. Medical situation awareness in the theater increases the capability previously found in the joint medical workstation system.

#### ***Medical References***

D-17. The MC4 handhelds enable easy access to reference resources on the device. The medical reference application is available on MC4 laptops and serves as the medical reference tool that provides a series of medical guides to assist the provider while performing a clinical diagnosis. The medical reference application provides access to a collection of databases with disease, drug, acute care, and toxicology information. More information may be found concerning MC4 applications at the MC4 Web site (see the reference section of this publication).

#### ***Joint Theater Trauma Registry***

D-18. The Joint Theater Trauma Registry is a stand-alone, store-and-forward application on MC4 laptops used by deployed tri-Service nurse coordinators to collect battlefield injury demographics, care, and outcomes for both military and civilian casualties. The Joint Theater Trauma Registry is the largest injury database in existence, enabling senior leaders and researchers to study the information collected to uncover new ways to save lives on the battlefield through improved protective equipment and lifesaving procedures.

Data collected has already paid dividends by way of improved body armor, field tourniquets, and bandages with clotting agents. The Joint Theater Trauma Registry program facilitates the creation of trauma records that are transferred to, and maintained by, the U.S. Army Institute of Surgical Research.

#### ***Theater Medical Data Store***

D-19. The TMDS system offers users the ability to view individual patient encounters anywhere in the world (from a .mil domain). Providers can view captured medical data on the Soldier no matter where it was completed (while deployed in an operational area). Patient encounters in the operational area are entered through the MC4 laptop with AHLTA-T and DHIMS, to the MSAT server, where the records can be accessed via MSAT and TMDS. The records, except for Theater Medical Information Program Composite Health Care System Cache data, are also transferred to the clinical data repository as part of the Soldier's lifelong medical records. The TMDS provides blood inventory management capabilities.

#### **Nontheater Medical Information Program-Joint Systems**

D-20. The following applications are Army-specific or provided by other programs outside of the DHIMS program management office.

#### ***Defense Medical Logistics Standard Support***

D-21. The DMLSS system is an automated information system for Role 3 hospitalization units (Army CSHs), Air Force expeditionary medical systems, Navy hospital ships and expeditionary force hospitals. The DMLSS system delivers an automated and integrated information system with a comprehensive range of medical material, equipment, war reserve material, and facilities management functions for the Military Health System.

#### ***Transportation Command Regulating and Command and Control Evacuation System***

D-22. The Transportation Command Regulating and Command and Control Evacuation System is used by CSHs provides patient transportation information and in-transit visibility to the defense transportation community and medical support information to CSHs through a uniform resource locator link on the MC4 desktop.

#### ***Transportation Command Regulating and Command and Control Evacuation System Mobile***

D-23. The Transportation Command Regulating Command and Control Evacuation System Mobile is an application on MC4 laptops that helps deployed medical staff coordinate and monitor patient movement between MTFs during peacetime, contingencies, war, and MASCAL situations. The application provides visibility of the logistics of incoming and outgoing flights and enables the scheduling of patients' departures. The application enables users to quickly enter, access, and report information in a consistent method anywhere in the world.

#### ***Medical Environmental, Disease, Intelligence, and Countermeasures***

D-24. The Medical Environmental, Disease, Intelligence, and Countermeasures System is a Web-based medical reference application, developed by the National Center for Medical Intelligence which provides worldwide disease and environmental health risks information hyperlinked to Joint Service approved country-specific countermeasures and other pertinent military medical information. This system is used by medical planners and command surgeons in planning and executing operations. Appropriate medical and environment information from command surgeons is reported through the U.S. Army Public Health Command or other command information collection operations.

#### ***Office Automation***

D-25. The MC4 system includes various office automation, firewall, antivirus protection, common access card readers, and other plug-ins and desktop applications.

### *Electronic Postdeployment Health Assessment*

D-26. The electronic postdeployment health assessment is a suite of software used by deployed medical providers to document a Soldier's current physical and psychological health status on DD Form 2796 prior to the Soldier's return from deployment. Completed on MC4 handheld or MC4 laptops, the application helps the medical staff screen for at-risk Soldiers and facilitates the documentation of physical and psychological health data. This application can alert medical staff of potential warning signs and refer Soldiers for follow-on treatment. Data captured either through the handheld application of the Postdeployment Health Assessment, or the laptop computer version electronic postdeployment health assessment application is sent to through the electronic postdeployment health assessment Web portal hosted by the U.S. Army Medical Information Technology Center and then is sent to the medical protection systems database.

## **SECTION II — EMPLOYMENT OF THE MEDICAL COMMUNICATIONS FOR COMBAT CASUALTY CARE SYSTEM**

### **OPERATIONAL AREAS**

D-27. The MC4 system links the deployed Army health care providers, diagnostic systems, and organizations into a seamless AHS diagnostic, treatment, medical evacuation, and unit medical status capability. The MC4 system links both the HSS and FHP functions of the AHS across the roles of care and operations from deployed units to the Role 4 sustainment base and AHS leadership nodes. Support for MC4 employment into the operational area begins with predeployment operations with continual support and training throughout the duration of deployment enabling comprehensive AHS support across the ten medical functions, coupled with accurate and complete longitudinal health records for every deployed Soldier.

### **UNIT-LEVEL ADMINISTRATOR**

D-28. The unit-level administrator is an individual assigned to a medical unit with the primary or secondary duty of providing maintenance support for the MC4 systems. The commander or officer in charge should appoint a unit-level administrator formally assigned with the responsibility for executing MC4 sustainment and support. Areas of responsibility include—

- Complete and maintain Health Insurance Portability and Accountability Act training.
- Complete Level 1 information assurance security officer training.
- Attend the MC4 unit-level administrator sustainment and troubleshooting course.
- Set up and maintain all system user accounts.
- Perform Tiers 1 and 2 routine maintenance of backups, databases, transmission applications, and log files to ensure optimal system operability.
- Perform Tiers 1 and 2 troubleshooting of the MC4 systems.
- Report all MC4 system-related issues to the MC4 technical support teams and inform their commander of ongoing or related issues.

### **SUPPORT FOR MEDICAL COMMUNICATIONS FOR COMBAT CASUALTY CARE EMPLOYMENT DURING PREDEPLOYMENT OPERATIONS**

D-29. Periodically, and particularly prior to deployment, units should evaluate their training, equipment, and personnel readiness. Detailed preparation and training during the predeployment phase ensures units arrive in the operational area ready to complete their MC4 mission. The following types of training are available—

- New equipment training is the initial transfer of knowledge on the operation and maintenance of new and improved equipment with associated software from MC4 to the user.

- Computer and Web-based training products are available for individual self-development. Training is available on the MC4 Web site (see the reference section of this publication).
- Collective training includes training at home station, training at combat training centers, and training while deployed.
- Institutional training may be found at professional development courses at institutions such as the United States Army Medical Department Center and School, the Uniformed Services University of the Health Sciences, and other institutions. These courses familiarize personnel with MC4 prior to new equipment training and assist in sustaining MC4 knowledge and skills.

## **SUPPORT FOR MEDICAL COMMUNICATIONS FOR COMBAT CASUALTY CARE EMPLOYMENT DURING DEPLOYMENT**

D-30. Medical communications for combat casualty care support will vary in the operational area dependent upon the duration of the operation and resources available.

- Mobile training support teams for MC4 are available in the operational area dependent upon resources to assist units and users.
- Distributed learning materials for MC4 are available on the “Army Training Network 2 Go”, application that supports Soldiers everywhere. (See the MC4 Web site for further information concerning distributed learning and other learning modalities.)

## **DEPLOYED MEDICAL COMMUNICATIONS FOR COMBAT CASUALTY CARE AT ROLES 1 AND 2**

D-31. The MC4 system is used at MTFs that vary in size, employment, amount, and type of care provided. A Role 1 and 2 MTF varies significantly from a Role 3 MTF; therefore, not all MC4 software components are necessary at every MTF. The Theater Medical Information Program Composite Health Care System Cache’ and large AHLTA-T servers are located at Role 3; however, they serve Role 1 and 2 patients as they transit through the roles of care from Role 1 through intervening roles up to Role 4.

## **Appendix E**

# **Medical Support Section Brigade Special Troops Battalion**

The brigade special troops battalion (BSTB) provides both the mission command and sustainment functions to its organic and attached units so they can support the BCT commander and staff. The BSTB provides AHS support to its organic and attached units.

### **CAPABILITIES**

- E-1. The medical support section of the BSB provides—
- Tactical combat casualty care.
  - Advanced trauma management.
  - Routine sick call services.
  - Triage for MASCAL operations.
  - Ground medical evacuation from supported units/elements to the medical support section's Role 1 MTF.
  - Maintenance of field medical records.
  - Class VIII supply/resupply within the BSB.
  - Combat and operational stress control support and training.
  - Behavioral health referrals.
  - Clinical support and technical supervision for subordinate medical personnel/elements.

### **ORGANIZATION AND FUNCTIONS**

E-2. The medical support section is part of the support platoon of the HHC, BSB. The medical support section provides Role 1 AHS support for the BSB and operates a Role 1 MTF for the BSB and attached units. The medical support section is composed of the treatment team, the evacuation squad, with Role 1 medical personnel attached to the engineer and military intelligence companies; and the military police platoon.

### **EMPLOYMENT OF THE TREATMENT TEAM**

E-3. The treatment team (see Table E-1 on page E-2) establishes the Role 1 MTF for the BSB by providing routine sick call, TC3 and ATM.

### **TREATMENT TEAM**

E-4. This team does not execute split-based operations. The treatment team refers patients to the Role 2 MTF of the supporting BSMC for patients requiring further treatment, consultation, or diagnostic referrals.

**Table E-1. Treatment team**

<i>Paragraph</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Treatment Team	65D00	O3	Physician Assistant	SP	1
	68W4O	E7	Health Care NCO	NC	1
	68W3O	E6	Health Care Sergeant	NC	1
	68W1O	E4	Health Care Specialist		1
<b>LEGEND:</b>					
AOC area of concentration		NCO noncommissioned officer			
MOS military occupational specialty		SP Army Medical Specialist Corps			
NC noncommissioned					

*Note.* The ABCT medical support section (treatment team) adds one health care sergeant (MOS 68W2O), and adds one health care specialists (MOS 68W1O/E3).

**Evacuation Squad**

E-5. The evacuation squad (see Table E-2) provides two medical evacuation teams (with two M997A2 ambulances) for Role 1 ground medical evacuation from the point of injury, CCP, AXP, or other casualty/patient pick-up point within the BSTB’s AO. The evacuation squad provides TC3 and ground medical evacuation to the medical support section treatment team.

**Table E-2. Evacuation squad**

<i>Paragraph</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Evacuation Squad	68W2O	E5	Emergency Care Sergeant	NC	1
	68W1O	E4	Ambulance Aide/Driver		2
	68W1O	E3	Ambulance Aide/Driver		3
<b>LEGEND:</b>					
AOC area of concentration		NC noncommissioned			
MOS military occupational specialty					

**Engineer Company**

E-6. The engineer company of the BSTB receives AHS support and TC3 from assigned Soldiers as depicted in Table E-3. The medical support section (treatment team and evacuation squad) provides Role 1 MTF and ground medical evacuation support to the engineer company. The PA assigned to the treatment team of the BSTB provides technical supervision and clinical support to the medical personnel assigned to the engineer company. The health care NCO (MOS 68W4O/E7) provides mentorship, training, leadership, and supervision for the Soldiers assigned to the engineer company.

**Table E-3. Engineer company**

<i>Paragraph</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Engineer Company	68W2O	E5	Health Care Sergeant	NC	1
	68W1O	E4	Health Care Specialist		1
<b>LEGEND:</b>					
AOC area of concentration		NC noncommissioned			
MOS military occupational specialty					

*Note.* The engineer company of the ABCT changes the TOE to one combat medic (MOS 68W1O/E4) assigned see (Table E-4).

**Combat Medic Section**

E-7. Combat medics assigned to the military intelligence company and the military police platoon (Table E-4) provides TC3 and Role 1 medical support to the elements to which assigned. As stated in paragraph E-1, the medical support section provides the Role 1 MTF, ground medical evacuation support, and technical supervision provided to the combat medic section by the medical support section of the BSTB.

**Table E-4. Combat medic section**

<i>Paragraph</i>	<i>AOC/MOS</i>	<i>Grade</i>	<i>Title</i>	<i>Branch</i>	<i>Quantity</i>
Military Intelligence Company	68W1O	E4	Combat Medic		1
Military Police Platoon	68W1O	E4	Combat Medic		1
Engineer Company (ABCT)	68W1O	E4	Combat Medic		1
<b>LEGEND:</b>					
AOC area of concentration		MOS military occupational specialty			
ABCT armored brigade combat team					

---

*Note.* The combat medics receive technical and clinical supervision from the BSTB PA; in addition, they are mentored, trained, and supervised by the BSTB's health care NCO.

---

**This page intentionally left blank.**

# Glossary

This glossary lists acronyms and terms with Army or joint definitions. Where Army and joint definitions differ, (Army) precedes the definition. Terms for which this publication is the proponent are marked with an asterisk (\*). The proponent publication for other terms is listed in parentheses after the definition.

## SECTION I — ACRONYMS AND ABBREVIATIONS

<b>ABCA</b>	American, British, Canadian, Australian, and New Zealand (Armies)
<b>ABCT</b>	armored brigade combat team
<b>ADP</b>	Army doctrine publication
<b>ADRP</b>	Army doctrine reference publication
<b>AHLTA</b>	Armed Forces Health Longitudinal Technology Application
<b>AHLTA-M</b>	Armed Forces Health Longitudinal Technology Application-Mobile
<b>AHLTA-T</b>	Armed Forces Health Longitudinal Technology Application-Theater
<b>AHS</b>	Army Health System
<b>AMEDD</b>	Army Medical Department
<b>AO</b>	area of operations
<b>AOC</b>	area of concentration
<b>AR</b>	Army regulation
<b>ATM</b>	advanced trauma management
<b>ATP</b>	Army techniques publication
<b>attn</b>	attention
<b>ATTP</b>	Army tactics, techniques, and procedures
<b>AXP</b>	ambulance exchange point
<b>BAS</b>	battalion aid station
<b>BCT</b>	brigade combat team
<b>BFSB</b>	battlefield surveillance brigade
<b>BMSO</b>	brigade medical supply office
<b>BSB</b>	brigade support battalion
<b>BSMC</b>	medical company (brigade support battalion)
<b>BSTB</b>	brigade special troops battalion
<b>CAB</b>	combat aviation brigade
<b>CBRN</b>	chemical, biological, radiological, and nuclear
<b>CCP</b>	casualty collection point
<b>CEMR</b>	civilian employee medical record
<b>COSC</b>	combat and operational stress control
<b>COSR</b>	combat and operational stress reaction
<b>CPT</b>	captain
<b>CSH</b>	combat support hospital
<b>DA</b>	Department of the Army
<b>DCAM</b>	Defense Medical Logistics Standard Support Customer Assistance Module

<b>DD</b>	Department of Defense
<b>DHIMS</b>	Defense Health Information Management System
<b>DMLSS</b>	Defense Medical Logistics Standard Support
<b>DNBI</b>	disease and nonbattle injury
<b>FHP</b>	force health protection
<b>FIB</b>	fires brigade
<b>1LT</b>	first lieutenant
<b>FM</b>	field manual
<b>FSMP</b>	forward support medical evacuation platoon
<b>FST</b>	forward surgical team
<b>GSAB</b>	general support aviation battalion
<b>HHC</b>	headquarters and headquarters company
<b>HREC</b>	health record
<b>HSS</b>	health service support
<b>IBCT</b>	infantry brigade combat team
<b>LTC</b>	lieutenant colonel
<b>MAJ</b>	major
<b>MASCAL</b>	mass casualty
<b>MC4</b>	medical communications for combat casualty care
<b>MCAS</b>	medical company (area support)
<b>MEB</b>	maneuver enhancement brigade
<b>MEDBDE (SPT)</b>	medical brigade (support)
<b>MEDCOM (DS)</b>	medical command (deployment support)
<b>MEDLOG</b>	medical logistics
<b>MMB</b>	medical battalion (multifunctional)
<b>MOS</b>	military occupational specialty
<b>MSAT</b>	Medical Situational Awareness in the Theater
<b>MTF</b>	medical treatment facility
<b>NATO</b>	North Atlantic Treaty Organization
<b>NCO</b>	noncommissioned officer
<b>OE</b>	operational environment
<b>PA</b>	physician assistant
<b>PVNTMED</b>	preventive medicine
<b>S-1</b>	personnel staff officer
<b>S-2</b>	intelligence staff officer
<b>S-3</b>	operations staff officer
<b>S-4</b>	logistics staff officer
<b>SBCT</b>	Styker brigade combat team
<b>SF</b>	standard form
<b>STANAG</b>	Standardization Agreement
<b>TC3</b>	tactical combat casualty care

<b>TM</b>	technical manual
<b>TMDS</b>	Theater Medical Data Store
<b>TOE</b>	table of organization and equipment
<b>U.S.</b>	United States

## SECTION II — TERMS

### **advanced trauma management**

Resuscitative and stabilizing medical or surgical treatment provided to patients to save life or limb and to prepare them for further evacuation without jeopardizing their well-being or prolonging the state of their condition. (FM 4-02)

### **Army Health System**

A component of the Military Health System that is responsible for operational management of the health service support and force health protection missions for training, predeployment, deployment, and postdeployment operations. Army Health System includes all mission support services performed, provided, or arranged by the Army Medical Department to support health service support and force health protection mission requirements for the Army and as directed, for joint, intergovernmental agencies, coalition and multinational forces. (FM 4-02)

### **\*battalion aid station**

The forward-most medically staffed treatment location organic to a maneuver battalion.

### **chemical, biological, radiological, or nuclear incident**

Any occurrence, resulting from the use of chemical, biological, radiological, and nuclear weapons and devices; the emergence of secondary hazards arising from counterforce targeting; or the release of toxic industrial materials into the environment, involving the emergence of chemical, biological, radiological, and nuclear hazards. (JP 3-11)

### **collection point(s) (patient or casualty)**

A specific location where casualties are assembled to be transported to a medical treatment facility. It is usually predesignated and may or may not be staffed. (FM 4-02)

### **decisive action**

The continuous, simultaneous combinations of offensive, defensive, and stability or defense support of civil authorities tasks. (ADRP 3-0)

### **defensive task**

A task conducted to defeat an enemy attack, gain time, economize forces, and develop conditions favorable for offensive or stability tasks. (ADRP 3-0)

### **force health protection**

(Joint) Measures to promote, improve, or conserve the mental and physical well-being of Service members. These measures enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards. (JP 4-02) (Army) Force health protection encompasses measures to promote, improve, conserve or restore the mental or physical well-being of Soldiers. These measures enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards. These measures also include the prevention aspects of a number of Army Medical Department functions (preventive medicine, including medical surveillance and occupational and environmental health surveillance; veterinary services, including the food inspection and animal care missions, and the prevention of zoonotic disease transmissible to man; combat and operational stress control; dental services [preventive dentistry]; and laboratory services [area medical laboratory support]). (FM 4-02)

### **health service support**

(Joint) All services performed, provided, or arranged to promote, improve, conserve, or restore the mental or physical well-being of personnel. These services include, but are not limited to the

management of health services resources, such as manpower, monies, and facilities; preventive and curative health measures; evacuation of the wounded, injured, or sick; selection of the medically fit and disposition of the medically unfit; blood management; medical supply, equipment, and maintenance thereof; combat and operational stress control and medical, dental, veterinary, laboratory, optometry, nutrition therapy, and medical intelligence services. (JP 4-02) (Army) Health service support encompasses all support and services performed, provided, and arranged by the Army Medical Department to promote, improve, conserve, or restore the mental and physical well-being of personnel in the Army. Additionally, as directed, provide support to other Services, agencies, and organizations. This includes casualty care (encompassing a number of Army Medical Department functions—organic and area medical support, hospitalization, the treatment aspects of dental care and behavioral/neuropsychiatric treatment, clinical laboratory services, and treatment of chemical, biological, radiological, and nuclear patients), medical evacuation, and medical logistics. (FM 4-02)

### **offensive task**

A task conducted to defeat and destroy enemy forces and seize terrain, resources, and population centers. (ADRP 3-0)

# References

## REQUIRED PUBLICATIONS

These documents must be available to intended users of this publication.

This publication is available online at [www.apd.army.mil](http://www.apd.army.mil)

ADRP 1-02, *Terms and Military Symbols*, 24 September 2013.

This publication is available online at <http://www.dtic.mil/doctrine>.

JP 1-02, *Department of Defense Dictionary of Military and Associated Terms*, 8 November 2010.

## RELATED PUBLICATIONS

These documents contain relevant supplemental information.

### NATO STANAGs

These documents are available online at <https://nsa.nato.int> (password required).

2014, *Formats for Orders and Designation of Timings, Locations and Boundaries*, Edition 9, 17 October 2000.

2132, *Documentation Relative to Initial Medical Treatment and Evacuation—Allied Medical Publication-8.1*, Edition 3, 11 June 2013.

2136, *Requirements for Water Potability During Field Operations and in Emergency Situations—Allied Medical Publication-4-9*, 21 March 2014.

2454, *Road Movements and Movement Control—Allied Movement Publication-1(A)*, Edition 3, 27 January 2005.

2885, *Emergency Supply of Water in Operations*, Edition 5, 13 January 2010.

2931, *Orders for the Camouflage of Protective Medical Emblems on Land in Tactical Operations—Allied Tactical Publication-79*, Edition 3, 12 March 2013.

2939, *Minimum Requirements for Blood, Blood Donors and Associated Equipment*, Edition 5, 8 February 2010.

2982, *Essential Field Sanitary Requirements*, Edition 1, 26 August 1994.

### ABCA PUBLICATION AND STANDARD

These documents are available online at <http://www.abca-armies.org> (password required).

Publication 256, *Coalition Health Interoperability Handbook*, Edition 3, April 2013.

Standard 815, *Blood Supply in the Area of Operations*, Edition 1, 21 October 1991.

### PUBLIC LAW

This document is available at <http://aspe.hhs.gov/admnsimp/pl104191.htm>.

Public Law 104-191, 104<sup>th</sup> Congress, *Health Insurance Portability and Accountability Act of 1996*.

### DEPARTMENT OF DEFENSE PUBLICATIONS

Department of Defense publications are available online at <http://www.dtic.mil/whs/directives/>.

DODI 3025.21, *Defense Support of Civilian Law Enforcement Agencies*, 27 February 2013.

### JOINT PUBLICATIONS

Most joint publications are available online at [www.dtic.mil/doctrine/new\\_pubs/jointpub.htm](http://www.dtic.mil/doctrine/new_pubs/jointpub.htm).

JP 3-11, *Operations in Chemical, Biological, Radiological, and Nuclear (CBRN) Environments*, 4 October 2013.

JP 4-02, *Health Service Support*, 26 July 2012.

### MULTISERVICE PUBLICATIONS

Most multiservice doctrinal publications are available online at <http://www.apd.army.mil>.

FM 4-02.7/MCRP 4-11.1F/NTTP 4-02.7/AFTTP 3-42.3, *Multiservice Tactics, Techniques, and Procedures for Health Service Support in a Chemical, Biological, Radiological, and Nuclear Environment*, 15 July 2009.

TM 8-227-11/NAVMED P-5123/AFI 44-118, *Operational Procedures for the Armed Services Blood Program Elements*, 1 September 2007.

### ARMY PUBLICATIONS

Most Army doctrinal publications are available online at <http://www.apd.army.mil>.

ADP 3-0, *Unified Land Operations*, 10 October 2011.

ADRP 3-0, *Unified Land Operations*, 16 May 2012.

ADRP 3-07, *Stability*, 31 August 2012.

ADRP 3-28, *Defense Support of Civil Authorities*, 14 June 2013.

ADRP 3-90, *Offense and Defense*, 31 August 2012.

AR 40-66, *Medical Record Administration and Healthcare Documentation*, 17 June 2008.

ATP 4-02.5, *Casualty Care*, 10 May 2013.

ATTP 4-41, *Army Field Feeding Class I Operations*, 14 October 2010.

FM 3-04.111, *Aviation Brigades*, 7 December 2007.

FM 3-09, *Field Artillery Operations and Fire Support*, 4 April 2014.

FM 3-81, *Maneuver Enhancement Brigade*, 21 April 2014.

FM 4-02, *Army Health System*, 26 August 2013.

FM 4-02.43, *Force Health Protection Support for Army Special Operations Forces*, 27 November 2006.

FM 27-10, *The Law of Land Warfare*, 18 July 1956.

### WEB SITES

Medical Communications for Combat Casualty Care (MC4). (<http://www.mc4.army.mil>)

### RECOMMENDED READINGS

These readings contain relevant supplemental information.

ADP 1, *The Army*, 17 September 2012.

ADP 4-0, *Sustainment*, 31 July 2012.

ADP 5-0, *The Operations Process*, 17 May 2012.

ADP 6-0, *Mission Command*, 17 May 2012.

ADRP 4-0, *Sustainment*, 31 July 2012.

ADRP 5-0, *The Operations Process*, 17 May 2012.

ADRP 6-0, *Mission Command*, 17 May 2012.

AR 40-5, *Preventive Medicine*, 25 May 2007.

AR 71-32, *Force Development and Documentation*, 1 July 2013.

ATP 4-25.13, *Casualty Evacuation*, 15 February 2013.

ATP 4-90, *Brigade Support Battalion*, 2 April 2014.

ATP 4-93, *Sustainment Brigade*, 9 August 2013.

ATTP 3-97.11/MCRP 3-35.1D, *Cold Region Operations*, 28 January 2011.

- DA Pamphlet 40-11, *Preventive Medicine*, 22 July 2005.
- DODD 6490.02E, *Comprehensive Health Surveillance*, 8 February 2012.
- DODI 1400.32, *DOD Civilian Work Force Contingency and Emergency Planning Guidelines and Procedures*, 24 April 1995.
- DODI 6490.03, *Deployment Health*, 11 August 2006.
- FM 3-55.1, *Battlefield Surveillance Brigade (BFSB)*, 14 June 2010.
- FM 4-02.1, *Army Medical Logistics*, 8 December 2009.
- FM 4-02.17, *Preventive Medicine Services*, 28 August 2000.
- FM 4-02.51, *Combat and Operational Stress Control*, 6 July 2006.
- FM 6-22.5, *Combat and Operational Stress Control Manual for Leaders and Soldiers*, 18 March 2009.
- FM 21-10/MCRP 4-11.1D, *Field Hygiene and Sanitation*, 21 June 2000.
- TB MED 507/AFPAM 48-152(I), *Heat Stress Control and Heat Casualty Management*, 7 March 2003.
- TB MED 508, *Prevention and Management of Cold-Weather Injuries*, 1 April 2005.
- TB MED 530, *Occupational and Environmental Health Food Sanitation*, 30 October 2002.
- TB MED 577/NAVMED P-5010-10/AFMAN 48-138\_IP, *Sanitary Control and Surveillance of Field Water Supplies*, 1 May 2010.
- TB MED 593, *Guidelines for Field Waste Management*, 15 September 2006.
- TC 8-800, *Medical Education and Demonstration of Individual Competence (MEDIC)*, 6 May 2009.
- TM 8-227-12/NAVMED P-6530/AFH 44-152\_IP, *Armed Services Blood Program Joint Blood Program Handbook*, 1 December 2011.

## PRESCRIBED FORMS

None.

## REFERENCED FORMS

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate (APD) Web site ([www.apd.army.mil](http://www.apd.army.mil)).

DA Form 1156, *Casualty Feeder Card*.

DA Form 2028, *Recommended Changes to Publications and Blank Forms*.

DA Form 7656, *Tactical Combat Casualty Care (TCCC) Card*.

Department of Defense (DD) forms are available on the Office of the Secretary of Defense (OSD) Web site ([www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm](http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm)).

DD Form 1380, *U.S. Field Medical Card*.

DD Form 2766, *Adult Preventive and Chronic Care Flowsheet*.

DD Form 2766C, *Adult Preventive and Chronic Care Flowsheet (Continuation Sheet)*.

DD Form 2795, *Pre-Deployment Health Assessment (PDHA)*.

DD Form 2796, *Post-Deployment Health Assessment*.

Standard forms (SF) and/or optional forms (OF) are available on the U.S. General Services Administration (GSA) Web site ([www.gsa.gov](http://www.gsa.gov)).

SF 558, *Medical Record, Emergency Care and Treatment (Patient)*.

SF 600, *Medical Record, Chronological Record of Medical Care*.

SF 603, *Health Record, Dental*.

**This page intentionally left blank.**

# Index

References are to paragraph numbers except where otherwise specified.

## A

ABCT. See armored brigade combat team.

advanced trauma management (ATM), 1-6, 1-9, 2-24—26, 2-33, 2-50, 2-56, 2-59, 2-61, 2-77, 2-79, 2-81, 2-113, 2-117, 2-122, 2-132, 2-136, 2-138, Table 3-2, Table 3-3, 4-7, 4-15, 4-20, E-3, E-1.

AHS. See Army Health System.

ambulance exchange point (AXP), 2-27, 2-35, 2-65, 2-67, 2-76, 2-102, 2-119, 2-139, 2-140, Table 3-1, 4-24, Table C-5, E-4.

AO. See area of operations.

area of operations, 2-2—3, Table 2-1, Table 3-4, 2-7, 2-12, 2-41, 2-46, 2-50, 2-53, 2-55—57, 2-65, 2-69, 2-76, 2-88—89, 2-91, 2-102—103, 2-108—110, 2-138, 2-148, 2-154—155, 3-12, 3-15, 3-20, Chapter 4 (Introduction), 4-2, 4-5, 4-7, 4-10—15, 4-24—25, B-9, E-4.

armored brigade combat team (ABCT), 2-7, Figure 2-3, 2-15, Table 2-5—8, 2-44, 2-46, 2-64, Table 2-16, Table E-1, Table E-3, Table E-4.

Army Health System, Preface, 1-1, 1-5—6, 1-11—12, Table 2-1—5, 2-7—14, 2-17, 2-22, 2-45, 2-50, 2-57, 2-59, 2-69—70, 2-75—78, 2-81, 2-86

ATM. See advanced trauma management.

AXP. See ambulance exchange point.

## B

BAS. See battalion aid station.

battalion aid station (BAS), 2-8, 2-19—20, 2-24—27, 2-32—38, 2-50, 2-59, 2-121—123, 2-127, Table 3-2, 3-9, Table 3-3, Appendix A (Introduction), C-1, Table C-5, D-10.

BCT. See brigade combat team.

BMSO. See brigade medical supply office.

brigade combat team (BCT), Preface, Chapter 1 (Introduction), 1-11, Chapter 2 (Introduction), 2-1, 2-3, 2-5, 2-7, 2-10, 2-12—13, 2-17—18, 2-42, 2-44—45, 2-48, 2-50, 2-54, 2-57, 2-68—70, 2-75, 2-89, 2-114, 2-120—121, 2-124—125, 2-127, Table 2-1, 3-10, Table 3-4, 4-5, Appendix E (Introduction).

brigade medical supply office, 2-23, 2-42—43, 2-53, 2-68—69, Table 2-17, 4-26.

BSMC. See medical company (brigade support battalion).

## C

CAB. See combat aviation brigade.

casualty collection point (CCP), 2-27, 2-32, 2-50, 2-67, 2-76, 2-102, 2-127, 2-139, 2-140, Table C-11, E-4.

CCP. See casualty collection point.

CEMR. See civilian employee record.

civilian employee record (CEMR), Appendix B (Introduction), B-3, B-6—7, B-15—17.

combat and operational stress control (COSC), 1-4, 1-9—10, Table 2-1, 2-13, 2-25, 2-50, 2-55, 2-118, 4-7, 4-12, 4-21, Table C-1, Table C-6, E-1.

combat and operational stress reaction. Table 1-1, 2-25—26, 2-50, 2-55, 4-7, Table 3-1, A-9, A-25, Figure C-1.

combat aviation brigade (CAB), 2-18, 2-71—80, 2-82—86, 2-94—96, 2-101—103, 2-105, 2-127.

combat support hospital (CSH), 2-12, 2-76, 2-128, 3-18, 4-10, 4-22, Figure C-1, D-10, D-20, D-21.

COSC. See combat and operational stress control.

CSH. See combat support hospital.

## D

DCAM. See Defense Medical Logistics Standard Support Customer Assistance Module.

Defense Medical Logistics Standard Support (DMLSS), 2-23, D-20.

Defense Medical Logistics Standard Support Customer Assistance Module (DCAM), 2-23, 2-42, 2-129, D-14

disease and nonbattle injury, 1-7, Table 2-1, 2-50, 2-54, 2-62, Table 3-1, Table C-1.

DMLSS. See Defense Medical Logistics Standard Support.

DNBI. See disease and nonbattle injury.

## E

Emergency medical treatment, 1-9, 2-132, 4-7.

## F

FHP. See force health protection.

force health protection (FHP), Chapter 1 (Introduction), 1-1—2, 1-4, Table 2-1, 2-12, 2-54, 2-77, 2-151, Table C-4, D-2, D-26

forward surgical team (FST), 1-9, 2-3, 2-10, 2-47, 2-60, 2-62, 3-4, Table 3-2, Table 3-3, 4-4, Table C-5.

FST. See forward surgical team.

## H

HSS. See health service support.

health record (HREC), Tables 2-1, Appendix B (Introduction), B-1—3, B-5—7, B-9, B-12, B-15—17, C-1, D-10, D-12, D-26.

health service support (HSS), 1-1—3, 2-12, 2-77, 2-151, Table 2-1, Table C-4, D-2, D-26.

HREC. See health record.

**I**

IBCT. See infantry brigade combat team.

infantry brigade combat team (IBCT), Preface, 2-7, 2-10, 2-15—16, Table 2-6—7, 2-44, 2-46, Table 2-8, Table 2-12, Table 2-16, 2-75.

**M**

MASCAL. See mass casualty.

mass casualty (MASCAL), Table 2-1, 2-29, Appendix A (Introduction), A-1—3, 2-29, 2-50, 3-14, A-10, A-12—13, A15, A-19, A-22—26, D-22, E-1.

MC4. See Medical Communications for Combat Casualty Care.

MCAS. See medical company (area support).

Medical Communications for Combat Casualty Care (MC4), Table 2-1, 2-42, 2-58, Appendix D (Introduction), D-1—9, D-16—18, D-21—22, D-24—30.

medical company (area support) (MCAS), 1-9, 2-13, 2-79, 2-114, 2-128, 2-139, Chapter 4 (Introduction), 4-1—5, 4-7, 4-10—15, 4-20—22, 4-24—26

medical company (brigade support battalion), 1-9, 2-15, 2-36, 2-42—45, 2-50, 2-53, 2-57—59, 2-61—63, 2-65—69, 2-79, 2-128, 3-9, 4-26, Table C-5, E-3.

medical evacuation, 1-3, 1-7, 1-9, 1-10, Table 2-1, 2-17, 2-27, 2-30, 2-32, 2-35—36, 2-62—2-67, 2-76, 2-84—85, 2-87—88, 2-90, 2-92, Table 2-26, 2-93, 2-102, 2-105—106, 1-108—110, Table 2-35, 2-113, 2-116, 2-119, Table 2-40, 2-120, 2-124, 2-126—128, 2-133, 2-136, 2-140—141, 2-147, 2-150, 2-153, Table 2-55, Chapter 3 (Introduction), 3-3, 3-6, Table 3-1, 3-9, 3-11, 3-13—15, Table 3-5, 4-4, 4-7, 4-23—26, A-5, A-12, A-17, A-25, Table C-5, D-26, E-1, E-4—5, E-7.

medical treatment facility (MTF), Chapter 1 (Introduction), 1-6—7, 1-9, 2-29, 2-35, 2-41—43, 2-50, 2-57, 2-59, 2-61—62, 2-66—67, 2-76, 2-79, 2-81, 2-86, 2-92, 2-100—101, 2-108, 2-127, 2-136—137, 2-139, 2-152—153, Chapter 3 (Introduction), Table 3-2, 3-11, Table 3-3, 3-13, 3-15, 3-

18, 3-22, 4-7, 4-10, 4-13—15, 4-18—21, A-13, A-15—17, A-20, A-22, A-24, B-1, B-3, B-6—7, B-9, B-11—16, B-18, C-1, C-5, Figure C-1, C-7, Table C-5, D-5, D-22, D-30, E-1—3, E-5, E-7.

MTF. See medical treatment facility.

**P**

preventive medicine (PVNTMED), 1-4, 1-9—11, Table 2-6, 2-13, 2-25, 2-54, Table 2-9, Table 3-5, 4-26, Appendix C (Introduction), Table C-1.

PVNTMED. See preventive medicine.

**S**

SBCT. See Stryker brigade combat team.

Stryer brigade combat team (SBCT), 2-7, 2-15, 2-30, 2-32, 2-44, 2-46—47, 2-50, 2-53, 2-56, 2-59, 2-64, 2-67, 2-69.

**T**

tactical combat casualty care (TC3), 1-6, 1-9, Table 2-1, 2-24, 2-26, 2-32, 2-56, 2-66, 2-79, 2-81, 2-83, 2-102, 2-104, 2-113, 2-117, 2-119, 2-122—123, 2-133, 2-136, 2-140, 2-142, 2-153, Table 3-2, 4-25, C-1, E-1, E-3—6.

TC3. See tactical combat casualty care.

**ATP 4-02.3**  
9 June 2014

By order of the Secretary of the Army:

**RAYMOND T. ODIERNO**  
*General, United States Army*  
*Chief of Staff*

Official:

A handwritten signature in black ink, appearing to read "Gerald B. O'Keefe". The signature is written in a cursive style with a large initial "G" and a distinct "O'Keefe" ending.

**GERALD B. O'KEEFE**  
*Administrative Assistant to the*  
*Secretary of the Army*  
1415001

**DISTRIBUTION:**

*Active Army, Army National Guard, and United States Army Reserve:* Distributed in electronic media only (EMO).

