

CHAPTER 5

UNIT-LEVEL HEALTH SERVICE SUPPORT

Section I. TYPE UNITS SUPPORTED

5-1. Mission and Functions

a. The mission and functions of unit-level (Echelon I) HSS elements are—

- Prevention of disease and illness through applied PVNTMED programs.
- Acquisition and immediate treatment of the sick, injured, and wounded.
- Clinical stabilization of the critically injured or wounded.
- Provision for routine medical care (sick call) and the immediate RTD of soldiers "fit to fight."

b. Echelon I HSS is reinforced by Echelon II and III HSS; each providing increased support to the patient. During lulls in operations, unit-level medical personnel conduct tactical and technical proficiency training. When required, they provide instructions to nonmedical personnel in self-aid/buddy aid (first aid), CLS procedures, patient evacuation, field sanitation, and personal hygiene.

c. Unit level HSS within the division is provided by organic medical elements assigned to combat battalions, selected CS battalions, division headquarters, CAB headquarters, and the DIVARTY headquarters. Their purpose is to provide direct HSS to subordinate elements of the organization. This support is provided by medical platoons or sections in the following organizations/units:

- Armored Battalion—Medical Platoon, HHC.

- Mechanized Infantry Battalion—Medical Platoon, HHC.

- Infantry Battalion—Medical Platoon, HHC.

- Division Artillery-Medical Section, Headquarters and Headquarters Battery (HHB).

- Combat Aviation Brigade (CAB)—Medical Section, HHC.

- Field Artillery Battalion (Direct Support), DIVARTY—Medical Section, Headquarters and Headquarters and Service Battery (HHS).

- Attack Helicopter Battalion, CAB—Medical Section, Headquarters and Service Company.

- Reconnaissance Squadron (RECON SQDN), CAB—Medical Section, Headquarters and Headquarters Troop.

- Infantry Division (Light)—Medical Section, HHC.

d. The organic medical platoons and sections above are modular in design, and operate from mobile treatment shelters. They have organic vehicles which provide maximum deployability and mission responsiveness.

5-2. Area Support

Unit level HSS is provided on an area support basis to all organizations and units of the division without organic HSS by medical companies of the FSB, MSB, or DISCOM medical battalion. These companies are located in the BSA and DSA.

Section II. MEDICAL PLATOON

5-3. Assignment

A medical platoon is organic to each combat battalion HHC. The platoon is organized with a

headquarters section, a treatment squad (two treatment teams), an ambulance section, and a combat medic section. The medical platoon is organized as shown in Figures 5-1 and 5-2.

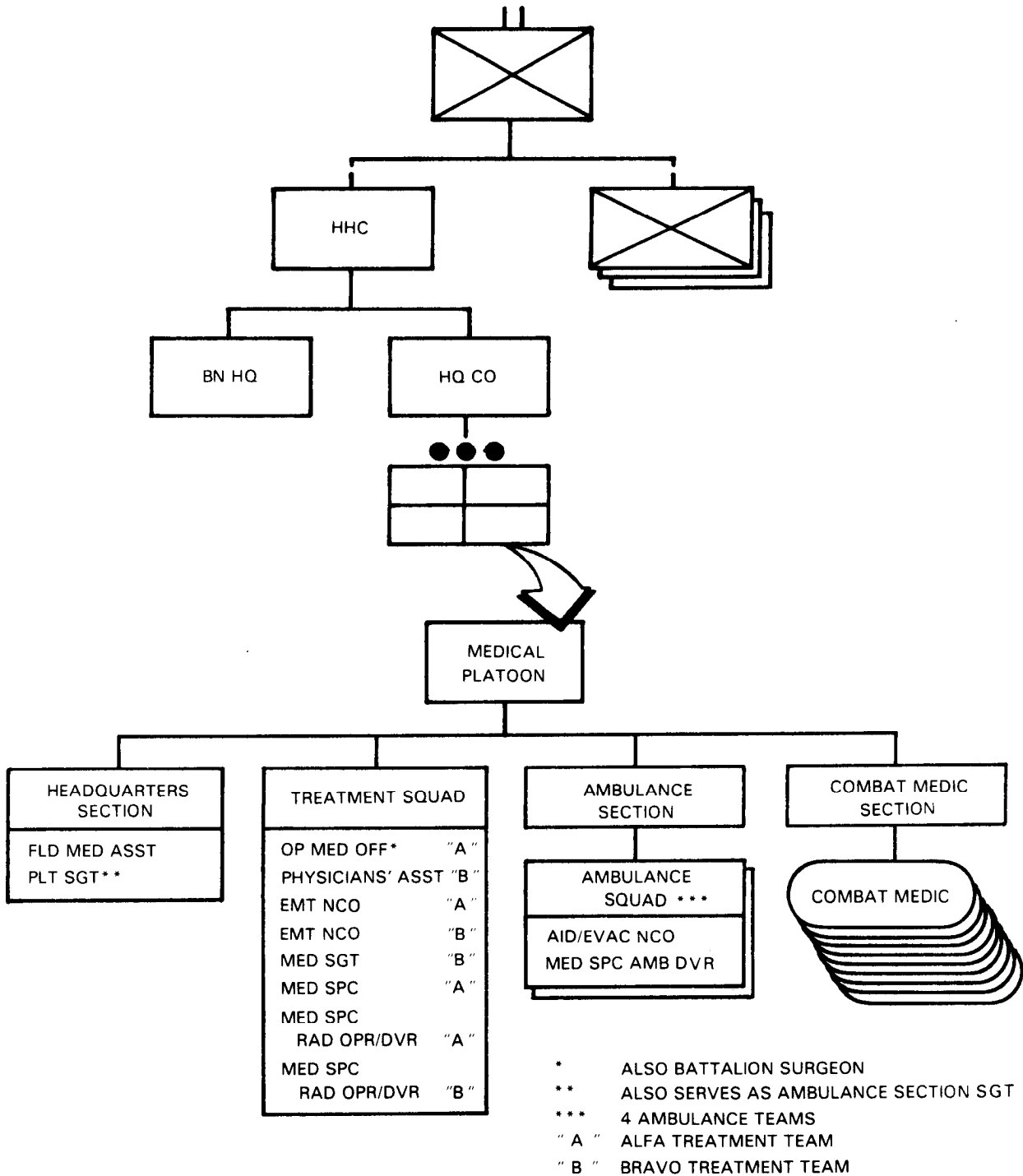
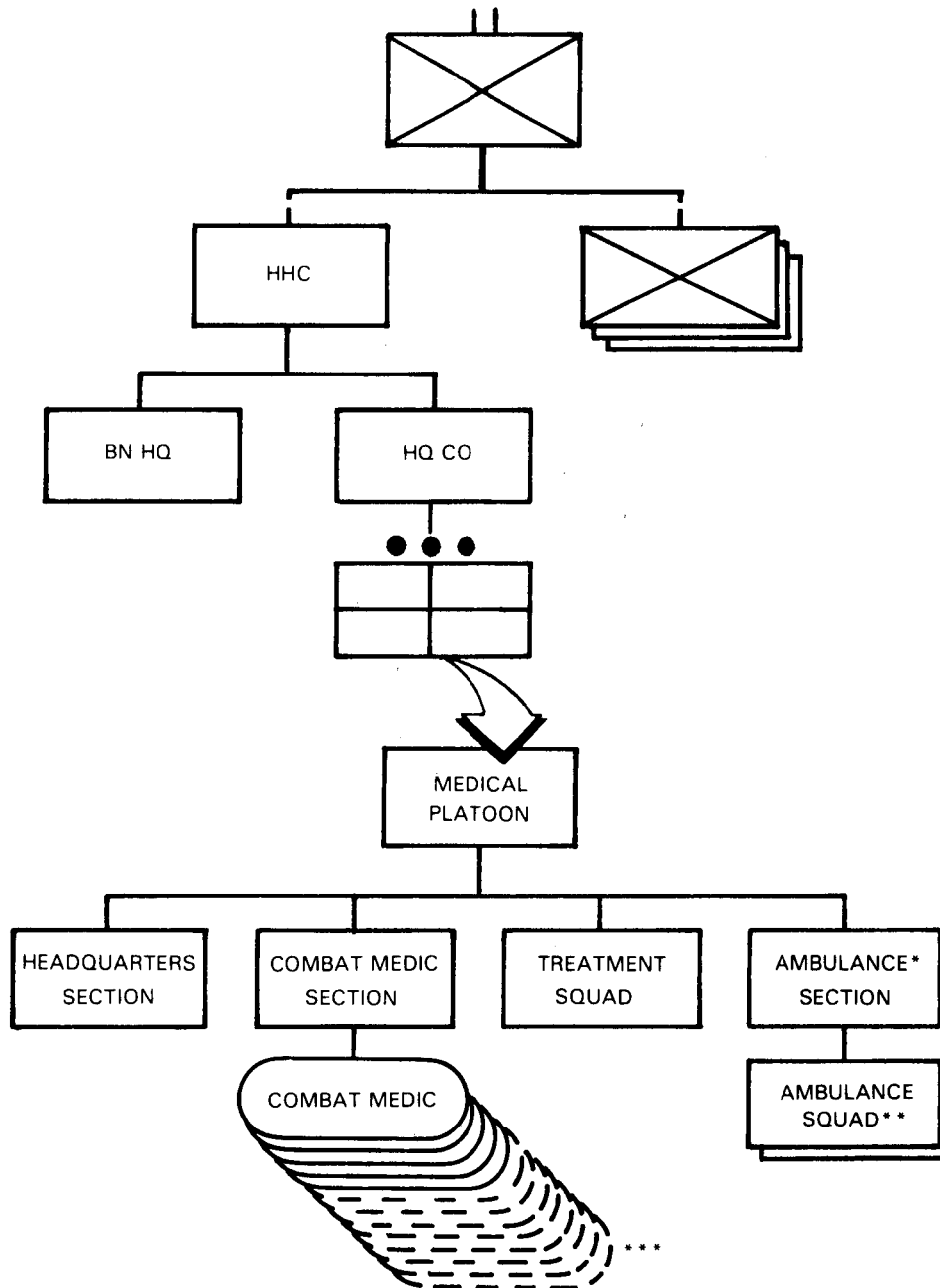


Figure 5-1. Medical platoon, HHC, light infantry battalion.



NOTE:

- * MECHANIZED INFANTRY AND ARMOR UNITS HAVE 4 AMBULANCE SQUADS.
- ** TWO AMBULANCE TEAMS.
- *** AIRBORNE OR AIR ASSAULT UNITS HAVE 12, ARMOR UNITS HAVE 5, AND MECHANIZED INFANTRY UNITS HAVE 13.

Figure 5-2. Medical platoon, heavy battalion.

5-4. Battalion Surgeon

The battalion surgeon/medical platoon leader is the medical advisor to the battalion commander and his staff. He is the supervising physician (operational medicine officer) of the medical platoon treatment squad. This officer is responsible for all medical treatment provided by the platoon. His responsibilities include—

- Planning and directing unit-level HSS for the battalion.
- Advising the battalion commander and his staff on the status of the health of the command.
- Supervising the administration, discipline, maintenance of equipment, supply functions, organizational training, and employment of assigned or attached personnel.
- Examining, diagnosing, treating, and prescribing courses of treatment for patients to include ATM.
- Coordinating the establishment and training of patient decontamination teams.
- Training CLS.
- Supervising the battalion preventive psychiatry program to include training troop leaders in the preventive aspects of stress on soldiers.
- Planning and conducting medical civic action programs (MEDCAP), when directed.

5-5. Platoon Headquarters

a. The headquarters section, under the direction of the battalion surgeon, provides for the command, control, communications, and logistics for the platoon. The platoon headquarters is manned by the field medical assistant and the platoon sergeant. It is normally collocated with the treatment squad to form the BAS. The command post includes the plans and operations functions performed by the field medical assistant. The platoon has access to the battalion wire communication network for communications with all major elements of the battalion and with

supporting units. Wireless communications for this section consists of a tactical FM radio mounted in the platoon headquarters vehicle. The medical platoon employs an FM radio network for HSS operations (Figure 5-3). The headquarters section serves as the net control station for the platoon.

b. The field medical assistant, an MSC officer, is the operations/readiness officer for the platoon. He is the principal assistant to the battalion surgeon for operations, administration, and logistics. The field medical assistant coordinates HSS operations with the battalion S3 and S4, and coordinates patient evacuation with the supporting medical company. This officer serves as the medical platoon leader in the absence of an assigned physician.

c. The platoon sergeant assists in supervising the operations of the platoon. He also serves as the ambulance section sergeant. This NCO prepares reports; requests general supplies as well as medical supplies; advises on supply economy procedures; and maintains authorized stockage levels of expendable supplies. He supervises the activities and functions of the ambulance section to include operator maintenance of ambulances and equipment; operations security (OPSEC); and EMT.

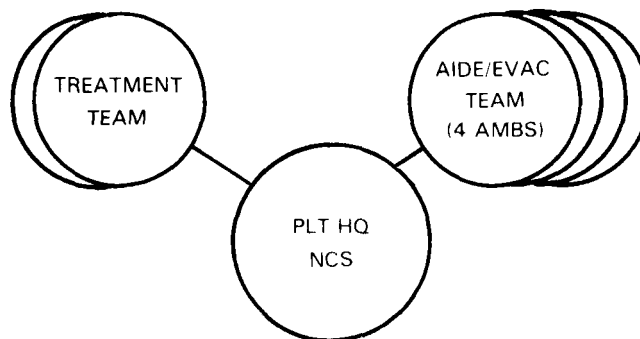


Figure 5-3. Medical platoon operations net.

d. The PA is a warrant officer. He performs general technical health care and administrative duties. The PA is ATM qualified and works under the clinical supervision of the medical officer. He performs the following duties:

- Establishes and operates a BAS or BAS minus (1 treatment team).
- Treats, within his ability, sick or injured patients. He refers those patients requiring treatment beyond his capability to the supervising physician.
- Provides initial resuscitation to wounded personnel.
- Conducts training for battalion personnel in first aid procedures (self-aid/buddy aid), CLS, field sanitation, evacuation of the sick and wounded, and the medical aspects of injury prevention.
- Assists in the conduct of the battalion preventive psychiatry program, to include training troop leaders in the preventive aspects of stress on soldiers.
- Trains medical personnel in emergency medical procedures. See Appendix A for a training procedures guide.

5-6. Treatment Squad

The treatment squad is the basic medical treatment element of the BAS. It provides routine medical care, triage, ATM, and tailgate medicine. This squad is staffed with an operational medicine officer (primary care physician/battalion surgeon), a PA, two EMT NCOs, and four medical specialists (refer to Figure 5-1). The squad's physician, PA, and EMT sergeants are all trained in ATM procedures, commensurate with their occupational positions/specialties.

5-7. Battalion Aid Station/Treatment Squad Operation

Battalion aid station is the generic term used in designating the unit-level medical treatment facility.

a. The treatment squad can split into two treatment teams and operate as two separate aid stations (BAS minus), normally not to exceed 24 hours. In continuous operations, when operating for

longer periods, personnel efficiency and unit capability will tend to deteriorate. Each team employs treatment vehicle(s) with two medical equipment sets (MES); one trauma set and one general sick call set. See Appendix D for an example of the treatment squad in the split team mode.

b. For communications, each treatment team uses a FM tactical radio and is deployed in the medical platoon's operations net. However, under certain tactical conditions the battalion S4 may require BAS elements to use the S4 net.

c. The BAS is under the tactical control of the battalion S4 and is normally deployed in the vicinity of combat trains (see Figures 5-4 and 5-5 for suggested layout of a BAS). To reduce ambulance turnaround time in providing ATM to patients within 30 minutes of wounding, the BAS may split and place its treatment teams as close to maneuvering companies as tactically feasible. The battalion S4 closely coordinates locations for forward positioning CSS elements (including medical treatment elements) with the battalion S3. This is to ensure that the location of these elements is known by commanders of maneuvering and CS forces. Coordination ensures that CSS elements are not placed in the way of friendly maneuvering forces; in line of direct (incoming) fires or supporting fires (outgoing); or in areas subject to be overrun by rapidly advancing enemy forces. Treatment teams situated close to (within 1000 meters of) maneuvering companies in contact must be prepared to withdraw to preplanned, alternate positions on short notice.

d. When maneuvering companies anticipate large numbers of casualties, augmentation of the medical platoon with one or more treatment teams from the FSMC should be made. Augmenting treatment teams are under the tactical control of the battalion S4; but are under the operational control of the battalion surgeon. 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, POL distribution points, or other targets that may be considered lucrative by the opposing force. Considerations for the location of the BAS should include—

- plan.
- Tactical situation/commander's
 - 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.
- Good hardstand drainage.
- Near an open area suitable for helicopter landing.
- Available communication means.

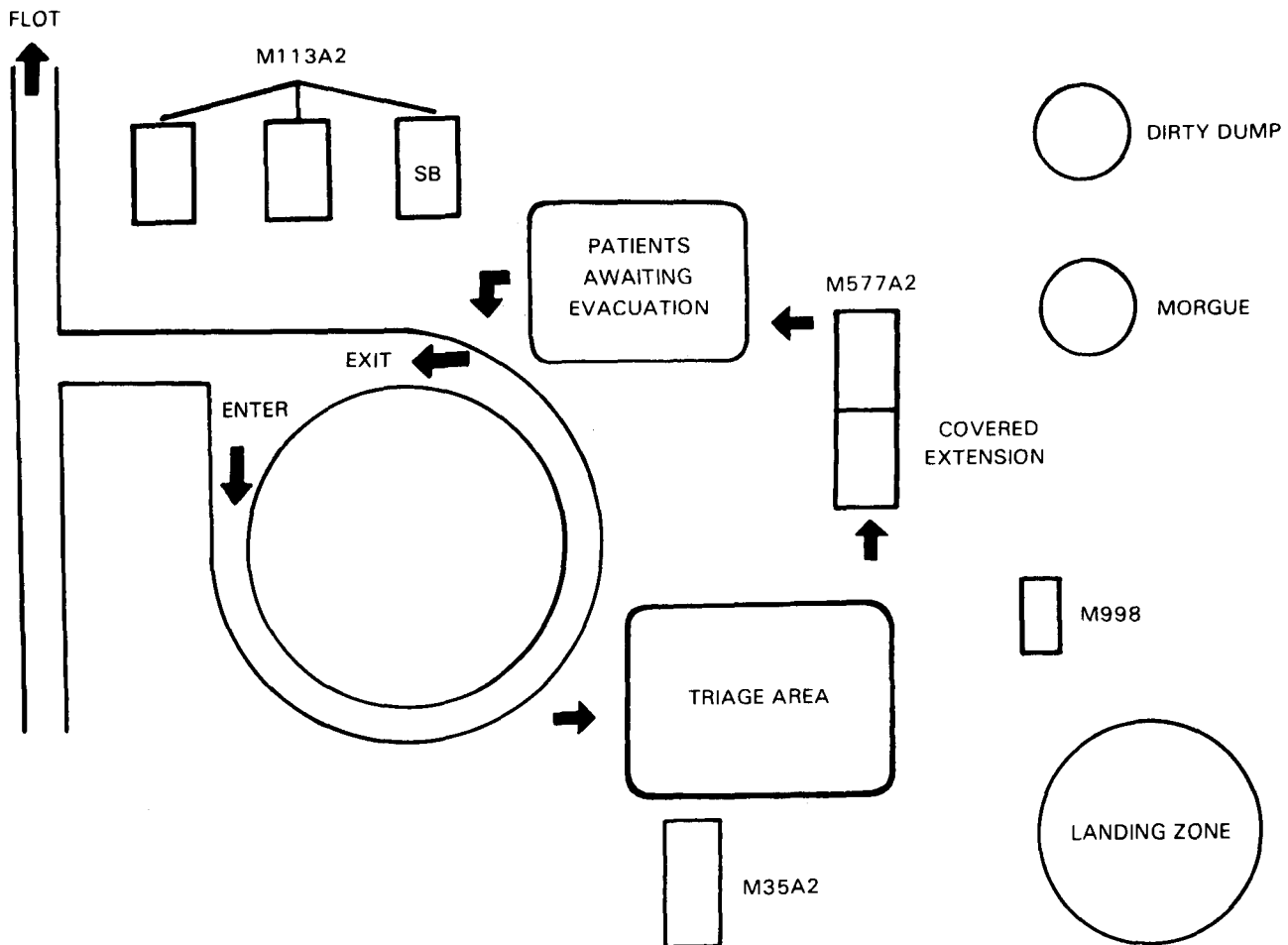


Figure 5-4. Layout of a battalion aid station (heavy).

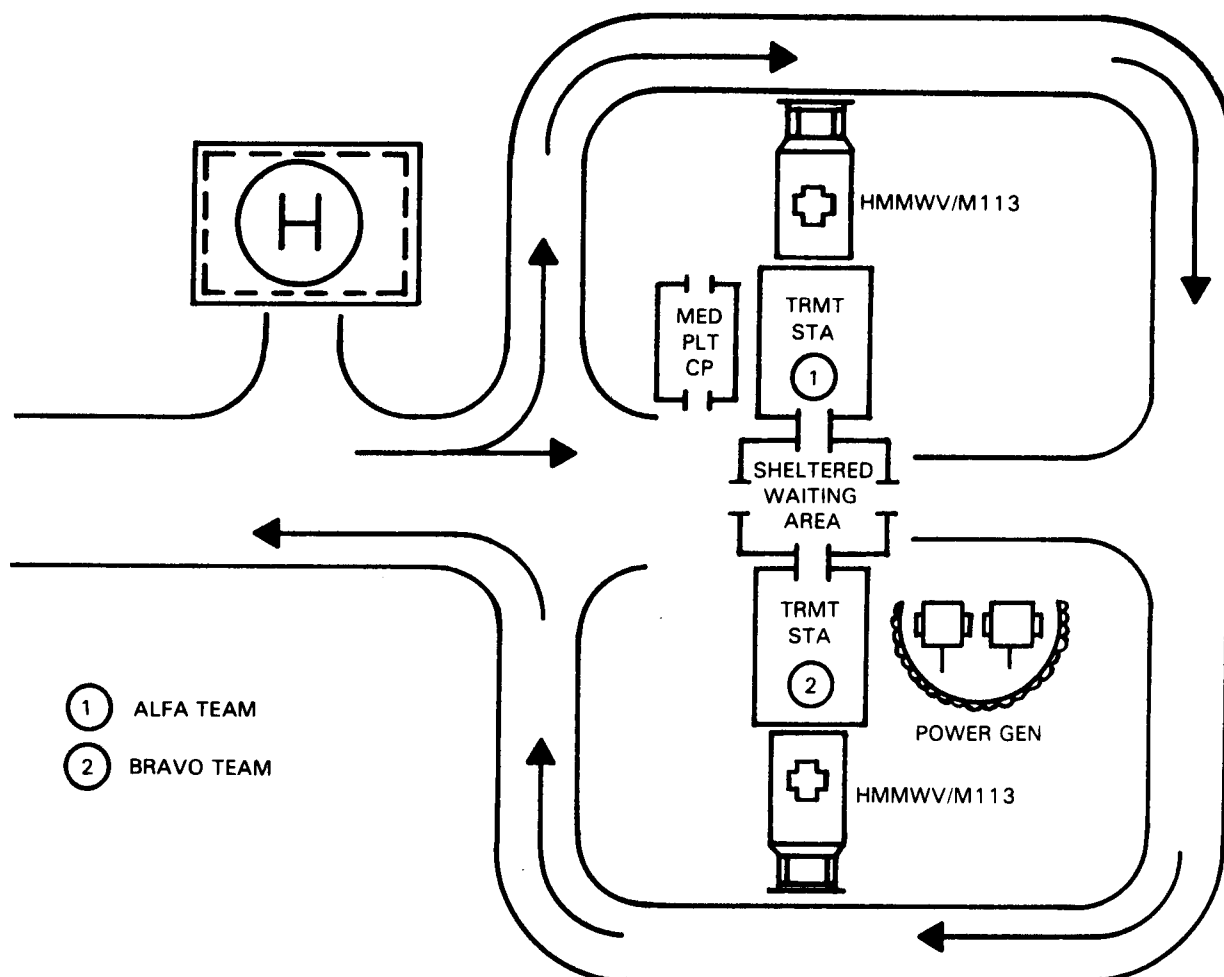


Figure 5-5. Layout of a battalion aid station without M577.

e. At the BAS, patients requiring further evacuation to the rear are stabilized for movement. Constant efforts are made to prevent unnecessary evacuation; patients with minor wounds or illnesses are treated and RTD as soon as possible. Other functions of the BAS include—

- Receiving and recording patients.
- Notifying the S1 of all patients processed through the BAS, giving identification and disposition of patients.
- Preparing field medical cards (FMCs) as required.
- Verifying information contained on FMC of all patients evacuated to the BAS.
- Requesting and monitoring medical evacuation of patients.
- Monitoring personnel, when necessary, for NBC contamination prior to medical treatment.
- Decontaminating and treating NBC patients (refer to TC 8-12, FM 8-9, FM 8-285, TM 8-215, and Chapter 6 of this manual).

NOTE

Patient decontamination (decon) is performed by a pretrained decon team. This team is composed of eight nonmedical personnel from supported units. Patient decon teams perform best when they train and exercise their skills with the supporting BAS (see Appendix E).

f. Evacuation from the BAS is performed by the FSMC's ambulance platoon and by corps air ambulance teams.

g. Patient holding and food service is 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.

h. Ammunition and individual weapons belonging to patients evacuated from the BAS are disposed of as directed by command SOP/policy. All excess equipment collected at the BAS is disposed of by the battalion S4 or as directed by command SOP.

NOTE

Patients will always retain their protective mask.

i. Patients requiring dental treatment are evacuated to the supporting medical company where emergency dental care is provided.

j. Patients requiring optometric services initially report to the BAS. For those patients requiring only routine replacement of spectacles, necessary information is obtained from the individual and forwarded to the division optometry section. The required spectacles are fabricated and forwarded to the BAS for issue to the patient. For optometry services other than routine repair or replacement of spectacles, patients are transported to the optometry section, located in the DCS.

5-8. Combat Medic Section

To foster good interpersonal relations and morale of combat troops, combat medics are attached to maneuver companies on a continuing basis. However, during lulls in combat operations, they should return to the medical platoon for consultation and proficiency training. Functions of combat medics are as follows:

- Performs triage and EMT for the sick and wounded.
- Arranges medical evacuation for litter patients and directs ambulatory patients to patient collecting points or to the BAS.
- Initiates the FMC for the sick and wounded and, as time permits, prepares an FMC on deceased personnel.
- Screens, evaluates, and treats, within his capabilities, those patients suffering minor illnesses and injuries. He RTD those patients requiring no further attention.
- Keeps the company commander and the battalion surgeon (or the PA in the absence of the surgeon) informed on matters pertaining to the health and welfare of the troops.
- Maintains sufficient quantities of medical supplies to support the tactical situation.
- Serves 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 (FM 21-10-1).

5-9. Ambulance Section

a. Medical platoon ambulances provide evacuation within the battalion. Ambulance teams provide medical evacuation and en route care from the soldier's point of injury to the BAS. In mass casualty 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 medical evacuation should be included in the battalion's tactical SOP.

NOTE

Performing operators maintenance on ambulances is an important part of each ambulance team's duties.

b. Under the modular medical system, the ambulance squad consists of two ambulance teams.

(1) The aid/evacuation NCO performs—

- Triage and advanced EMT procedures in the care and management of trauma patients.

- Assists in the care and management of battle fatigue patients.

- Prepares patient for movement.

- Provides patient care en route.

- Maintains contact with supported units.

- Collects casualties.

- Performs NBC detection procedures.

(2) The medical specialist/ambulance driver is trained in EMT procedures. He operates and maintains the ambulance and all on-board equipment. He assists the aid/evacuation NCO in the care and handling of patients.

c. Specific duties of the ambulance team are to—

- Maintain contact with supported elements.

- Find and collect the wounded.

- Administer EMT as required.

- Initiate or complete the FMC.

- Evacuate litter patients to the BAS.

- Director guide ambulatory patients to the BAS.

- Perform triage when necessary.

- Provide Class VIII resupply to combat medics.

- Serve as messengers within medical channels.

d. The number of ambulance squads in a section varies and is based on the type of parent organization. The infantry, airborne, and air assault maneuver battalions ambulance sections have two ambulance squads; each is equipped with high mobility multipurpose wheeled vehicle (HMMWV) ambulances. The heavy combat maneuver battalions ambulance sections have eight ambulance squads equipped with M-113 tracked ambulances.

5-10. Employment and Functions of the Ambulance Team

a. The ambulance team is a mobile combat medic team. Its function is to collect, treat, and evacuate the sick and wounded to the nearest treatment station or AXP. For communications, the ambulance team employs an FM tactical radio mounted on its assigned ambulance. The team is deployed in the medical platoon's operations net; however, in certain circumstances it may operate in the S4 net or as established by the battalion SOI.

b. The ambulance teams routinely deploy with the maneuver company trains; however, it operates as far forward as the tactical situation permits, and frequently finds and treats patients who have not been seen by the company medic. This team, when operating in a company's AO, is normally under the tactical control of the company XO or first sergeant, but remains under the technical and operational control of the medical platoon. An ambulance team is normally designated to support a specific company. To become familiar with the specific terrain and battlefield situation, the team maintains contact with the company during most combat operations.

c. During static situations where the company is not in enemy contact or is in reserve, the

team returns to the BAS to serve as back-up support for other elements in contact. However, during movement to contact, the ambulance team immediately deploys to its regularly supported company. During combat operations, the team may dismount (leaving the ambulance in the trains area), find, treat, and move patients to safety, and later evacuate them to the BAS. When moving patients to the ambulance location, patient collecting point, or company aid post, the team is normally assisted by nonmedical personnel.

a continuous movement of patients. Medical evacuation is the process of moving patients from the point of injury or illness to an MTF or between MTFs. Each stop in the process is to provide medical treatment to enhance the patient's early RTD or to stabilize him for further evacuation. The responsibility for patient evacuation rests with the level of HSS to which the patient is to be evacuated (see Patient Evacuation Flow, Figure 5-6). Ambulances go forward, pickup patients, and move them to the supporting MTFs.

5-11. Medical Evacuation

a. Optimum patient care and treatment is dependent upon an evacuation system that provides

(1) Ambulance teams of the medical platoon evacuate patients from the company aid post or patient collecting points to the BAS.

(2) Ambulance squads of the FSMC evacuate patients from the BAS to the DCS.

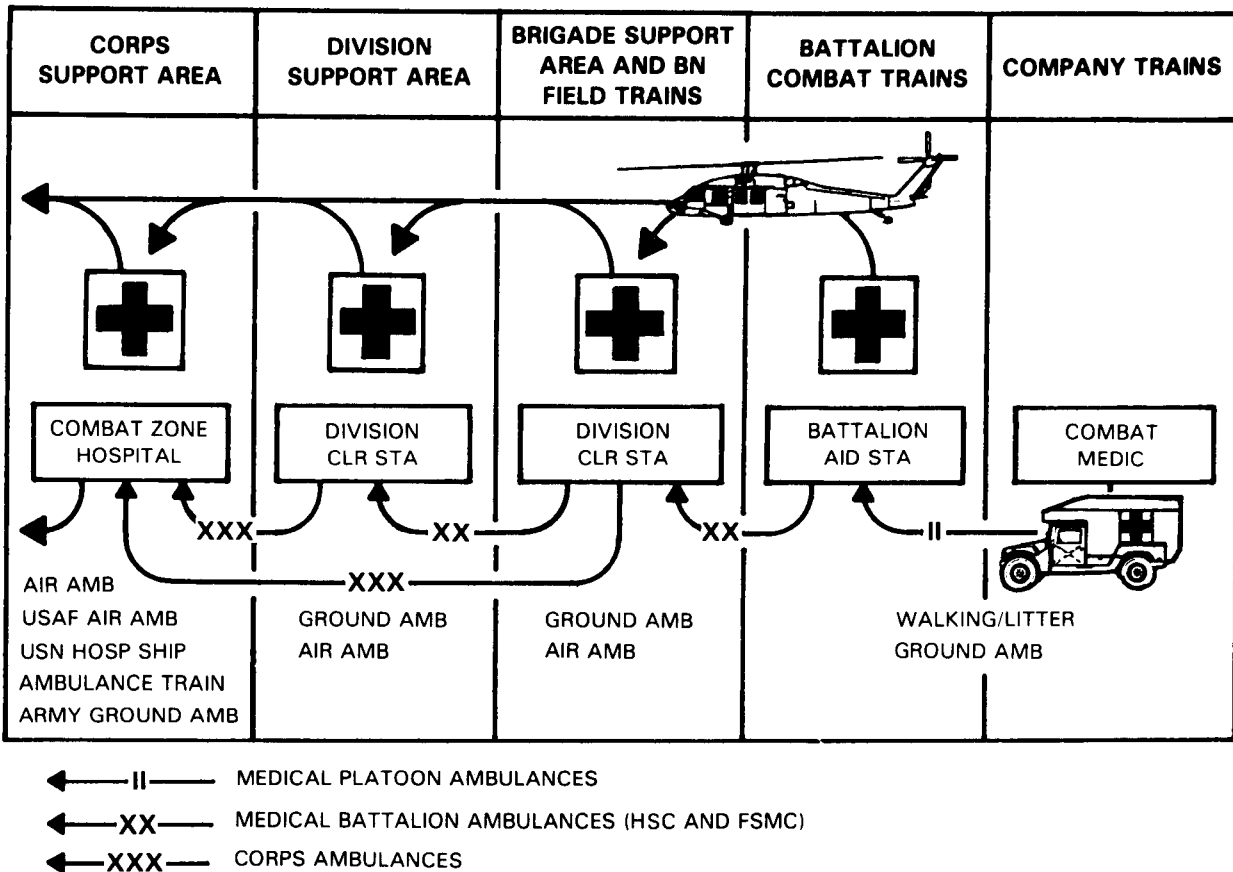


Figure 5-6. Patient evacuation flow.

b. An ambulance shuttle system may be set up between the FSMC DCS and the BAS. An AXP is established (Figure 5-7) so that ambulances are moving forward as others move rearward; thus

enabling a continuous rearward evacuation flow, while decreasing ambulance turnaround time. Patients are evacuated no further to the rear than their conditions require.

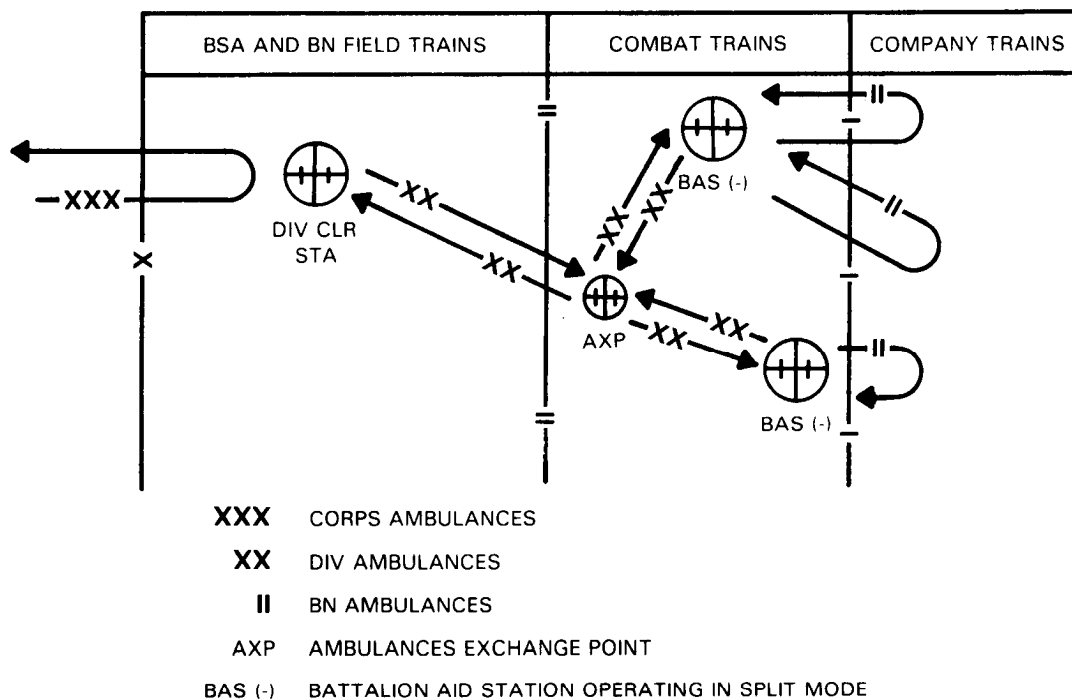


Figure 5-7. Ground ambulance shuttle system.

c. Aeromedical evacuation in the CZ should be used to the maximum extent possible for critically ill or wounded patients. Refer to Appendix F for medical evacuation request procedures. Normally, ground ambulances are used to evacuate the minimally ill or wounded and for those patients who cannot be evacuated by air. The specific mode of evacuation is determined by the patient's condition, aircraft/vehicle availability, the tactical situation, and weather conditions (METT-T factors). When both air and ground ambulances are used, specific factors are considered in determining which patients are to be evacuated by air and which are to be evacuated by ground ambulances (see FM 8-10-6). Normally, the physician or PA treating the patient (or the senior medic in their absence) makes this

determination; it is based on the medical condition of the patient. However, the goal is to get the trauma patient to the initial treatment/ATM element within 30 minutes of wounding.

5-12. Medical Supply

a. The medical platoon maintains a 2-day (48-hour) stockage of medical supplies. Normal medical resupply of the platoon is performed by the DMSO through backhaul or in coordination with the movement control office (MCO). Medical resupply may also be by preconfigured Class VIII packages (PUSH packages) throughput from the forward MEDSOM/MEDLOG battalion located in the corps support area (Figure 5-8).

Paragraph 5-13 implements STANAG 2128.

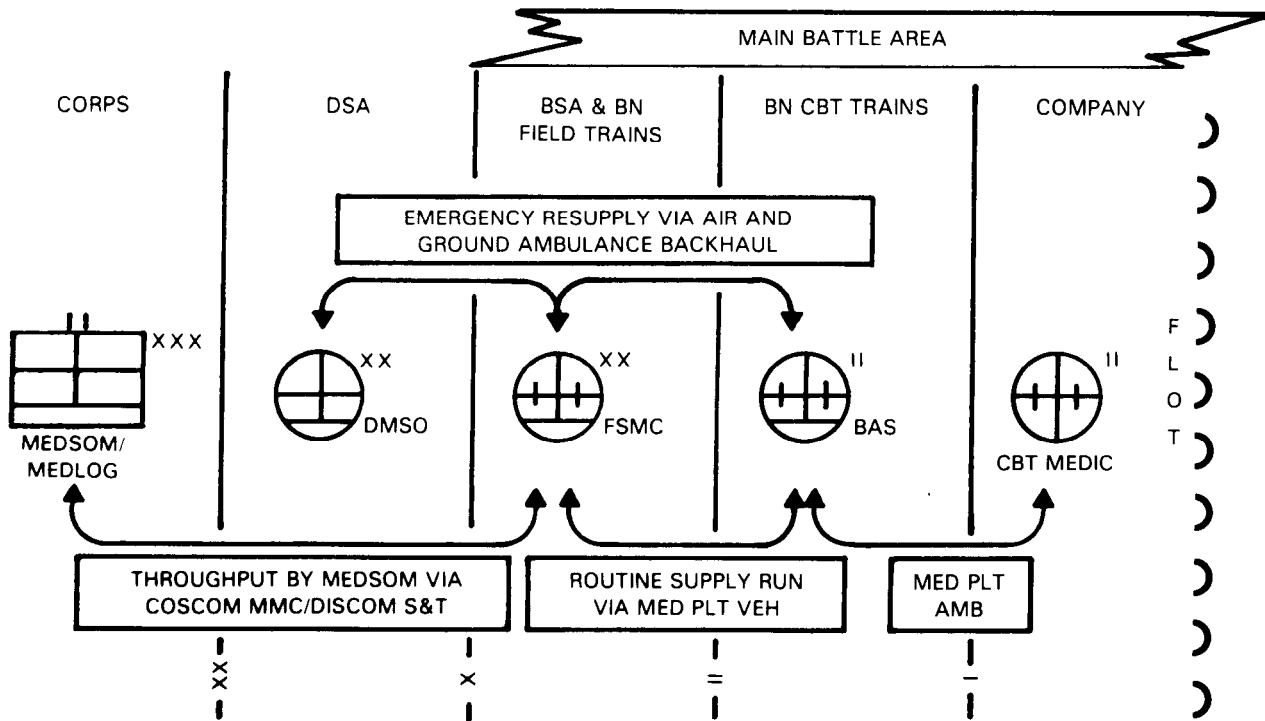


Figure 5-8. Flow of Class VIII supplies.

b. In a tactical environment, the emergency medical resupply (ambulance backhaul) system is used. In this environment, medical supplies are obtained informally and as rapidly as possible, using any available medical transportation assets. The medical platoon submits supply requests to the supporting FSMC, who in turn fills requests and ships supplies forward. Request for items not available at the FSMC are forwarded to the DMSO; the request is filled from division stocks and shipped to the requestor by the most expedient means available. Air ambulances from corps and ground ambulances from the DISCOM transport medical supplies directly to BASs. Class VIII resupply of combat medics is performed by ambulances of the medical platoon.

5-13. Property Exchange

Whenever a patient is evacuated from one treatment facility to another or is transferred from one ambulance to another, medical items such as casualty evacuation bags (cold weather type bags), blankets, litters, and splints remain with the patient. To prevent rapid and unnecessary depletion of supplies and equipment, the receiving agency exchanges like property with the transferring agency. Medical property accompanying patients of allied nations will be disposed of in accordance with command SOP and STANAG 2128, if applicable.

Section III. MEDICAL SECTIONS AND SPECIAL PURPOSE MEDICAL PLATOONS

5-14. Combat Support Unit and Division Headquarters Medical Section

Medical sections are organic to CS units and the division headquarters. With the exception of the

combat engineer battalion, a medical section in the light division normally consists of one treatment module. These treatment modules are designed to provide unit-level HSS for personnel of supported units. A medical section is relatively small in

comparison to a medical platoon; therefore, it will require augmentation from a supporting medical company in mass casualty situations.

organized as shown in Figure 5-9. Personnel staffing of this section includes a DIVARTY surgeon/operational medicine officer, a section sergeant/EMT NCO, and two medical specialists.

5-15. Medical Section, HHB Division Artillery

a. Organizations and Functions. The DIVARTY medical section/treatment team is

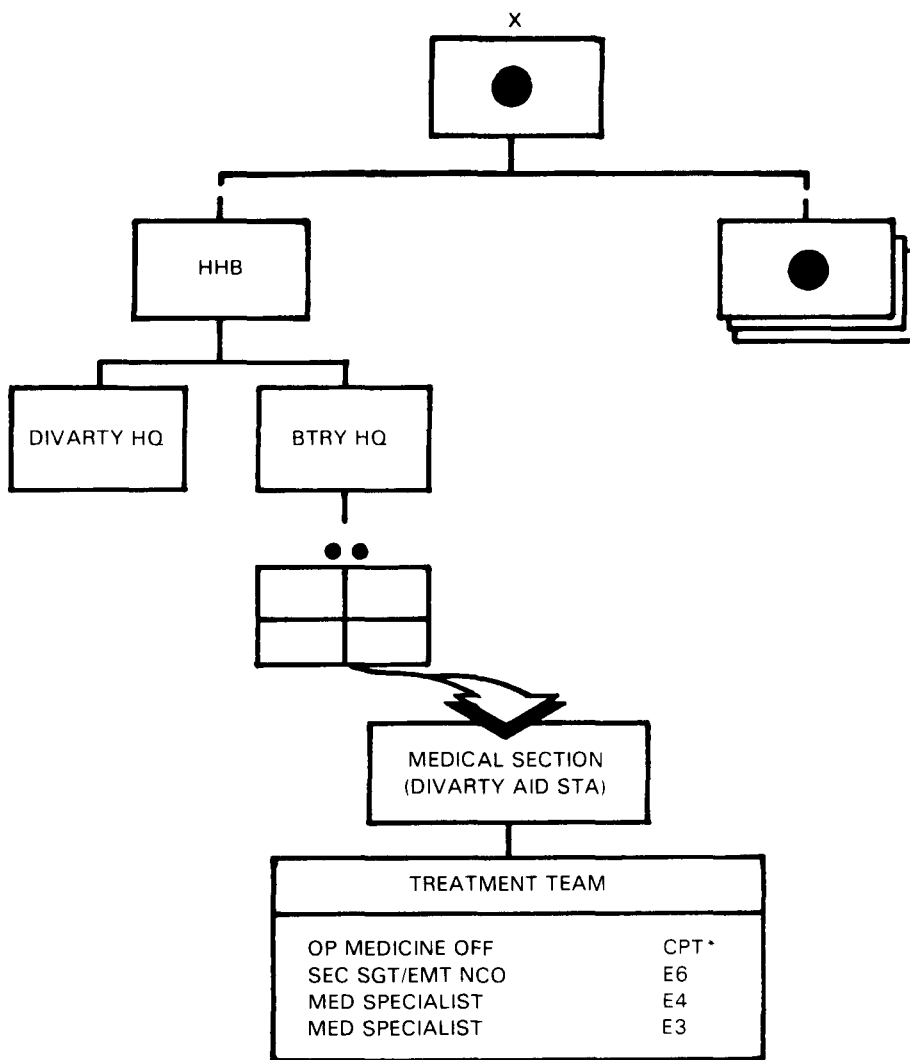


Figure 5-9. Medical section, HHB, division artillery.

(1) *DIVARTY Surgeon.* officer is the medical advisor to the DIVARTY commander and his staff. He is the primary care physician of the DIVARTY and is also the supervising physician for PA/medical section

leaders in the three FA battalions. Certain situations may require that the clinical supervision of PAs in FA units be passed to the physician in charge of the nearest supporting MTF. Such requirements, however, are coordinated through the

division surgeon. The DIVARTY surgeon is responsible for medical treatment provided by DIVARTY medical personnel (inclusive of medical personnel assigned to FA battalions). His duties include—

- Operating the DIVARTY aid station.

- Planning and directing unit-level HSS for members of the DIVARTY headquarters and FA battalions.

- Arranging for division-level HSS.

- Arranging for patient evacuation to the DCS.

- Supervising the administration and maintenance of equipment, the supply function, technical training, and the employment of medical personnel.

- Examining, diagnosing, treating, and prescribing courses of treatment for patients to include ATM for the trauma patient.

- Coordinating patient evacuation.

(2) *Section Sergeant.* The section sergeant, who is also an EMT NCO, assists the medical officer in accomplishing his duties and supervises the medical specialists. He prepares reports, requests general and medical supplies, maintains supply economy procedures, and maintains authorized stockage level of expendable supplies. This NCO also performs triage and ATM procedures in the care of trauma and NBC-insulted patients, and care and management of battle fatigue patients. He also performs routine patient care and NBC detection procedures. His duties further include—

- Establishing and operating the DIVARTY aid station.

- Maintaining the patient accountability/casualty reporting system.

- Maintaining medical equipment sets.

- Conducting tactical and technical proficiency training for subordinate members of the section.

- Conducting sanitation inspections of troop living areas, food service areas, waste disposal areas, and potable water distribution points and equipment.

(3) *Medical Specialists.* These specialists assist the section sergeant in accomplishing his duties. They perform triage and EMT. Their specific duties include—

- Erecting and breaking down field medical shelter systems, to include chemical/biological protective shelters.

- Performing patient care.

- Initiating patient records (FMC).

- Maintaining the patient daily disposition log.

- Operating and maintaining assigned vehicle, tactical radio, and power generation equipment. (Also may serve as a member on the battery field sanitation team.)

b. Employment. The medical section establishes a BAS near the DIVARTY headquarters and provides unit-level medical service for members of the DIVARTY headquarters and headquarters battery.

(1) The section employs a HMMWV treatment vehicle, a cargo trailer, and two medical equipment sets: one trauma treatment set and one general sick call set.

(2) For communications, the section employs a telephone set (TA 312/PT) and is deployed in the HHB wire net. It employs an FM tactical radio and is deployed as designated by the DIVARTY SOI. This section also has access to the supporting medical company's tactical operations net to request division-level HSS.

c. Operations. Paragraph 5-7 describes BAS operations; these are equally applicable to the

DIVARTY BAS. Figures 5-4 and 5-5 show suggested layouts of a BAS.

d. Medical Evacuation. The DIVARTY HHB medical section has no medical evacuation assets. Evacuation of patients to and from the DIVARTY BAS is provided by the supporting medical company in the DSA.

e. Medical Supply. The medical section maintains a 2-day (48-hour) stockage level of medical supplies for the HHB. Routine requests for medical supplies are submitted through command channels to the DMSO. Supplies may be picked up by the requesting unit or forwarded to the DIVARTY BAS during routine ambulance runs. For emergency resupply procedures, see paragraph 5-12 *b*.

f. Property Exchange. See paragraph 5-13.

5-16. **Medical Section, Headquarters and Headquarters Support Company, Direct Support Field Artillery Battalion**

This section is organic to the Headquarters and Headquarters Support Company (HHS) of the direct support (DS) FA battalions; it is organized as shown in Figure 5-10. Personnel staffing for this medical section includes a section leader/PA, a section sergeant/EMT NCO, two medical specialists, and three combat medics (battery aidmen).

a. Section Leader/Physicians' Assistant. The PA is an advisor to the battalion commander and his staff. He is the primary medical care provider for the battalion and supervises all activities of the medical section. The PA is trained in ATM procedures and works under the clinical supervision of a medical officer. He is responsible to the supervising physician for all treatment provided by medical personnel of the section. His specific duties include—

- Establishing and operating the BAS.
- Planning and supervising unit-level HSS and coordinating division-level HSS for the battalion.

- Treating, within his ability, patients reporting to him.

- Referring patients who require treatment beyond his capability to the supervising physician.

- Providing initial resuscitation (ATM) for the wounded.

- Training medical personnel and CLS in emergency medical procedures.

b. Section Sergeant. This NCO assists the PA in accomplishing his duties. The specific duties of this NCO are the same as those described for the medical section sergeant in the DIVARTY HHB (refer to paragraph 5-15 *a* (2)).

c. Medical Specialists. The duties and functions of these specialists are the same as those discussed in paragraph 5-15 *a* (3).

d. Combat Medics. Combat medics are allocated to a DS FA battalion on the basis of one to each firing battery. The duties and functions of combat medics are described in paragraph 5-8.

e. Employment. The medical section establishes a BAS near the DIVARTY headquarters and provides unit-level HSS.

(1) The section employs a HMMWV treatment vehicle, a cargo trailer, and two medical equipment sets: one trauma treatment set and one general sick call set.

(2) For communications, the section employs a telephone set (TA 312/PT) and is deployed in the HHS wire communications net. It also employs an FM tactical radio and is deployed in the net designated by the DIVARTY SOI. This section also has access to the supporting medical company's tactical operations net to request division-level HSS.

f. Operations. Paragraph 5-7 describes a BAS operation; these are equally applicable to the FA BAS. Figures 5-4 and 5-5 show suggested layouts of a BAS.

g. Medical Evacuation. The FA battalion's HHS medical section has no medical evacuation assets. Evacuation of patients to and from the BAS

is provided by the supporting medical company in the BSA.

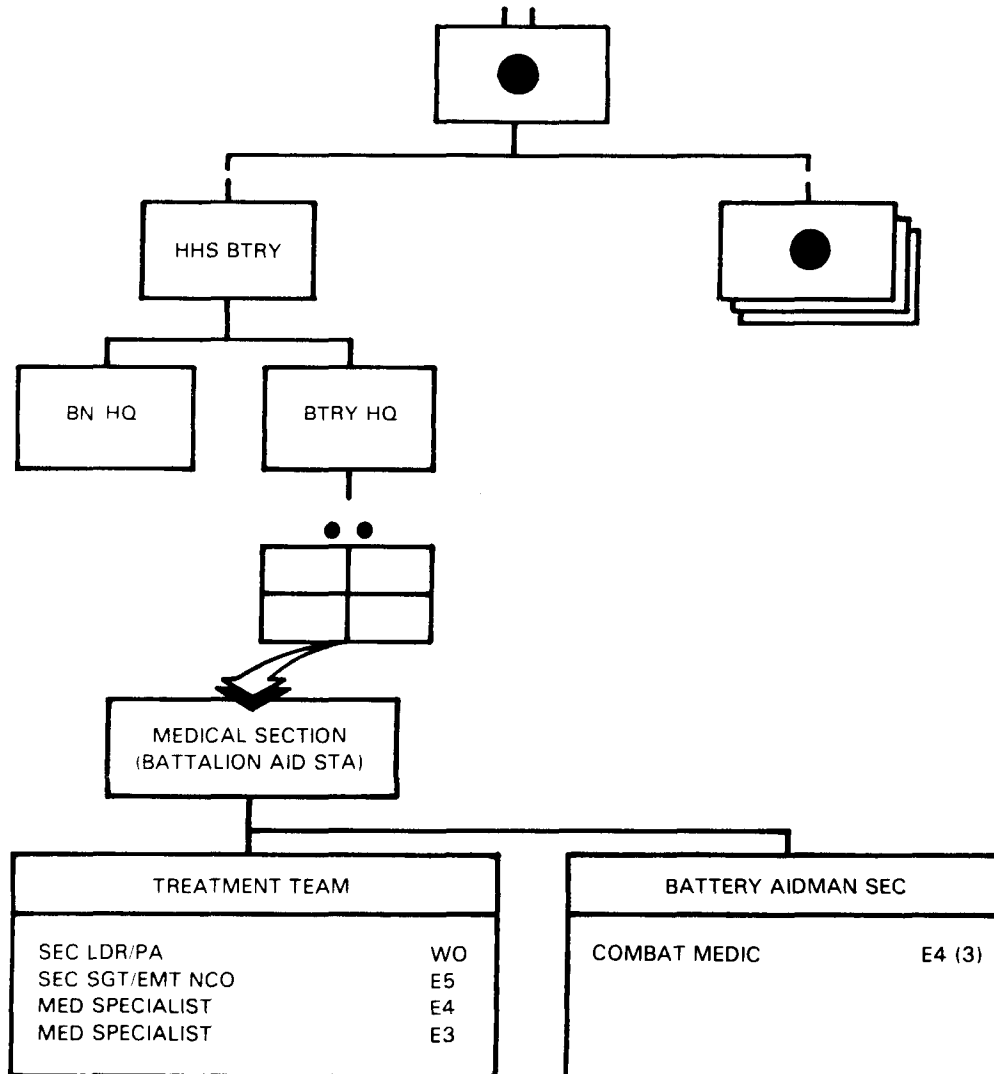


Figure 5-10. Medical section, HHS, direct support field artillery battalion.

h. Property Exchange. See paragraph 5-13.

5-17. Medical Section, Headquarters and Headquarters Company Combat Aviation Brigade/Combat Aviation Squadron

a. Organization and Functions. The CAB medical section is organized as shown in Figure 5-11. Personnel staffing this section include a flight surgeon, an assistant flight surgeon, a section sergeant/EMT NCO, and two medical specialists.

(1) The flight surgeon (brigade surgeon) is the medical advisor to the CAB commander and his staff. He is the primary care physician of the brigade. The flight surgeon is responsible for medical treatment provided by the medical section (brigade aid station). His duties include—

- Operating the brigade aid station.
- Examining and determining the medical qualification for flying status of

aviators within the brigade headquarters; or aviators referred to him by units without a flight surgeon.

- Planning and directing unit-level HSS for members of the brigade headquarters.
- Arranging for evacuation of patients to the DCS.
- Arranging division-level HSS.
- Supervising the administration and maintenance of equipment, the supply function, technical training, and the employment of medical personnel.

- Examining, diagnosing, treating, and prescribing courses of treatment for patients to include ATM for trauma patients.

(2) The assistant flight surgeon assists the flight surgeon in performance of his duties. He serves as the aviation brigade flight surgeon in the absence of the flight surgeon. His duties include—

- Examining and determining the medical qualification for flying status of aviators within the brigade headquarters; or aviators referred to his treatment section by units without a flight surgeon.
- Examining, diagnosing, treating, and prescribing courses of treatment for patients to include ATM for trauma patients.

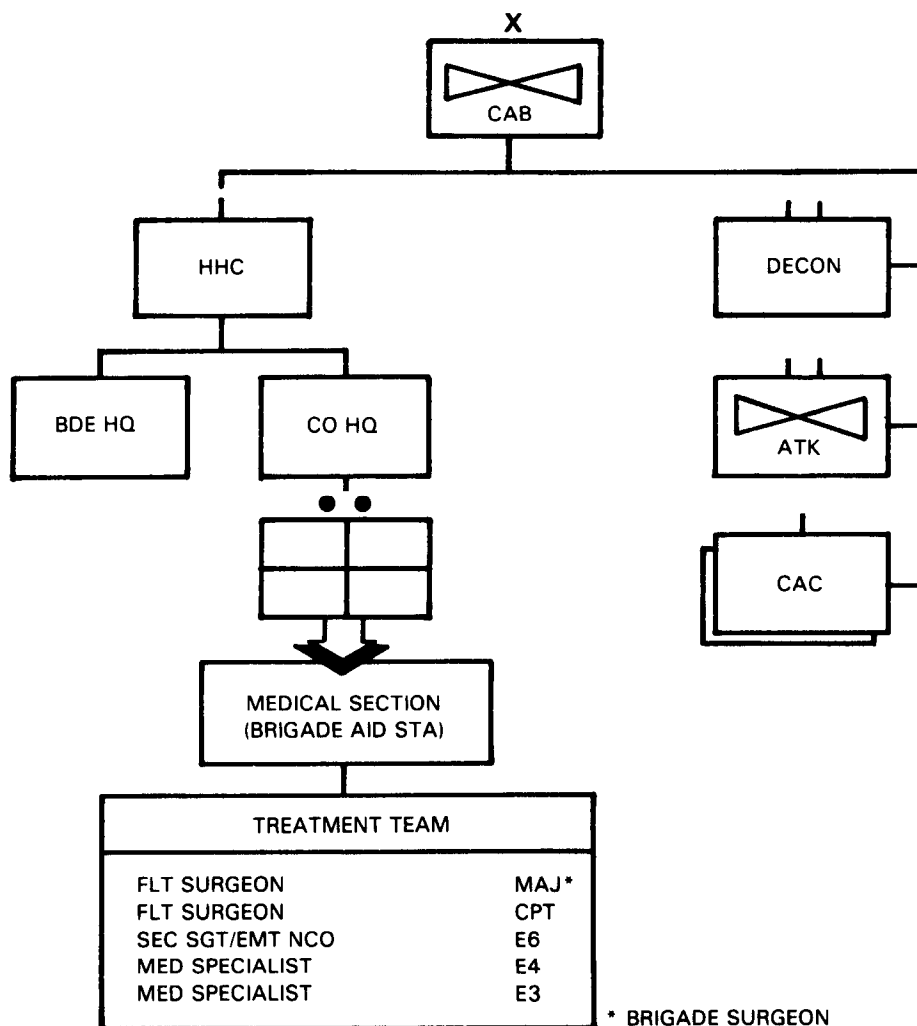


Figure 5-11. Medical section, HHC combat aviation brigade.

b. Employment. See paragraph 5-15 *b* for employment considerations.

c. Operations. Paragraph 5-7 describes aid station operations; these are equally applicable to the DIVARTY BAS. Figures 5-4 and 5-5 show suggested layouts of a BAS.

d. Medical Evacuation. The brigade HHC medical section has no medical evacuation assets. Evacuation of patients is provided by the supporting medical company.

e. Medical Supply. See paragraph 5-12.

f. Property Exchange. See paragraph 5-13.

5-18. Medical Section, HHC Attack Helicopter Battalion, CAB.

a. Organization and Functions. The attack helicopter battalion medical section is organized as shown in Figure 5-12. Personnel staffing this section include a section sergeant/EMT NCO, and two medical specialists. For further explanation, see paragraph 5-15 *a*.

b. Property Exchange. See paragraph 5-13.

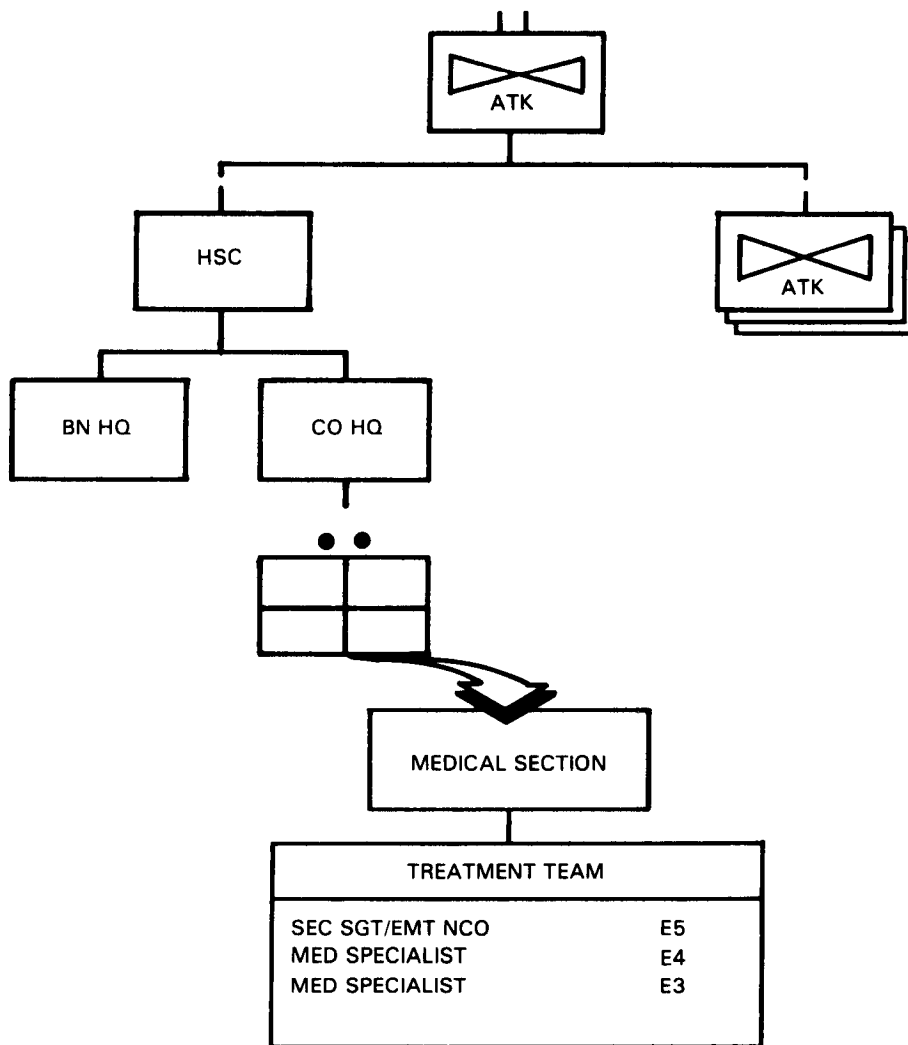


Figure 5-12. Medical section, HHC attack helicopter battalion.

5-19. Medical Platoon, HHT Reconnaissance Squadron, CAB.

a. Organization and Functions. The HHT reconnaissance squadron CAB medical platoon is organized as shown in Figure 5-13. Personnel staffing this platoon include a flight surgeon, a PA, a section sergeant/EMT NCO, two medical

specialists, six combat medics, four aid evacuation NCOs, and two aid evacuation specialists.

(1) For flight surgeon responsibilities, see paragraph 5-17.

(2) The PA performs general technical health care and administrative duties (refer to paragraph 5-5).

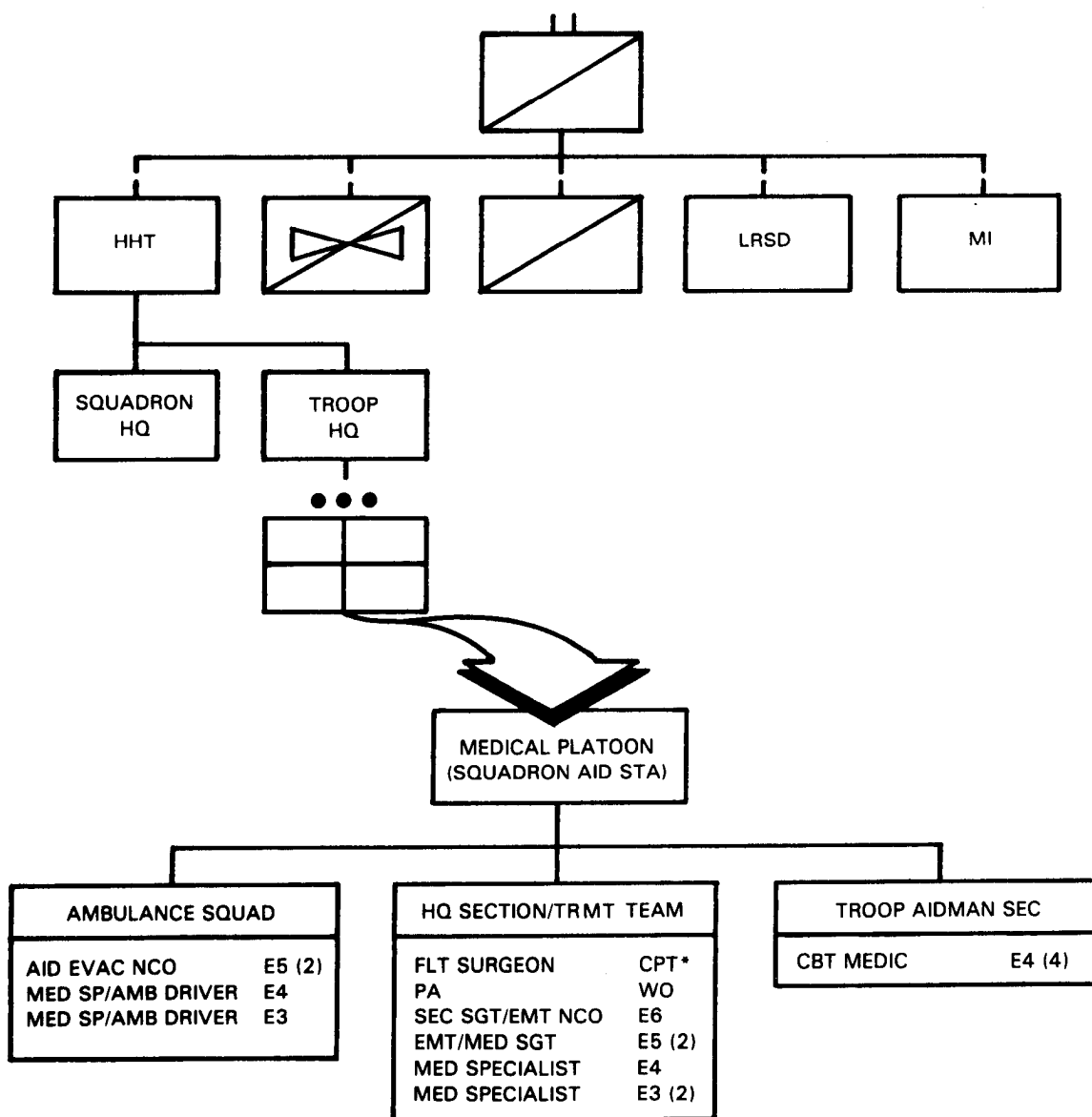


Figure 5-13. Medical platoon, HHT reconnaissance squadron.

b. Section Sergeant. This NCO assists the PA in accomplishing his duties. The specific duties of this NCO are the same as those described for the medical section sergeant in the DIVARTY HHB (refer to paragraph 5-15 a (2)).

c. Medical Specialists. The duties and functions of these specialists are the same as those discussed in paragraph 5-15 a (3).

d. Combat Medics. These aidmen are allocated to a squadron on the basis of one to each firing troop. The duties and functions of combat medics are described in paragraph 5-8.

e. Ambulance Squad. Paragraph 5-10 describes duties of ambulance squad members.

f. Employment. The medical section establishes a BAS near the squadron headquarters and provides unit-level medical service for members of the squadron.

(1) The section employs a HMMWV treatment vehicle, a cargo trailer, and two medical equipment sets: one trauma treatment set and one general sick call set.

(2) For communications, the section employs a telephone set (TA 312/PT) and is deployed in the HHS wire communications net. It also employs an FM tactical radio and is deployed in the net designated by the squadron SOI. This section also has access to the supporting medical company's tactical operations net for requesting division-level HSS.

g. Operations. Paragraph 5-7 describes an BAS operation; these are equally applicable to the squadron BAS. Figures 5-4 and 5-5 show suggested layouts of a BAS.

h. Medical Evacuation. Evacuation of patients from the BAS is provided by the supporting medical company.

i. Medical Supply. The medical section maintains a 2-day (48-hour) stockage level of medical supplies for the squadron. Routine requests for medical supplies are submitted through command channels to the DMSO. Supplies may be picked up by the requesting unit or forwarded to the

BAS during routine ambulance runs. For emergency resupply procedures, see paragraph 5-12.

j. Property Exchange. See paragraph 5-13.

5-20. Medical Section, HHC Division Headquarters

a. Organizations and Functions. The HHC division headquarters medical section is organized as shown in Figure 5-14. Personnel staffing of this section includes an operational medicine officer, a section sergeant/EMT NCO, two medical specialists, and two aid evacuation specialists.

(1) *Operational medical officer.* The operational medical officer is responsible for medical treatment provided by HHC medical personnel. The specific duties of this medical officer are the same as those described in the DIVARTY HHB (refer to paragraph 5-15 a (1)).

(2) *Section sergeant.* Refer to paragraph 5-15 a (2).

(3) *Medical specialists.* Refer to paragraph 5-15 a (3).

(4) *Aid evacuation team.* Paragraph 5-10 describes employment of ambulance teams.

b. Employment. The medical section establishes a BAS near the division headquarters and provides unit-level HSS for members of the division headquarters and headquarters company.

(1) The section employs a HMMWV treatment vehicle, a cargo trailer, and two medical equipment sets: one trauma treatment set and one general sick call set.

(2) For communications, the section employs a telephone set (TA 312/PT) and is deployed in the HHB wire communications net. It also employs an FM tactical radio and is deployed in the net designated by the division SOI. This section also has access to the supporting medical company's tactical operations net to request division-level HSS.

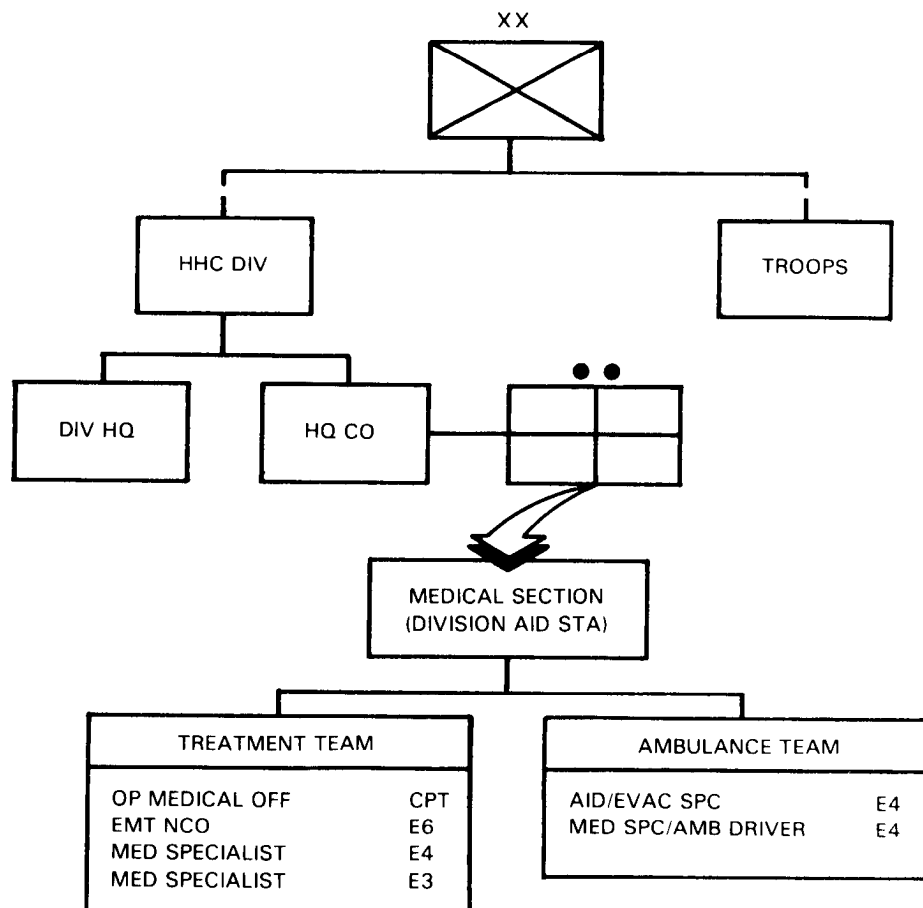


Figure 5-14. Medical section, HHC, division headquarters.

5-21. Medical Platoon, HHC Combat Engineer Battalion

a. Organization and Functions. The combat engineer battalion medical platoon is organized as shown in Figure 5-15. Personnel staffing this section include an operational medical officer, a section sergeant/EMT NCO, an emergency medical NCO, two medical specialists, six combat medics, and two aid evacuation specialists. The operational medical officer (battalion surgeon) is the medical advisor to the combat engineer battalion commander and his staff. He is the primary care physician of the battalion. He is responsible for medical treatment provided by the medical platoon. The specific duties of this medical officer are the same as those described in the DIVARTY HHC (refer to paragraph 5-15 a (1)).

b. Section Sergeant. Refer to paragraph 5-15 a (2).

c. Medical Specialists. Refer to paragraph 5-15 a (3).

d. Combat Medics. The duties and functions of combat medics are described in paragraph 5-8.

e. Aid Evacuation Specialist. The duties of the aid evacuation specialist are described in paragraph 5-10.

f. Employment. The medical section establishes a BAS near the engineer battalion and provides unit-level HSS.

(1) The section employs a HMMWV treatment vehicle, a cargo trailer, and two medical equipment sets: one trauma treatment set and one general sick call set.

(2) For communications, the section employs a telephone set (TA 312/PT) and is

deployed in the HHB wire communications net. It also employs an FM tactical radio and is deployed in the net designated by the engineer SOI. This section

also has access to the supporting medical company's tactical operations net to request division-level HSS.

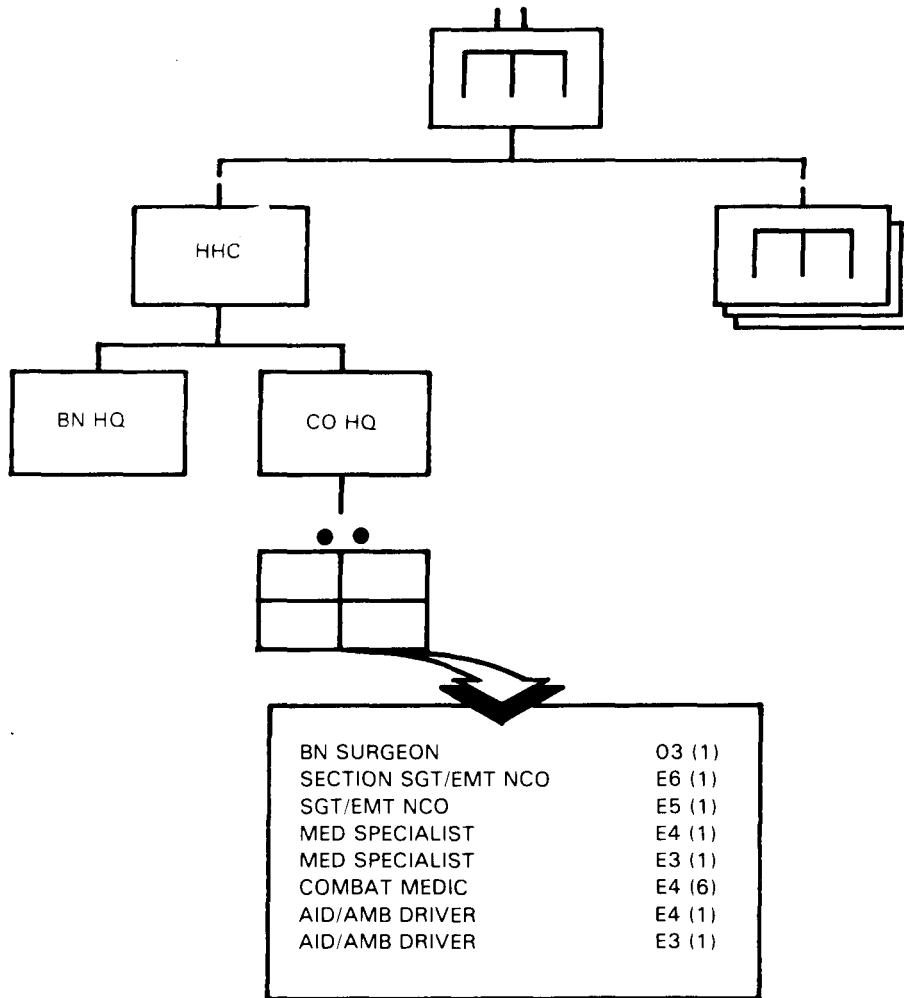


Figure 5-15. Medical platoon, HHC engineer battalion.

Section IV. OPERATING THE MEDICAL PLATOON

5-22. Introduction

a. Responsibilities. The medical platoon leader is responsible for providing quality HSS to the battalion. A medical operations officer, a platoon sergeant, a PA, and combat medics are assigned to help accomplish this mission.

b. Organization and Functions. An effective platoon leader must first understand the organization and functions of the platoon. The

officers basic course and Sections I, II, and III of this chapter explained how it is supposed to work. Now find out how the platoon really works: How is it unique? What are its strengths and weaknesses? It will take time to assess this, but the platoon leader should begin immediately by being observant and asking questions.

c. Structure. Look at the physical plant. How is the garrison BAS laid out? Who has offices and desks? Why? Is there awaiting area for sick call

patients? Is it adequate? Where are patients screened? Where does the PA see patients? Are there exam tables? Does the layout make the best use of the available space? Is the lighting adequate? Where are medical records maintained and are they secure? Where are the sets, kits, and outfits (SKOs) kept? Where are the medical supplies kept? Is the aid station clean? Does it need to be painted?

d. Getting to Know the Platoon.

- How do assigned soldiers interact? Are they cohesive? Who are the informal leaders? Ask the S3 how the platoon performed on the last Army Training Evaluation Plan (ARTEP); how it did at Combat Training Center (CTC); how it performed on other major field training exercises. What does the HHC commander think of the platoon? What does the HHC first sergeant think of it? Are the line company commanders satisfied with the HSS they are receiving? What does the brigade's medical company commander think of the unit? What are the division surgeon's/DMOC's evaluations? Is the battalion commander satisfied with the HSS he is receiving?

- These are just some of the many questions a platoon leader should begin to answer. As he becomes familiar with the platoon, he will find other areas which need attention. The key is to LEARN!

- Mistakes are part of the learning process. A platoon leader should not be afraid to make mistakes; however, the key is to learn from mistakes and not make the same one twice.

e. Personnel. A platoon leader must get to know his platoon members.

(1) *Medical operations officer.* What is the medical operations officer's background? What were his previous assignments? Has he participated in operational planning for employment of medical units? Does he understand tactical operational procedures and maneuvers? Can he organize unit loading plans for best support operations? Does he understand the Army Equipment Maintenance Program? Does he have a working knowledge of general and medical supply operations? How does he get along with other members of the platoon? Does he train personnel in administrative,

maintenance, and logistical procedures? Does he provide tactical training for platoon personnel?

(2) *Platoon sergeant.* What is the platoon sergeant's background? What were his previous assignments? How long has he been in the unit? What is his education level? Is he EMT certified? Does he have the EFMB? What did he score on his last SQT? Is he physically fit? Does he possess a good military appearance? What is his management style? How do the soldiers react to him? How does he see his role? What does he think of his own previous performance? What does he think of the platoon? What does he expect of the platoon leader? How does he see the leader's role? The platoon sergeant-platoon leader relationship is vital, especially knowing, understanding, and trusting one another. If the platoon sergeant is good, learn from him. If he is mediocre, push him. If he is bad, counsel him (document the counseling and coordinate further actions with the HHC commander).

(3) *Physicians' assistant.* Many of the same questions asked of the platoon sergeant should be asked of the PA. Many of the same observations should be made. Additionally, an attempt should be made to evaluate the PA's technical expertise. Does he train the medics? Does he "teach" the medics? How does he handle himself with patients? The brigade surgeon should be asked for his evaluation of the assigned PA; the platoon leader should keep the brigade surgeon informed of his impressions of the PA, positive or negative.

(4) *Combat medics.* Why are they medics? Why are they in the Army? What do they think of the platoon? Do they have EMT/EFMB certifications? Can they read a map? Can they use a radio properly? How did they score on their last SQT? How did they score on their last Army Physical Readiness Test (APRT)? Married? Children? Previous assignments? Age? How is their haircut, uniform, weight? Do they want to stay in the Army? What is their job (in their own words)? How do they like their jobs? Are they satisfied with their own performance? What are their goals?

f. Transportation. Getting to know the vehicles.

(1) *Status.* Does the platoon have all the vehicles it is authorized? If not, why? Do the

vehicles have communications (commo)? Does it work? What is the maintenance status of the vehicles? Are they generally well maintained? (Ask the XO or motor sergeant.) Are the vehicles painted with the appropriate color scheme? Do they have the Geneva emblem?

(2) *Preventive maintenance checks and services.* Have the platoon sergeant teach preventive maintenance checks and services (PMCS) for each of the assigned vehicles using the -10 technical manual standards. Spend a Saturday morning doing this if necessary. Get with the motor sergeant or XO and become familiar with maintenance procedures. Spend time in the motor pool every day. Learn to operate all of the vehicles. The more knowledge the platoon leader has about maintenance in general and the status of each of the assigned vehicles, the better off the platoon will be.

g. Learn Standard Procedures. A platoon leader must familiarize himself with the unit's SOPs; the tactical SOP, administrative-logistics SOP, and maintenance SOP. What additional SOPs does the platoon use; sick call, deployment, maintenance, training, and Medical Proficiency Training Program (MPTP)? Are the SOPs adequate. Are they simple and understandable?

5-23. Garrison Operations

a. Routine Activities. The primary job for soldiers is to be prepared for war. They prepare for war by training, which means frequent field exercises. Field exercises are vitally important; however, the majority of most soldiers' time is spent in garrison. The manner in which routine garrison activities are conducted is indicative of the way soldiers will perform during training exercises and in combat. Run a tight ship in garrison; it will pay big dividends in combat.

b. Battalion Aid Station Administration. Sick call is a daily activity which usually takes place first thing in the morning. It is normally scheduled for 1 hour, starting between 0530 and 0730. There is no standard method of conducting sick call. An aid station should have a sick call SOP which explains the unit's sick call procedures. Review the SOP with the PA and other members of the unit to ensure their satisfaction with it. To improve your

operations, visit other aid stations to see how they conduct sick call. A sequence in which sick call may be conducted is—

- Patient reports to the aid station with a sick slip (DA Form 689) signed by his company commander/representative.
- The patient is met at reception desk; a medic takes the sick slip, and directs the patient to a seat in the waiting area.
- Receptionist “logs patient in” using some type of aid station log book.
- Receptionist pulls patient's health record (HREC) from the file and annotates the date and patient's unit of assignment on a SF 600 (Health Record-Chronological Record of Medical Care).
- Receptionist places a sign-out card (OF 23) in place of the HREC in the file drawer.
- Receptionist places patient's sick slip in HREC folder and gives HREC to medic designated to take vital signs.
- Prior to taking vital signs, medic ensures that the SF 600 is filled out correctly.
- Medic calls for patient by name.
- Medic checks vital signs and records them on the SF 600.
- Medic obtains patient history, performs evaluation, and records the information on SF 600. Medic must sign the entry.
- Physician/PA reviews the record, discusses the case with the medic, and either treats the patient or directs the medic as to proper treatment. Physician/PA makes notes as appropriate and countersigns the SF 600.
- Patient is treated/medications dispensed.
- Patient is returned to duty (RTD), put on quarters, or sent to troop medical clinic (TMC).

- Receptionist “signs patient out” in log book.

NOTE

When physician/PA is not present, medics may use DA Form 5181-R (Screening Notes of Acute Medical Care [LRA]) in accordance with instructions to evaluate patient and countersign notes.

c. Medical Records Administration.

(1) Purpose.

- The HREC is a permanent and continuous file which is begun when a soldier enters the service. The records kept in it are prepared as the member receives medical and dental care or takes part in research.

- The primary purpose of the HREC is to ensure that AMEDD personnel have a concise but complete medical history of everyone on active duty or in a Reserve Component.

(2) Terminal digit filing system.

(a) Medical record folders (DA Form 3444-series) are 10 differently colored folders. The color of the folder represents the last two digits (the primary group) of the patient’s social security number (examples: orange folder—00-09; light green—10-19). Using the terminal digit filing system (TDFS), HRECs are filed with those of like color.

(b) Under the TDFS, the sponsor’s (soldier’s) SSN is divided into three groups. Records are filed using the last two groups; these are the last four digits of the social security number. The last two digits are known as the primary group; the next-to-last two digits are the secondary group. Records are arranged first by their primary group numbers, resulting in folders of like colors being filed together. Within each primary group, the records are arranged in order of their secondary group numbers. Within the secondary group,

records are filed numerically by the first five digits of the SSN.

(3) *Policies and procedures.* Army Regulation 40-66 sets policies and procedures for preparing and using Army medical records. These regulations should be read and kept handy. They provide the “what” and “how to” of medical records administration.

(4) *Inventories and records review.* HRECs should be inventoried monthly for accountability and quarterly for compliance with AR 40-66. When conducting the quarterly review of HRECs, medics should ensure the following criteria are met:

- Medical records jacket is filled out correctly (AR 40-66).

- All forms in the medical record are in correct order as shown in AR 40-66.

- The privacy act statement (DD Form 2005) which is printed on the inside (back) of the DA Form 3444-series jacket is signed and dated as required by AR 40-2.

- A completed SF 88 and SF 93 (as required) are in the medical record and have a physician’s signature (AR 40-501).

- Medical records for personnel with allergies are identified with DA Label 162 and a DD Form 3365 present (AR 40-15).

- Ensure that DA Form 3444-series record jackets are being used for active duty personnel. This includes all temporary/new medical records.

- Immunizations are recorded in the medical record and in the PHS-731 as prescribed in AR 40-66.

- Ensure that immunizations are given to all personnel in accordance with AR 40-562 and as directed by the surgeon.

- Ensure that TB Tine tests have been administered with every periodic physical (AR 40-26).

- Ensure that at least one set of fitted earplugs is in the soldiers' possession upon arrival.
- Ensure that service member's blood type is entered on front of medical record jacket (AR 40-66).
- Determine if personnel who wear glasses need CB mask inserts ordered, or need a new prescription if the last one is over 2 years old?
- Ensure laboratory reports and x-ray report forms are mounted on their respective display sheets.
- Ensure that the medical record jacket has the correct tape coding (AR 40-66).
- Ensure medical records removed from the files are accounted for by use of a signed card (OF 23).
- Records for personnel who PCS (Permanent Change of Station) or ETS (Expiration Term of Service) are logged in the PCS/ETS book.
- Medical record files are screened at least quarterly (AR 40-66).

5-24. Medical Assemblage and Equipment Sets Management

a. Assemblage. Medical assemblage management is not a difficult task. Yet, this is one area in which medical platoon leaders frequently run into trouble. Failure to account for materiel is inexcusable. The best way to prevent accountability problems is to become thoroughly familiar with the property management system and then use it. The medical platoon leader is accountable for the supplies and equipment issued to the platoon. The medical platoon leader has supervisory responsibility for all property; he may be held liable for damage or loss even if he has not signed for any property.

b. Equipment Sets. The medical equipment set (MES), frequently referred to as sets, kits, and outfits (SKO), provides the capability for the

medical platoon to perform its mission. The MES contains the medical supplies and equipment used in providing HSS to the battalion. It is contained in metal chests which are stored in the BAS.

(1) *Types of sets.* There are two types of medical equipment sets: service-unique MES and multi service MES. The set issued to the battalion medical platoon is a service-unique MES. It is managed by the Army Medical Department and consists of medical and nonmedical items under a single stock number. Service-unique MES are identified in Volume I of the Department of Defense (DOD) medical catalog. Revisions to components of the MES are published annually in the supply bulletin (SB) 8-75 series. The supply bulletin revisions constitute authority for updating assemblages.

(2) *Component accountability.* The medical platoon MES (National Stock Number 6545-00-457-6858) consists of expendable, durable, and nonexpendable items. It is important to maintain control of all types of supplies; however, property accounting records of nonexpendable items must be kept. DA Pamphlet 710-2-1 explains procedures to use in maintaining these records.

(3) *Inventory.* Components of the MES are inventoried at least every six months and after each FTX. This is done to maintain accountability and assure readiness. During the inventory, a serviceability inspection is also conducted. Replace obsolete, deteriorated, and outdated items; repair or replace unserviceable items. Ensure that the MES storage area provides adequate security and protection from extreme temperatures.

(4) *Control of medications.*

(a) A DD Form 4998-R (Quality Control and Surveillance Records for TOE Medical Assemblages) is prepared for each dated item of medical supply. Inventory these medications regularly to ensure 100 percent accountability. Check with the DMSO and ask for the local procedures for drug rotation. The DMSO should allow rotation of medications which are nearing their expiration date (example: 90 days from expiration). Effective drug rotation requires management of quality control cards and coordination with the

DMSO. It increases the efficiency of the medical supply system and saves battalion budget dollars.

(b) Controlled medical items (scheduled drugs) may not be stored at the BAS during peacetime. However, a prepared DA Form 2765-1 (Request for Issue or Turn-in), less document number, with an 06/05 priority designator for required medications (code R&Q items) is maintained. The DMSO will fill these requests upon notification of the unit's deployment.

(c) Expired stocks of medical supplies and items determined to be unsafe or unsuitable for use will be destroyed in accordance with AR 40-61. Destruction is normally accomplished at the DMSO, not the BAS; usually on a monthly basis and requires a DA Form 3161 (Request for Issue or Turn-in) from the supported unit.

5-25. The Division Medical Supply System

a. Health Services Materiel Officer. The HSMO is a special staff officer who provides medical logistical support to the division. This support is in the form of both medical supply and maintenance of medical equipment. The HSMO also provides advice and assistance on matters pertaining to medical materiel. The HSMO is a member of the division medical supply section of the MSMC.

b. Mission. In peacetime, the DMSO resupplies the DISCOM medical companies and the division medical platoons using supply point distribution. (This means supported units pick up supplies from the supply point.) The Class VIII supply point (DMSO warehouse) is normally located in the MSMC's AO. Each supported unit has a supply account with the DMSO. Routine supply requests come from the supported unit directly to the DMSO. However, requests for nonexpendable items must go through the requestor's unit property book officer (PBO). Refer to the battalion SOP for specific procedures.

c. Receipt for Supplies. To establish a Class VIII supply account, the supported unit must provide the DMSO a DA Form 1687 (Notice of Delegation of Authority-Receipt for Supplies). The DA Form 1687 is prepared in accordance with AR

710-2 and AR 40-61. A new DA Form 1687 must be submitted upon change of approving authority; upon the addition or deletion of a designated individual; or at a minimum, every 12 months. Only those individuals designated on the DA Form 1687 are authorized to receipt for medical supplies.

d. Request Document. The DA Form 2765-1 is used to request medical supplies. Information needed to complete this form can be found in the Army Master Data File (AMDF). The original completed DA Form 2765-1 should be given to the PBO/DMSO. The BAS should retain the third copy (flimsy) of the DA Form 2765-1 in a due-in status file.

e. Durable Items. Request for durable items of medical supply are handled in much the same way. Some additional documentation, such as a memorandum explaining why the item is needed, is normally required for durable items. Request for durable medical items are sent from the unit supply room to the DMMC. Upon receipt of the item, the DMMC notifies the unit supply room and a designated individual from the unit receipts for the item. The item is then placed on the unit's property book (hand receipt) and issued to the medical platoon.

f. Document Register. The BAS must maintain a DA Form 2064 (Document Register) which lists all medical supply transactions. The document register should be kept in accordance with DA Pam 710-2-1 and should be reconciled monthly. The DMSO can provide assistance in establishing or reconciling the document register.

g. Priority Designator System. In medical supply, a priority designator system is used to establish priority for requested supplies. The priority designators authorized for use are the same as used in requesting other classes of supplies. Priority designators and their uses are—

- 13 (12 in USAREUR and some CONUS units) —this number is used for all normal supply transactions.

- 06 (05 in USAREUR and some CONUS units) —this number is used for items which, by their absence, cause a unit's mission to be

impaired. The DMSO will attempt to immediately fill an 06/05 request. The company commander of the requesting unit must sign the back of the DA Form 2765-1 for 06/05 requests.

- **03 (02 in USAREUR and some CONUS units)** —this is the highest priority available for medical supplies and denotes a life or limb emergency. Supply requests with an 03/02 priority must be signed by a physician and authenticated by the battalion commander of the requesting unit. The DMSO will immediately fill an 03/02 request. If the item is not available, the DMSO stops all other activity and uses every available means to secure the needed item. Thousands of dollars may be expended to get the high priority item to the location in which it is needed by the most rapid means; therefore, ensure that the correct priority designator is used on a supply request.

h. Excess Materiel. It is important that units not maintain more medical supplies than they are authorized. However, situations arise where a unit acquires excess supplies. Turn in these supplies to the DMSO using a DA Form 2765-1. Check with the DMSO for local policies governing the turn-in of excess medical materiel.

5-26. Immunizations

a. Responsibility. Commanders are responsible for assuring that all unit personnel receive required immunizations and that records of such immunizations are maintained.

b. Immunization Records. Soldiers are issued PHS Form 731 (International Certification of Vaccination, II Personal Health History) when they receive initial immunizations upon entering the military service. At the same time, a SF 601 (Immunization Record) is initiated and placed in the soldier's health record. These forms are compared for accuracy when the soldier in processes to a new unit. If the soldier requires immunizations, refer him to the supporting TMC or hospital.

c. Administering Immunizations. On occasion, immunizations may be given at the BAS, such as flu shots. When this is done, a "member of the medical department/service trained and qualified in emergency resuscitative techniques" (this normally means a physician or PA) must be

present. An emergency tray (shock tray) must also be on hand for immediate treatment of serious reactions. Personnel administering immunizations must be trained in immunization procedures. A list of personnel authorized to administer immunizations should be maintained at the BAS. When planning to give immunizations at the BAS, coordinate with the supporting TMC and brigade/division surgeon.

d. Status of Personnel. The BAS maintains an immunization status composite record of all personnel in the unit. AR 40-66 and DA Pam 600-8 require that this record be inspected by the unit commander at specific intervals.

5-27. Maintenance

a. Maintenance Program. An effective maintenance program is essential to ensure a unit's ability to perform its mission. The most important element in a unit maintenance program is the equipment operator. He must be familiar with his equipment and able to maintain it. Leaders ensure that operators are trained in equipment maintenance procedures.

b. Procedures. This section represents a basic overview of maintenance procedures. Use it as a starting point from which to learn maintenance and maintenance management procedures. To learn what you need to know requires that you "learn by doing."

c. Levels of Maintenance. Maintenance operations are divided into three levels (unit, intermediate, and depot) to efficiently coordinate them with other military operations.

- **Unit maintenance.** Unit maintenance is similar to the maintenance applied to privately - owned vehicles. It focuses primarily on minor repairs, adjustments, and replacing minor components, such as starters, generators, brakes, and spark plugs. The equipment operator/crew with the aid of unit mechanics perform unit maintenance. This is the level of maintenance with which a platoon leader is primarily involved.

- **Intermediate maintenance.** The intermediate level of maintenance has two

orientations, direct support (DS) and general support (GS).

- **Direct support maintenance units** perform repair and return to the user functions. They are organic to the division and focus on far forward support. Direct support maintenance units perform repair work beyond the capability of unit maintenance.

- **General support maintenance units** perform major repairs and overhauls. Items repaired at the GS level are returned to the supply system. General support maintenance does not perform a repair and return to the user function.

- **Depot maintenance.** Depot maintenance is performed at fixed facilities in CONUS and major overseas areas. Depot maintenance is characterized by overhaul and rebuild functions.

d. Maintenance Terms and Functions. To understand maintenance, a platoon leader must first become familiar with terms used to describe various maintenance functions.

- **Prescribed load list.** A prescribed load list (PLL) is the unit's repair parts stockage. It is composed of an authorized stockage list (ASL) which is a list of parts prescribed for a unit; also demand supported and command supported items. Demand supported items are parts for which sufficient need has been historically established to justify their stockage. Command supported items are parts which the unit commander has directed be stocked.

- **Preventive maintenance checks and services.** Preventive maintenance checks and services (PMCS) consist of periodic checks (before, during, and after operations; daily, weekly, monthly) and scheduled services (Q-services). The operator's technical manual (-10) for each item of equipment lists the PMCS to be conducted and their frequency.

- **Cannibalization.** Authorized removal of serviceable parts from unrepairable equipment by maintenance units.

- **Controlled exchange.** Removal of serviceable parts from unserviceable but repairable

equipment to bring a like piece of equipment to operational status. This requires command authorization.

- **Technical manuals.** Technical manuals (TMs) provide technical information (operator instructions, repair procedures, and repair parts) about specific pieces of equipment. Technical manuals are referred to as -10s (operator's manual), -20s (unit and DS maintenance manuals), -30 (DS/GS manuals), -40 (GS and depot manuals), and -14 (applies to all levels).

e. Battle Damage Assessment and Repair. Battle damage assessment and repair (BDAR) techniques expedite return of a damaged piece of equipment to the current battle.

- Battle damage assessment is used to determine the extent of damage to equipment. Equipment is classified according to the type of repair needed; plans are made for repair of each item. Priorities for repair of battle damaged items are usually—

- Most essential to the immediate mission.

- Repairable in the least time.

- Repairable but not in time for the immediate mission.

- Battle damage repair involves use of emergency repair techniques to return a system to a mission capability. Normally BDAR is only used in combat at the direction of the commander. It includes—

- Shortcuts in parts removal or installation.

- Modifying components from other items.

- Using parts from a noncritical function elsewhere on an item to restore a critical function.

- Bypassing noncritical components to restore basic function capability.

- Cannibalization.

- Making parts from kits or available material.
- Using substitute fuels, fluids, or lubricants.
- The BDAR program is not to be used in the repair of medical equipment. Only medical equipment repair personnel are adequately trained to effect the type of temporary fixes associated with this concept. Due to the delicate, technological complex nature of most medical equipment, temporary fixes even by a medical equipment repairer is discouraged.

5-28. Maintenance Forms and Records

Numerous forms and records are used to document maintenance activities. These records are maintained for historical purposes, to ensure necessary services are performed, and to establish requirements for repair parts stockage.

a. Dispatch. DD Form 1970 (Motor Equipment Utilization Record) is commonly referred to as a "dispatch." It is issued to the vehicle operator by the unit maintenance clerk before the vehicle is used.

b. Inspection and Maintenance Worksheet. DA Form 2404 (Equipment Inspection and Maintenance Worksheet) is the "bread and butter" form of unit level maintenance (see TM 38-750). The operator uses this form to record faults that he cannot correct. Unit maintenance personnel refer to the form to identify necessary repairs and annotate corrective actions. It is used when conducting scheduled service and during other technical inspections. The DA Form 2404 is quite versatile and is the most frequently used form in the motor pool.

c. Maintenance Request. DA Form 2407 (Maintenance Request) is used by unit maintenance personnel as a request to support units (DS) for repair work.

d. Lubrication Order. Lubrication order (LO) is more like a technical manual than a maintenance form. It details how to lubricate the vehicle, the types of lubricants to use, intervals to

be observed, and special precautions. An LO should be kept on each vehicle with the appropriate TM.

5-29. Unit Maintenance Organization

a. Battalion Maintenance Assets. The battalion's maintenance assets (unit - level maintenance) are organized somewhat similar to its medical assets. All maintenance assets are organic to the battalion maintenance platoon. They are apportioned out to support the various companies.

b. Company Maintenance Section. Within the company maintenance section, the key players are the battalion motor sergeant, normally an E-8, and the motor officer, usually the company XO. The motor sergeant allocates jobs to his mechanics and supervises their activities. He also runs the motor pool shop office. The motor officer is responsible to the company commander for the unit's maintenance status.

c. Battalion Maintenance Platoon. The battalion maintenance platoon is run by the battalion motor officer (BMO). The battalion motor sergeant, an E-8, and the battalion maintenance technician, a warrant officer, assist the BMO. The battalion maintenance technician is the technical expert in the field of maintenance. He frequently interfaces with DS maintenance and maintenance support teams.

5-30. Training

a. Importance. "The more you sweat in training, the less you bleed in war." This ancient Chinese proverb expresses the importance of training very simply and accurately. Much more has been said and written about training, the bottom line of which is that to be prepared for war, we must train. Leaders have an obligation to ensure that effective training takes place in the unit. For training procedures, see Appendix A.

b. How to Train. Army training management can be a difficult task, particularly for a new platoon leader. Do not expect to become an immediate expert. Study the system read Army training literature (AR 350-1, 25-series field manuals, 8-series field manuals, local policies,

regulations, and SOPs); talk with supervisors; and learn from NCOs.

c. Get Involved in Training. The importance of a leader's involvement in training cannot be overemphasized. Officers and NCOs do not only plan and present training, they also participate. Leader participation motivates soldiers; it emphasizes the importance of the training event. As a participant, the leader can evaluate the quality of the training being presented. Participating in training allows officers and NCOs to brush-up on their skills and, in many cases, to develop new skills.

d. Training Responsibilities. Unit training consists of individual and collective training. Individual training is conducted for tasks which the soldier must be able to complete unassisted, such as applying a pressure dressing. Individual training develops the technical proficiency of the soldier. Collective training builds on individual skills and provides the basis for unit proficiency in executing its missions, such as establishing an aid station and providing HSS in a mass casualty situation. Generally, officers are responsible for collective training and NCOs are responsible for individual training.

e. Battle Focus. The unit's wartime missions are the source from which all training activities are derived. This is known as battle focus. A successful training program is achievable by narrowing the focus to vital tasks that are mission essential. This is accomplished through the development of a mission essential task list (METL).

f. Mission Essential Task List Development.

- The commander of each unit in the Army from corps to company level must develop a METL. The medical platoon, being a unique organization in a combat arms battalion, should also develop a METL. This is done by first considering the battalion's mission and reviewing the battalion METL. The medical platoon METL must support the battalion METL. The next step is to get a copy of the FSMC's METL and discuss it with the FSMC commander. The medical platoon METL must be coordinated with the FSMC METL. Other sources to consider are SOPs; emergency deployment

readiness exercise (EDRE) plans; and division surgeon and DMOC plans and policies. The final step is to present the medical platoon METL (which should consist of roughly a half-dozen tasks) to the battalion commander. Once the battalion commander approves the METL, it becomes the source document for developing the medical platoon training plans. It should be changed only when the unit's mission changes.

- Involve the PA, medical operations officer, platoon sergeant, and other platoon members in the METL development process. This creates a common understanding of the unit's critical wartime requirements; it is essential in developing the platoon training plans.

- A condition statement and standards list for each mission essential task is developed. The resulting training objective provides a clear list of expected training performance. The platoon sergeant will take the METL and develop a supporting individual task list for each mission essential task. Some documents which will assist in developing these collective and individual tasks are—

- Mission training plans.
- Soldiers training publications.
- Deployment or mobilization plans.
- General defense plan.
- Army, MACOM, and local regulations.
- Local SOPs.

g. Planning.

(1) *Needs assessment.* The first step in planning for training is the assessment. Assess current training proficiency by reviewing training evaluations, such as CTC take-home packages, FTX after-action reports, and inspection results. Also consider recent or projected personnel turnover or new equipment fielding. Finally, ask subordinates for their opinions and consider your own observations and impressions. Rate each task "T"

(trained), “P” (needs practice), “U” (untrained), or “?” (unknown). The training requirements are simply the training necessary to achieve and sustain the desired levels of proficiency for each mission essential task.

(2) *Training strategy.* With the assistance of platoon members, develop a strategy to accomplish each training requirement. This should include plans to improve proficiency in some tasks and sustain proficiency in others. The training strategy establishes priorities by indicating the frequency each mission essential task will be performed during the training period. The strategy includes guidance that links METL with training events (coordinate training with the HHB/HHC/HHT/HHS commanders, S3 and, if necessary, battalion commander).

h. Planning Calendars.

(1) *Battalion training schedules.* The battalion produces long-range, short-range, and near-term training schedules covering 1 year, 3 months, and 1 week respectively. The weekly training schedules are normally provided for each company. The medical platoon should get a copy of these schedules.

(2) *Medical platoon input.* The medical platoon should hold regular training meetings of key leaders within the platoon to develop medical platoon input to the battalion’s training schedules. Before the long-range training schedule is prepared, the medical platoon leader should tell the HHC commander, in general terms, what training the medical platoon needs during the upcoming year. Upon receipt of the long-range training calendar, the medical platoon should meet and refine plans for training in the first quarter. The medical platoon leader then provides specific information to the HHC commander for inclusion in the battalion quarterly training schedule. The medical platoon then holds weekly training meetings to—

- Review training conducted during the previous week.
- Discuss training planned for the current week.
- Make firm coordination for training scheduled for the upcoming week.

Provide final details of medical platoon training plans for the upcoming week for inclusion in the weekly HHC training schedule.

(3) *Coordinating medical platoon training.* Remember, all medical platoon training must be conducted within the parameters established by the battalion/company training schedule. For example, the battalion training schedule calls for a FTX with a company force-on-force exercise; perhaps the medical platoon can conduct an evacuation exercise concurrently. This requires coordination with the S3, company commander, and possibly the FSMC commander and others. Most of all, conforming medical platoon training plans and activities to the parent unit activities require creativity, flexibility, and initiative on the part of the medical platoon leader. Training must be conducted without detracting from the HSS being provided the companies undergoing training.

i. Expert Field Medical Badge.

(1) *The program.* The Expert Field Medical Badge (EFMB) program has received high level attention in recent years. In many units, the medical platoon leader’s evaluation is directly tied to the percentage of his platoon which passed the EFMB test. In some divisions, awards are given to the battalion with the highest EFMB pass rate. Aside from these facts, the EFMB is an excellent program and is a good measure of training success and unit motivation. If planned and administered correctly, EFMB training can tie directly into your platoons METL-based training program.

(2) *Training and test management.* EFMB training is managed differently at various posts around the Army. Some provide centralized EFMB training, while others leave it to the unit. In most divisions, EFMB training is conducted in the unit with some type of centralized training for all division EFMB candidates. EFMB testing is standardized; however, the frequency of testing may vary. For additional information on EFMB training and testing, see TC 8-100.

(3) *Command.* The medical platoon leader should find out how much emphasis the battalion commander places on the EFMB and plan training accordingly. Call the division surgeon or

DMOC to get details of local EFMB training and testing procedures.

j. Army Medical Department Systematic Modular Approach to Realistic Training. The Army Medical Department Systematic Modular Approach to Realistic Training (ASMA) was created to provide hospital-based clinical skills training and development to medical personnel. The program allows an established number of medics from each unit to rotate through the hospital at set intervals.

Normally, medics will be enrolled in ASMA for a period of 90-180 days. The ASMA offers an excellent opportunity for medical personnel to sharpen their clinical skills through work in the emergency room or in a hospital ward or clinic. However, the program must be closely monitored to ensure that the participants are receiving good training. If, as medical platoon leader, you are not satisfied with the training being provided through the ASMA, discuss your concerns with the division surgeon and/or hospital commander.

Section V. EMPLOYMENT OF THE MEDICAL PLATOON

5-31. Planning and the Health Service Support Plan

a. Planning. To ensure that HSS is responsive to the battalion (squadron), the medical platoon leader or the medical operations officer must attend all operational briefings and planning sessions. They are responsible for providing the HSS portion of battalion SOPs, OPLANs, and operation orders (OPORDs). The HSS planned for tactical operations is addressed in the administrative and logistics annex of the battalion OPORD. It should include—

- Location of forward treatment sites.
- Ground and air medical evacuation routes, ambulance exchange points, and far forward patient collecting points.
- Location of the supporting DCS (medical company).

NOTE

The battalion surgeon and the medical operations officer must keep the medical platoon personnel informed of the tactical situation.

b. Health Service Support Plan. The health service support plan (HSSPLAN) must be responsive and support the maneuver commander's intent. The HSSPLAN is best disseminated through the use of an overlay showing preplanned treatment team/BAS locations and ambulance exchange points. The HSSPLAN is keyed to the maneuver battalion's OPORD. Once approved, the overlay is distributed to maneuver company commanders, elements of the medical platoon, the tactical operations center, and the ambulance platoon leader of the supporting FSMC. A sample overlay (HSSPLAN) depicting preplanned positions for ALFA and BRAVO treatment teams of a BAS and AXP of a FSMC ambulance platoon is shown in Figure 5-16. To effectively execute the HSSPLAN, the medical operations officer monitors the tactical situation. He maneuvers the treatment teams and coordinates changes for AXP locations based on the progress of the battle. This allows the HSS system to rapidly clear the battlefield of casualties; to treat patients early; and to return minimally injured soldiers to the fight.

5-32. Combat Medic

a. Allocation. As was mentioned previously, combat medics are allocated to mechanized infantry on the basis of one medic per platoon and a senior medic for each company. In armor units, the allocation is one medic per company. Normally, one ambulance team is positioned in the company area.

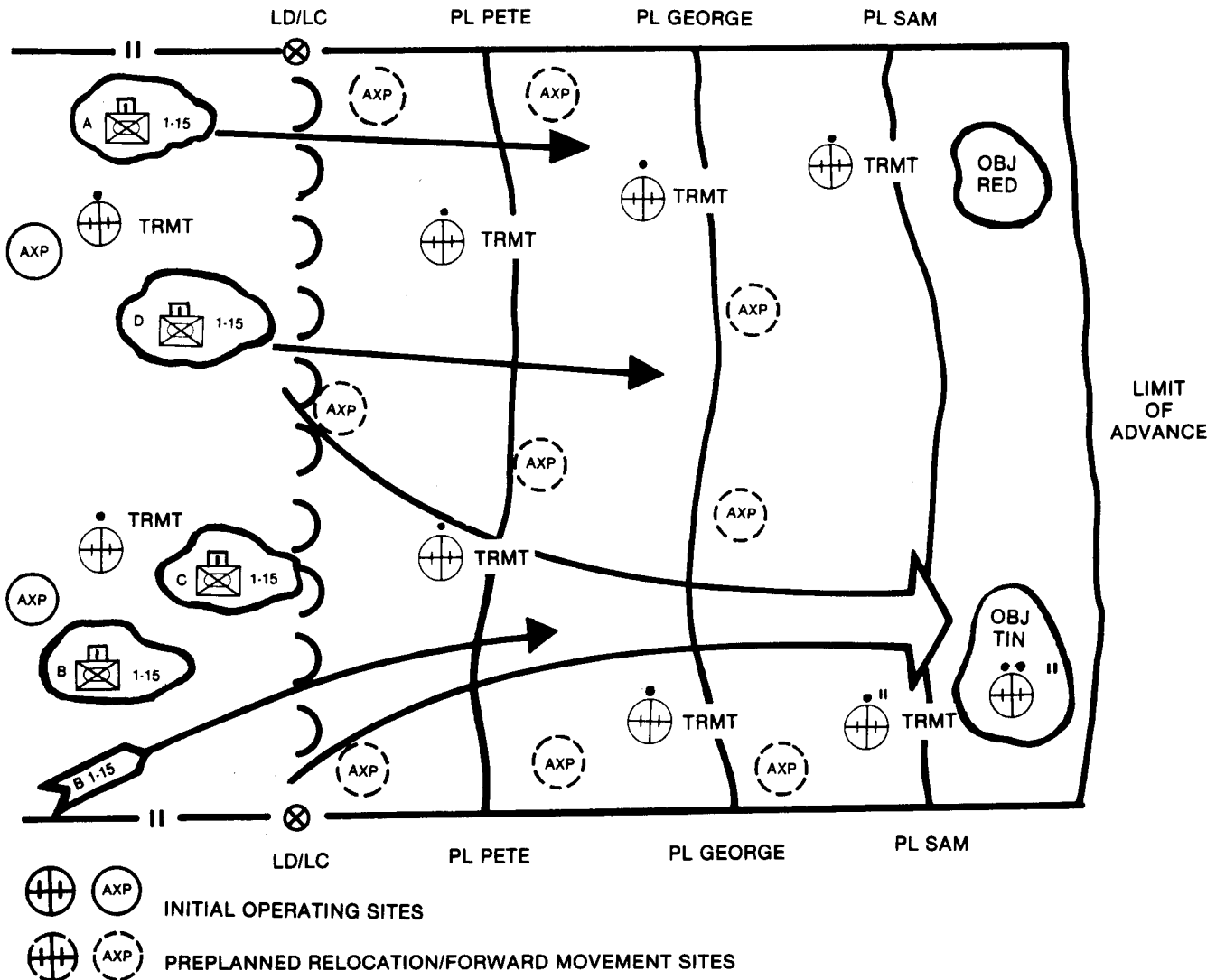


Figure 5-16. Preplanned position of treatment teams and ambulance exchange points.

b. Platoon Medic Location. The platoon combat medic normally locates with, or near, the element leader. When the platoon is moving on foot in the platoon column formation, he positions himself near the element leader trailing the base squad forward of the second team (Figure 5-17). This formation is the platoon's primary movement formation. When the platoon is mounted, the combat medic will normally ride in the same vehicle as the platoon sergeant (Figure 5-18). The combat medic will provide care to the occupants of his vehicle. He will not be able to treat occupants of other vehicles while the platoon is moving or engaged.

c. Company Medic. The company combat medic normally collocates with the first sergeant. When the company is engaged, the combat medic will remain with the first sergeant and provide medical advice as necessary. As the tactical situation allows, he will provide medical treatment and prepare patients for evacuation. The combat medics assigned to the company's evacuation vehicle work with the company medic in a coordinated effort. When a casualty occurs in a tank or an armed fighting vehicle, the aid/evacuation team will move as close to the armored vehicle as possible, making full use of cover, concealment, and defilade. Assisted, if possible, by the vehicle's crew,

they will extract the casualty from the vehicle and administer emergency medical treatment. The aid/evacuation team moves the patient to the treatment squad/BAS or to a collecting point to await further

evacuation. The company medic normally remains with the company command post, but may be used anywhere in the company, assisting the aid/evacuation teams in some situations.

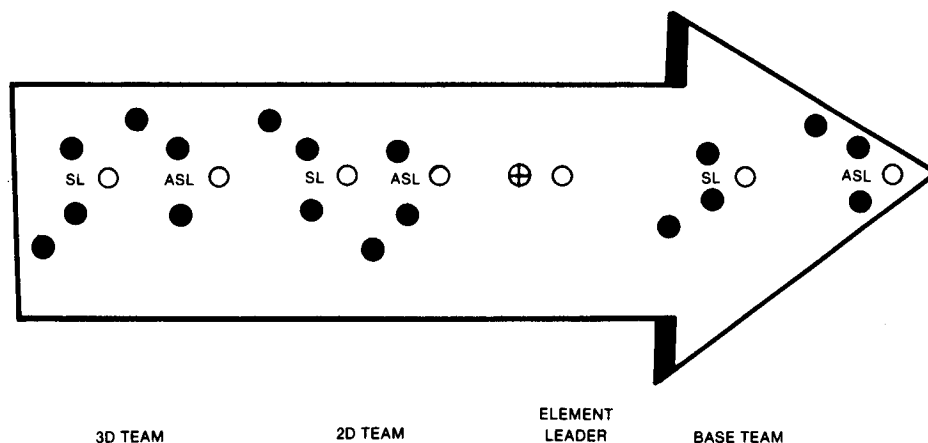


Figure 15-17. Dismounted platoon.

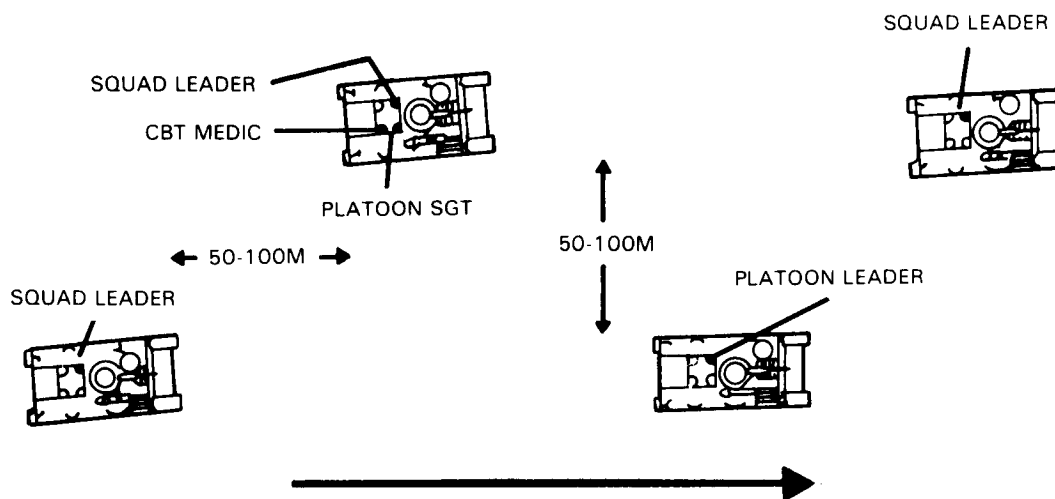


Figure 5-18. Mounted column.

5-33. Combat Lifesavers

Combat lifesavers are nonmedical unit members who have received additional training to increase their skills beyond basic first aid procedures. The primary duty of the CLS does not change. He is a fighter first and medic second. The CLS medical duties are performed when the situation permits. The CLS carries a CLS's medical equipment set and

receives his medical supplies (resupply) through his unit supply section. For CLS training material and equipment, see Appendix B.

5-34. Preparation for Tactical Operations

a. *Planning.* The lack of adequate planning on the part of medical platoon leaders and FSMC

commanders has been repeatedly noted at the National Training Center.

b. Tailoring Medical Platoon Organization to Mission. The platoon organization best suited for specific combat operations are discussed in Sections II and III of this chapter. However, it is important to realize that although the medical platoon is authorized a certain number of personnel and amount of equipment with which to accomplish its mission, on-hand figures seldom match those authorized. The ability to accomplish the mission with less personnel and equipment than authorized is one of the greatest challenges which leaders face Armywide.

c. Reconnaissance. All key personnel within the medical platoon, especially evacuation NCOs, conduct personnel through reconnaissance before and between phases of an operation. If an on-site reconnaissance is not possible, a map recon is conducted. During the map recon, primary and secondary evacuation routes through each company's sector are designated. Prepare an overlay displaying evacuation routes, BAS locations at various points in the operation, and if possible, the FSMC location. In developing the HSS overlay, use phase lines designated for the maneuver elements. Key BAS relocation upon maneuver units crossing certain phase lines. Refer to FM 101-5-1, Operational Terms and Symbols, for correct overlay symbols and techniques. Distribute a completed overlay to each company commander, the S3, the FSMC commander, and ensure that senior company medics and evacuation NCOs have copies.

d. Medical Platoon Operations Order. As the map recon is conducted, also develop the medical platoon OPORD. The medical platoon OPORD must be tied to the parent battalion OPORD and should be coordinated with the FSMC. It may be written or oral, but must use the five paragraph OPORD format. Prior to the operation, issue this order to members of the medical platoon and attached/supporting medical personnel.

5-35. Deployment

a. Complexity of Deployment. Field operations begin with a deployment. This may be as simple as loading vehicles and convoying to a

training area on-post, or as complicated as loading the entire unit for an overseas deployment.

b. Movement Plans. The key to a successful deployment is accurate movement plans. Each company should have a movement officer responsible for maintaining a unit movement file. This file contains detailed information on the unit's capability to deploy. It specifies transportation requirements necessary to support the unit's movement by various modes of travel, such as air, rail, or convoy. Among the most basic and most important information assembled by the unit movement officer is a list of prime movers (trucks designated to move trailers) and their designated trailers, and load plans for each vehicle.

c. Medical Platoon Loading Plans. The medical platoon must be able to move all of its personnel (less company and platoon medics) and equipment to the field with its organic vehicles. The platoon's load plans prescribe the method by which this is done. The load plan specifies exactly what supplies and equipment will be carried on which vehicle. It specifies a prime mover for each trailer. The MES, BAS is divided between the platoon's aid station vehicles to give each treatment team equal capability. The load plan allows for personal baggage, tentage, camouflage nets and poles, heaters/stoves, tools, and any other miscellaneous supplies and equipment. See Appendix D for an example.

d. Evaluate Load Plan. The platoon load plan must be accurate and workable. The only way to be sure load plans are valid is to test them. Periodically, the medical platoon should load-out all of its supplies and equipment in accordance with the platoon load plan (FTX deployments are good opportunities to do this). This will reveal any shortcomings in the load plans and will result in more workable loading arrangements. Any changes made during these practice load-outs should be reported to the company movement officer. Once an efficient load plan is developed for each vehicle, it is published so that the crew becomes familiar with the configuration. Before deployment, inspect each vehicle to ensure its configuration matches the load plan.

e. Convoy. The final step in the deployment process is normally a convoy to the maneuver area.

The convoy will most likely be conducted as a tactical road march consisting of several march units dispersed over various routes. The battalion tactical SOP prescribes convoy procedures; it includes intervals between vehicles, speed, rest halt intervals, safety briefings, and night and blackout drive procedures. Convoys are relatively simple operations but require much coordination, close control, and active attentive participation by drivers.

5-36. Establishing the Battalion Aid Station/Company Aid Post

a. Site Selection. Prior to deployment, an initial site for the BAS is designated as well as future sites to be used as the operation progresses. This is done during the map recon, is coordinated with other staff members, and is published in the battalion's OPOD and the HSS overlay. An example of a BAS arrangement is depicted in Figures 5-4 and 5-5. Some factors to consider when selecting a site for the BAS include—

- *Cover and concealment.* The area selected should provide maximum cover and concealment without hampering mission or communications. Overhead cover is desirable for protection from biological/chemical contamination, if attacked.

- *Accessibility.* The site should provide adequate access to all approach and evacuation routes.

- *Space.* The site should have adequate space for the unit's operation and expeditious loading and unloading patients, supplies, and equipment.

- *Drainage.* The site should provide good drainage during inclement weather.

- *Decontamination area.* The area should be large enough to provide an area for patient decontamination, if required.

- *Landing site.* Provide an area for a helicopter landing site.

- *Security.* The site should provide security and be defensible.

- *Communications.* When considering all factors of site selection, remember that terrain can impede FM communication systems.

NOTE

If the BAS is collocated with the combat trains or if another staff member selects the BAS site, the medical platoon leader must ensure the above factors are considered.

b. Establish Battalion Aid Station. When the BAS elements arrive at the operational site, the following actions are taken:

- An advance party is on location and has the area secured.

- Move BAS vehicles into position (covered and concealed, if possible).

- Establish perimeter security, if necessary.

- Configure supplies and equipment into tailgate medicine operational posture.

- Establish helicopter landing site and equipment to support patient care.

- Report to the main CP, combat trains CP, and FSMC that the BAS is operational.

- Make radio check with each company senior medic.

- Erect extension/tentage. An example of a M577 extension configured as a BAS (treatment station) is depicted in Figure 5-19.

- Erect camouflage nets.

- Operators perform after operation check of vehicles.

- Complete final preparation to receive patients, incorporate sleep/work schedule to ensure radios are continuously monitored.

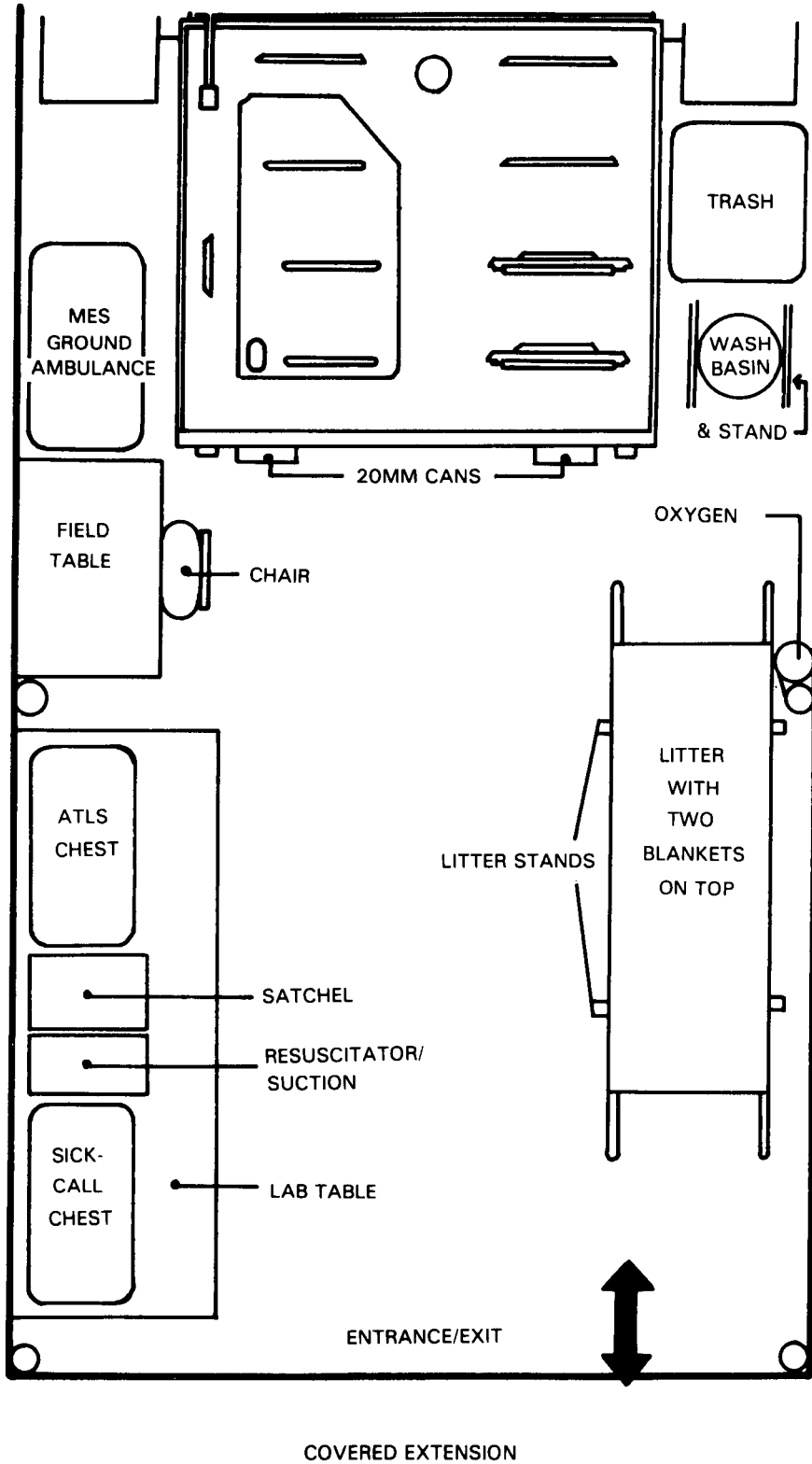


Figure 5-19. M577 configured as a BAS.

c. Establish Company Aid Post. When establishing a company aid post, take the following actions:

- Company medic remains with or near first sergeant; this is his transportation.
- If possible, collocate aid post with medical evacuation vehicle (company medic must not depend upon this vehicle for his transportation). The company medic must remain with the company.
- Prepare area to receive patients.
- Make radio check with platoon medics, if possible.
- Camouflage as necessary.

5-37. Treat and Evacuate Patients

a. Combat Medic Care. When casualties occur, first aid will usually be rendered by buddy aid or perhaps CLS care. The platoon medic/company medic will then go to the casualty's location or the casualty will be brought to the medic. The combat medic makes his assessment; administers initial medical care; initiates a DD Form 1380 (Field Medical Card); then requests evacuation or returns the individual to duty. A vehicle from the evacuation section (usually pre-positioned forward) picks-up the patient and transports him to the BAS.

b. Battalion Aid Station Care. When the patient arrives at the BAS, initially he is taken to a triage point. When the treatment teams are collocated, the PA usually performs triage (if the treatment teams are separated or a mass casualty situation exists, an EMT NCO performs triage). The patient is categorized as immediate, delayed, minimal, or expectant. Depending upon his triage category and the patient load, the patient is then taken to either the patient holding area or the treatment area. Ultimately, medical treatment is administered and the patient is either evacuated to the DCS or returned to duty.

c. Mass Casualty Situation. Keep in mind that the type of operation being supported will to a great extent determine the rate of casualties generated. In a high-intensity conflict, mass

casualty situations will develop. Medical treatment and evacuation capabilities may be temporarily overwhelmed. Self/buddy aid and CLS care will be critical. Nonmedical vehicles may be required to evacuate casualties (FM 8-10-6). It is possible that a decision will have to be made to abandon patients; however, if patients have to be abandoned, a medic with medical supplies must remain with them. In any scenario, the guiding principle is to provide the greatest good for the greatest number of patients.

5-38. Disestablish a Field Medical Treatment Facility

When a unit receives orders to relocate, load vehicles according to loading plans in order to provide HSS while en route or at the relocation site. All potential sources of intelligence which could be used by enemy forces are removed before leaving the area. All wires that were used for communications are recovered and serviced. Prior to departing, all personnel are briefed on the move and issued strip maps. Patients awaiting evacuation are moved with the BAS, if possible. The BAS must maintain communications and continue to monitor the battle.

5-39. Field Sanitation

a. Medical Threat. Poor field hygiene and sanitary practices pose a very real threat to units both in training and combat. In fact, throughout recorded history, DNBI have accounted for a higher percentage of casualties than have battle injuries. (In US history, this ratio is three to one.) Even today, outbreaks of diarrheal disease, food poisonings, arthropod bites, and environmental injuries (heat and cold) account for significant training time loss. Although the medical threat consists of hundreds of casualty-producing injuries and illnesses, the causes can be, reduced to six primary categories.

- Heat injuries caused by combinations of heat stress and insufficient water consumption.
- Cold injuries caused by combinations of inadequate clothing, low temperatures, wind, and wetness.

- Diseases caused by biting arthropods.

- Diarrheal diseases caused by drinking impure water, eating contaminated foods, or not practicing good individual and unit PVNTMED measures.

- Diseases, trauma, or injuries caused by physical or mental unfitness.

- Environmental or occupational injuries caused by carbon monoxide, noise, blast overpressure, and solvents.

b. Preventive Medicine Measures. The medical platoon leader is responsible for monitoring the health of the soldiers in his battalion. He can be proactive in this regard by ensuring the provision of the following PVNTMED measures.

- Large amounts of water to combat the threat of heat injury. Joint planning factors indicate that as much as 20 gallons per person per day will be required during operations in hot weather environments.

- Adequate changes of socks and clothing to prevent cold injuries caused by wet clothing.

- Arthropod repellents, aerosol insecticide, bed nets, and louse powder for the individual; pesticides and associated equipment for field sanitation teams; and PVNTMED units support to prevent arthropod-borne disease.

- Iodine tablets and calcium hypochlorite to maintain water potability.

- Adequate fresh air ventilation in confined vehicles and in maintenance and sleeping areas. Proper ventilation prevents carbon monoxide poisoning.

- Adequate hearing protection.

- Adequate vision protection to prevent traumatic eye injury from laser devices, sighting devices, and secondary projectiles.

(1) *Individual protective measures.*

The mobility and dispersion of modern fighting forces require that individual soldiers take actions to protect themselves against the medical threat. These simple individual actions are called PVNTMED measures. Applying these measures can significantly reduce the time loss due to DNBI. The soldier should—

- Protect himself against heat by—

- Drinking plenty of water.

- Using the correct work/rest cycle as directed by his leader.

- Eating all meals to replace salt.

- Recognizing the risk associated with wearing mission-oriented protection posture (MOPP) clothing, body armor, or when inside armored vehicles.

- Modifying his uniform as directed/authorized by his leader.

- Protect himself against the cold by—

- Drinking plenty of water to replace loss of fluids during periods of strenuous exercise.

- Wearing his uniform properly in loose layers to hold maximum body heat.

- Washing his feet daily and keeping them dry by changing socks several times a day.

- Keeping his body warm by exercising his trunk and limbs whenever possible. Exercising his feet, hands, and face to increase circulation.

- Protect himself against biting arthropods by—

- Using his uniform as a barrier.

- Using arthropod/insect repellent.

or tablets as prescribed.

aerosol insecticide at night.

uniform clean.

diarrhea by—

drink, or ice approved by medical authorities.

available. When not available, treating water by using iodine tablets or chlorine ampules, or boiling it.

fitness by—

infections.

disease.

urinary tract infections (drinking plenty of water).

stress.

ventilation while in closed spaces such as when firing weapons from inside an armored vehicle.

- Taking antimalarial pills

- Using a bed net and

- Keeping himself and his

- Protect himself against

- Only consuming food,

- Using treated water when

- Washing his hands.

- Washing his mess kit.

- Burying his waste.

- Maintain physical and mental

- Exercising.

- Preventing skin

- Preventing dental

- Preventing genital and

- Bathing when possible.

- Minimizing sleep loss.

- Improving resistance to

- Ensuring adequate

Wearing hearing protection while associated with source of noise (that is, aircraft, tactical vehicles, and all calibers of weapons).

Wearing eye protection when exposed to sources of traumatic injury such as lasers.

(2) *The field sanitation team.* The company field sanitation team consists of organic medical personnel; or at least two soldiers, one of whom is an NCO, when organic medical personnel are not available. The team is specially trained in water supply, food service sanitation, waste disposal, pest management, environmental injuries, and non-NBC chemical hazards (see FM 21-10-1). The field sanitation team serves as an aid to the unit commander in protecting the health of his company. Through regular inspections, the field sanitation team ensures sanitary standards are maintained and PVNTMED measures are practiced. Table 5-1 is helpful in identifying activities which are of PVNTMED significance.

5-40. Medical Training in the Field

a. Importance. Conducting medical training during a battalion FTX can be a challenge. When properly conducted, however, medical play can lend significant realism to training exercises. This benefits both the medical platoon and the battalion as a whole. The medical platoon learns to perform medical treatment and evacuation operations under simulated combat conditions. The battalion learns to complete its mission under situations in which it is suffering casualties. For information on planning for deployment to CTC, see Appendix G.

b. Lessons Learned. Previously, the key challenge in incorporating medical play into training exercises was sometimes convincing the battalion commander to do it. Fortunately, Combat Training Center experience has shown the need for realistic training to include medical play. Now, the challenge is in operating and reacting to realistic casualty scenarios. Again, this tests the initiative, creativity, and flexibility of medical platoon leaders. Observations and lessons learned at CTC are presented in Appendix G.

Table 5-1. Activities of Preventive Medicine Significance

ITEM OF INTEREST	DIVISION	LOCATION CORPS	PREVENTIVE MEDICINE SIGNIFICANCE
1. Maneuver companies	Highly dispersed and concealed.		Items of interest 1 through 3 contain
2. Maneuver battalions	Highly dispersed and concealed.		<ul style="list-style-type: none"> ● Combat soldiers subject to the medical threat.
3. Maneuver brigades	In the main battle area and in the reserve area.	In reserve.	<ul style="list-style-type: none"> ● Field kitchens that may be the source of disease. ● Medical companies that know how much preventable disease is occurring ● Unit headquarters that know the locations of subordinate units requiring preventive medicine support.
4. Main supply route (MSR)	Roads through brigade support area and division support area.	Roads through the corps support area.	Towns and villages can have diseases which will be spread along any MSR.
5. Airfields	Usually near division support area.	Staging areas on existing airfields and tactical airfields.	Airfields contain the aircraft used in aerial insect control missions. The supply points at airfields can be the focus of disease spread. The USAF weather stations can provide information useful for control of heat or cold injury and for aerial control of insect disease vectors.
6. Water points	Near brigade support areas.	Near base cluster.	Adequate quantities of potable water are required to sustain troops.
7. Ice plants	Villages.	Villages.	Village ice plants used for production of ice for use by US soldiers.
8. Ration breakdown and storage facilities/points	Brigade support area. Division support area.	Base clusters.	Bulk storage sites, refrigeration sites, and transportation units all handle potentially hazardous (perishable) foods which can cause disease.
9. Field dining facilities	Battalion trains.	Base clusters.	Kitchens and serving dining areas can all be sources of diarrheal disease.
10. Enemy-prisoner-of-war camps.	Division rear and back. Collection points forward.		MP company and stockade contain EPW who can be sources of communicable disease.

Table 5-1. Activities of Preventive Medicine Significance (continued)

ITEM OF INTEREST	LOCATION	DIVISION	CORPS	PREVENTIVE MEDICINE SIGNIFICANCE
11. Refugee camps.	Division rear off major supply route.		Corps rear off major supply route.	Forward tactical support company, rear area support company, and refugee camps can be the source of communicable disease.
12. Hospital dispensaries	Brigade support area. Division support area.		Base clusters.	Outpatient information on incidence of preventable disease; supplies for preventive medicine personnel.
13. Maintenance facilities	Brigade support area. Division support area.		Base clusters.	Vehicle refit/repair, equipment repair, and retrograde cargo site (all of these can have hazardous occupational exposures).
14. Laundries	Brigade support area. Division support area.		Base clusters.	Field laundry required to provide vermin-free clothing exchange.
<p>LEGEND:</p> <p>^a May serve as focal point for reservoirs of vector-borne diseases of military importance such as malaria, dengue, or leishmaniasis. If these areas are not targeted for preventive medicine support operations, interfacility transmission of vector-borne diseases will compromise the capabilities of medical personnel and other personnel in the surrounding area.</p>				

NOTE

The key to mission success is detailed preplanning. A HSSPLAN must be prepared for each support mission. Ensure that the HSSPLAN is in concert with the tactical plan. Use the plan as a starting point and improve on it while providing HSS.