

APPENDIX D

INTERIM BRIGADE COMBAT TEAM

Section I. INFANTRY BATTALION MEDICAL PLATOON

D-1. Medical Platoon

The medical platoon of the infantry battalion is organized with a headquarters section, a treatment squad, an evacuation section, and a combat medic section (see Figure D-1). For more detailed information on the functions and operations of the medical platoon, see Chapter 2, Sections IV and VI.

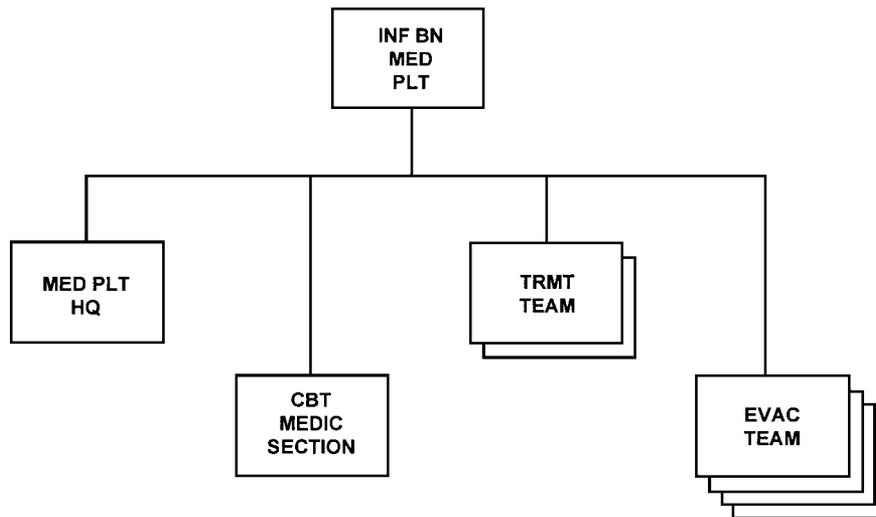


Figure D-1. Medical platoon infantry battalion.

a. Platoon Headquarters. The headquarters section operates under the direction of the medical platoon leader/battalion surgeon who is responsible for overseeing platoon operations. The platoon headquarters section is comprised of a field medical assistant and the platoon SGT. It is normally collocated with a treatment team or a treatment squad to form the BAS. The CP includes the plans and operations functions performed by the field medical assistant. The platoon has access to the infantry battalion HHC wire communication network for communications with all major elements of the battalion. 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 CHS operations. The platoon headquarters section serves as the NCS for the platoon (see Figure D-2). Table D-1 lists the information and communications assets available to the platoon.

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(1) The field medical assistant, an MS officer, is the operations/readiness officer for the platoon. He is the principal assistant to the platoon leader for operations, administration, and logistics. The field medical assistant coordinates CHS operations with the infantry battalion S1 and S4, and MEDEVAC with the brigade support medical company (BSMC).

(2) The platoon SGT assists in supervising the operations of the platoon. He also serves as the evacuation section SGT.

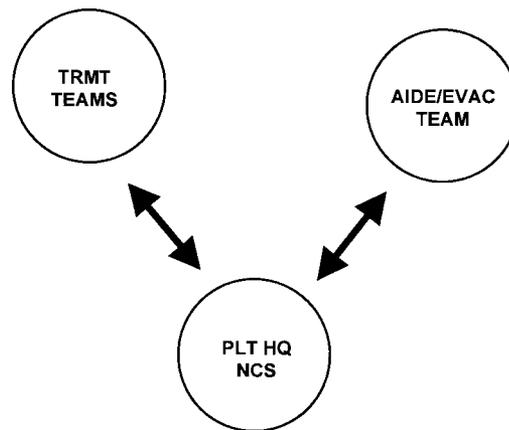


Figure D-2. Medical platoon internal communications net.

Table D-1. Information and Communications Assets Available to the Infantry Battalion Medical Platoon

RADIO SETS	
AN/VRC-89F	PLATOON HEADQUARTERS VEHICLE AND TREATMENT TEAM ALPHA (SURGEON) VEHICLE (1 EACH)
AN/VRC-88F	TREATMENT TEAM BRAVO
AN/VRC-90F	PLATOON AMBULANCE (1 EACH)
ROUTERS	COMPUTER SYSTEMS
TACTICAL LAN	MC4 LAPTOPS FOR EACH TREATMENT AND AMBULANCE VEHICLE
LAN ROUTER	MC4 (DISMOUNTED, HAND-HELD) PIC READER/WRITER (1 EACH, TRAUMA SPECIALIST) FBCB2, 1 IN EACH VEHICLE ASSIGNED TO THE MEDICAL PLATOON
OTHER SYSTEMS	
FBCB2	MEDICAL PLATOON VEHICLE (1 EACH)
GPS	MEDICAL PLATOON VEHICLE (1 EACH)
EPLR	MEDICAL PLATOON VEHICLE (1 EACH)
BCIS	MEDICAL PLATOON VEHICLE (1 EACH)
DVE	MEDICAL PLATOON VEHICLE (1 EACH)

b. Treatment Squad. The treatment squad consists of two treatment teams (Teams Alpha and Bravo). They operate the BAS and provide Echelon I medical care and treatment. This includes sick call, EMT, and ATM. Team Alpha is staffed with an operational medicine officer (primary care physician/battalion surgeon), a health care SGT, and two health care specialists. Team Bravo is staffed with a PA, a health care SGT, and two health care specialists. The physician, PA, and health care SGT and specialists are trained to provide EMT and assist with ATM procedures, commensurate with their occupational specialties. The treatment teams can operate for limited times in split-based operations in DS of battalion units. The teams can also operate in split-based operations when the BAS must move to a new location. One team remains at current location and continues to treat patients while the other team moves to the new location and establishes patient care capabilities. Once the jump team has established a treatment capability at the new location, the other team evacuates or returns to duty all patients and moves to the new location.

(1) The medical platoon leader is a working physician on Treatment Team Alpha. He is also the battalion surgeon. In this role, he is a special staff officer and advisor to the battalion commander on employment of the medical platoon and on the health of the battalion. He is also the supervising physician (field surgeon) of the medical platoon's treatment squad. This officer is responsible for all CHS provided by the platoon. His responsibilities include—

- Planning and directing CHS for the infantry battalion. He does this in conjunction with the battalion S1, who is the coordinating staff officer responsible to the commander for health and welfare of the troops.
- Advising the infantry battalion commander and his staff on CHS operations and the medical threat.
- Supervising the administration, discipline, maintenance of equipment, supply functions, organizational training, and employment of medical platoon personnel.
- Examining, diagnosing, treating, and prescribing courses of treatment for patients, to include ATM.
- Training CLS.
- Supervising the battalion CSC program.
- Planning and conducting humanitarian assistance programs, when directed.
- Providing PVNTMED support for the battalion. Requesting PVNTMED support from the brigade for PVNTMED requirements beyond his capabilities.
- Planning and overseeing PVNTMED training for battalion personnel.
- Advising the commander on the health of the battalion.
- Supervising the training of unit field sanitation teams.

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(2) The PA performs patient health care and administrative duties. The PA is ATM-qualified and works under the clinical supervision of the medical officer. The PA assumes the duties of the battalion surgeon/medical platoon leader in his absence. He performs the following duties:

- Establishes and conducts treatment team operations when deployed in split-based operations.
- Treats, within his ability, sick or injured patients. He refers those patients requiring treatment beyond his capability to the supervising physician.
- Provides EMT and ATM for wounded and DNBI patients.
- Conducts training for battalion personnel in first aid procedures (self-aid, buddy aid, and CLS), field sanitation, evacuation of the sick and wounded, and the medical aspects of injury prevention.
- Assists in the conduct of the battalion CSC program, to include individual and leader training on the prevention of BF and other stress-related conditions.
- Trains medical personnel in EMT procedures.
- Advising the command on PVNTMED concerns and conducting PVNTMED activities within the capabilities of medical platoon personnel. Assist in training unit field sanitation teams.

c. Combat Medic Section. Trauma specialists are allocated to the companies of the infantry battalion on the basis of one trauma specialist per platoon. The platoon trauma specialist normally locates with, or near, the platoon leader or platoon SGT. 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. When the platoon is mounted, the trauma specialist will normally ride in the same vehicle as the platoon SGT. A health care SGT is allocated on the basis of one per infantry company. The company health care SGT normally collocates with the 1SG. When the company is engaged, he remains with the 1SG and provides medical advice as necessary. As the tactical situation allows, he will manage the company CCP, provide medical treatment, and prepare patients for MEDEVAC.

d. Evacuation Section. Medical platoon ambulances provide evacuation and en route care from the soldier's point of injury or the company's CCP to the BAS. The ambulance team supporting the company works in coordination with the trauma specialists supporting the platoons. When a casualty occurs in a fighting vehicle, the evacuation team will move as close to the 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 EMT. In mass casualty situations, nonmedical vehicles may be used to assist in casualty evacuation as directed by the supported commander. Plans for the use of nonmedical vehicles to perform casualty evacuation should be included in the infantry battalion's TSOP and OPORD. Patients are evacuated from the BAS to the BSMC by BSMC ground ambulances or FSMT aeromedical evacuation aircraft. During entry operations, based on the current concept, air ambulances will not be available for the first 96 hours.

D-2. Medical Communications for Combat Casualty Care

a. The MC4 system will be a theater, automated CHS system, which will link commanders, health care providers, and supporting elements, at all echelons, with integrated medical information. The battalion will have one MC4 (dismounted) with two laptops and one server. The system will provide digital enablers to connect, both vertically and horizontally, all ten CHS functional areas. When developed, the MC4 system will receive, store, process, transmit, and report medical C2, medical surveillance, casualty movement/tracking, medical treatment, medical understanding, and CHL data across all echelons of care. This will be achieved through the integration of a suite of medical information systems linked through the Army data telecommunications architecture. The MC4 system begins with the individual soldier and continues throughout the health care continuum. The best way to visualize the MC4 system capability is as a piece of the Army digital computer network where all ten CHS functional areas have been digitized and this CHS information is available to specified commands, supported units, and their personnel. When fully developed, not only will the MC4 system provide Army commanders with CHS information, but will provide them with a seamless transition to the joint health service support environment.

b. The MC4 system will consist of three basic components: software, hardware, and telecommunications systems.

(1) *Software system.*

(a) The joint TMIP will provide GOTS/COTS software and interoperability standards to support joint theater operations. The software provides an integrated medical information capability that will support all echelons of care in a theater of operations with links to the sustaining base. Medical capabilities provided by the software to support commanders in the theater will address—medical C2 (including medical capability assessment, sustainability analysis, and medical intelligence); CHL (including blood product management and medical maintenance management); patient evacuation; and health care delivery.

(b) The MC4 system will support Army-unique requirements and any software needed to interface with Army information systems such as CSSCS, GCSS-A, FBCB2, Warrior Programs, and the Movement Tracking System.

(2) *Hardware systems.* The hardware will consist of COTS automation equipment supporting the above software capabilities. Examples include, but are not limited to, computers, printers, networking devices, and the PIC.

(3) *Telecommunications systems.* The MC4 system will rely on current and proposed Army solutions for tactical, operational, and strategic telecommunications systems to transmit and receive digitized medical information throughout the theater and back to the sustaining base. There will be no separate AMEDD communication system. Telecommunications at brigade and below will be accomplished through the tactical internet; above brigade level, telecommunications will be accomplished through the WIN architecture. The MC4 system will include hardware or software required to interface with current and emerging technologies supporting manual, wired, and wireless data transmission. At end-state, the MC4 system users will exchange data electronically via the WIN architecture. In the interim, commercial

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satellite and/or high frequency radio will be fielded to selected medical units (for example, MDT and so forth) receiving the MC4 system to support high bandwidth requirements until the WIN architecture is fully fielded. Personnel operating satellite assets are resourced in the MDT TOE and will be located with the MDT.

(4) *Patient treatment recording system.* In the future under MC4, medical information about each soldier will be entered into a local database maintained at the supporting BAS or troop medical clinic. This information will include the soldier's immunization status, medical deployability status, and dental deployability status. Until a digital patient record and the PIC are fully functional and fielded, and in accordance with AR 40-66, a field medical record jacket, DD Form 2766, and its accompanying records will be maintained by the soldier's primary care provider. See Appendix B for definitive information on management of the individual health records in the field.

c. When fielded, the MC4 system will be employed by the medical platoon in the conduct of its mission. The medical platoon will employ FBCB2 and other communications enablers for preparing and submitting daily patient feeder reports, transmitting medical surveillance information, requesting supplies, and conducting other administrative activities (see Table D-1 for types of medical platoon communication systems and enablers).

- The medical platoon headquarters will employ an FM radio as the platoon NCS.
- The treatment squad will employ FM radios and notebook computers to conduct treatment team/squad communications. The notebook computers will be used to read and enter patient data on the PIC; to conduct teleconsultation (TCON) and TMEN activities; provide patient flow/disposition information; and DNBI information to the battalion S1 and higher echelon medical leadership. The physician will provide TCON to the PA and receive TCON from the medical company or other medical activities out of theater through the MDT. The notebooks will be linked to others through FM radios. The platoon physician and PA will provide TMEN for ambulance personnel.
- The evacuation section will employ FM radios and notebook computers to conduct MEDEVAC communications. The notebook computers will be used to read and enter patient care information on the PIC. They will also use this device to receive TMEN from the physician and PA. The notebooks will be linked to the FM radios for communications operations.
- The trauma specialists will employ a hand-held device for reading and entering patient care information on the PIC.

D-3. Battalion Combat Health Support Planning

a. *Planning Considerations.* The battalion surgeon assisted by the field medical assistant and the platoon SGT is responsible for the CHS plan for the infantry battalion. As operational requirements or the mission changes, the CHS plan must be updated. The following factors should be considered:

- Commander's information requirements.

- Results of the mission analysis.
- Commander's intent.
- Planning guidance.
- Courses of actions.
- Tactical plan.
- Enemy.
- Terrain.
- Troops supported (unit and attached).
- Weather.
- Threat (including medical threat).
- Operational conditions and constraints.
- Civilian populace in the AO.
- Medical personnel status.
- Equipment status of the medical platoon.
- Supply status including Class VIII.
- Communications capability.
- Nuclear, biological, and chemical defense (including radiation OEG).
- Patient decontamination.
- Medical platoon's training status.
- Unit field sanitation team training.
- Unit personnel first aid training status, to include CLS.
- Casualty estimates.
- Medical evacuation requirements and capabilities.

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- Nonmedical support requirements from the battalion.
- Area support requirements.
- Special operations support requirement.
- Mass casualty operations in accordance with the TSOP.
- Medical records and reports requirements.
- Policy and procedure updates.

The foundation of the battalion CHS plan is the battalion commander's guidance and the brigade CHS plan.

- b. Plans.* See Chapter 3, paragraph 3-1.
- c. Operation Orders.* See Chapter 3, paragraph 3-2.
- d. Rehearsals.* See Chapter 3, paragraph 3-3.

D-4. Combat Health Support During Night Operations

See Chapter 4, paragraph 4-4.

D-5. Combat Health Support Tactical Standing Operating Procedures

The battalion surgeon/medical platoon leader is responsible for the development of the CHS annex for the battalion TSOP. The purpose of a TSOP is to establish routine protocols. The TSOP should not be dependent upon METT-TC factors. If a specific decision is required each time, it should not be included in the TSOP. The battalion TSOP is based on its higher headquarters TSOP and serves as the foundation for subordinate units to develop their TSOP. The battalion CHS annex to the TSOP should be clear and concise, yet provide sufficient detail of any procedural requirements. The CHS annex to the TSOP must reflect procedural guidance that supports current mission and doctrinal requirements. The CHS annex to the battalion TSOP should be maintained and reviewed at least every 6 months and revised as required. Most importantly, the TSOP must be used during training and understood at all levels prior to deployment or it has no real value.

Section II. RECONNAISSANCE, SURVEILLANCE, AND TARGET ACQUISITION SQUADRON

D-6. Medical Platoon

The medical platoon of the RSTA squadron provides Echelon I CHS for the squadron. The platoon is organized with a headquarters section, a treatment squad and an evacuation section (see Figure D-3). For more detailed information on the functions and operations of the medical platoon, see Chapter 4.

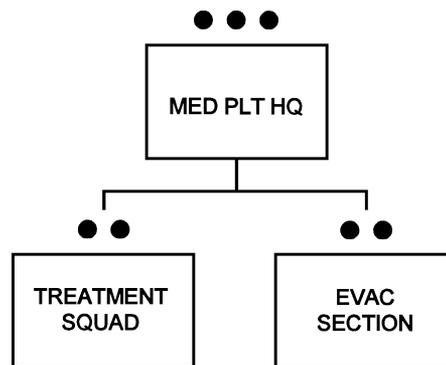


Figure D-3. Medical platoon, reconnaissance, surveillance, and target acquisition squadron.

D-7. Platoon Headquarters

a. The platoon headquarters section, under the direction of the platoon leader/surgeon that is assigned to the treatment squad, provides the C3 and logistics for the platoon. The platoon headquarters section is comprised of a field medical assistant, the platoon SGT and a medical specialist. It is normally collocated with a treatment team/squad to form the squadron aid station. The CP includes the plans and operations functions performed by the field medical assistant. The platoon has access to the HHT and the supported troop wire communication network for communications with all major elements of the squadron. 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 CHS operations. The platoon headquarters section serves as the NCS for the platoon. Table D-1 lists the information and communications assets available to the platoon.

b. The medical platoon leader is a working physician on Treatment Team Alpha. He is the medical advisor to the squadron commander and his staff. He is also the supervising physician (field surgeon) of the medical platoon's treatment teams. This officer is responsible for all medical treatment provided by the platoon. His responsibilities include—

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- Planning and directing CHS for the RSTA squadron.
- Advising the squadron commander and his staff on CHS operations and the medical threat.
- 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.
- Training the squadron's CLS.
- Supervising the squadron's CSC program, to include individual and leader training on the prevention of BF and other stress-related conditions.
- Planning and conducting humanitarian assistance programs when directed.
- Overseeing and coordinating the MEDEVAC of patients.

c. The field medical assistant, an MS officer, is the operations/readiness officer for the platoon. He is the principal assistant to the platoon leader for operations, administration, and logistics. The field medical assistant coordinates CHS operations within the squadron and with supporting brigade or corps medical elements. He coordinates MEDEVAC with the BSMC. The platoon SGT assists in supervising the operations of the platoon. He also serves as the evacuation section SGT.

D-8. Treatment Squad

The treatment squad has two treatment teams (Teams Alpha and Bravo) that are the basic medical treatment elements of the squadron aid station. They provide Echelon I medical care and treatment. This includes sick call, EMT, ATM, and triage for the management of mass casualty situations. Team Alpha is staffed with an operational medicine officer (primary care physician/squadron surgeon), a treatment squad leader (E-6), a health care SGT (E-5), and one health care specialist (E-3). Team Bravo is staffed with a PA, a health care SGT, and two health care specialists. The physician and PA are trained in ATM procedures, commensurate with their occupational positions or specialties. The PA assumes the duties of the squadron surgeon in his absence. The PA performs general technical health care and administrative duties. The PA works under the clinical supervision of the medical officer. He performs the following duties:

- Establishes and conducts treatment team operations when deployed to other locations away from the squadron aid station.
- Treats, within his ability, sick or injured patients. He refers those patients requiring treatment beyond his capability to the supervising physician.
- Provides EMT and ATM for wounded and DNBI patients.

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- Conducts training for squadron personnel in first-aid procedures (self-aid, buddy aid, and CLS), field sanitation, evacuation of the sick and wounded, and the medical aspects of injury prevention.
- Assists in the conduct of the squadron CSC program, to include individual and leader training on the prevention of BF and other stress-related conditions.
- Trains medical personnel in EMT procedures.

D-9 Evacuation Section

The RSTA squadron evacuation section employs interim armored vehicle (IAV) ambulances and provide MEDEVAC through DS or on an area support basis. Each RECON troop will normally have one ambulance team in DS. There are three ambulance teams providing DS and one area support ambulance team that is positioned with the squadron aid station. Each ambulance team consists of an aide/evacuation NCO (E-5) and two ambulance aide/evacuation drivers (E-4 and E-3). Ambulance teams provide MEDEVAC and en route care from either the soldier's point of injury or a CCP to the squadron aid station/treatment team or brigade medical element providing area support. 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 casualty evacuation should be included in the RSTA squadron TSOP and OPORD. The HHT and surveillance and target acquisition troop are provided Echelon I medical treatment and MEDEVAC support on an area support basis by the area support ambulance team. They will also operate dispersed throughout the RSTA squadron AO in support of RECON troops. These dispersed ambulances will evacuate to the nearest supporting Echelon I MTFs based on the OPORD and according to preplanned and coordinated area medical support responsibilities.

D-10. Squadron Combat Health Support Planning

a. The squadron surgeon, assisted by the field medical assistant and the platoon SGT, is responsible for the CHS plan for the RSTA squadron. Squadron CHS operations involve all of the factors that must be considered in the initial developmental stages of the squadron CHS plan. The CHS plan is updated to meet tactical or CHS operations requirements. The following factors should be considered:

- Information requirements (current task organization structure, medical troop strengths, projected weather and environmental factors, and maintenance status of medical equipment).
- Results of the mission analysis.
- Commander's intent.
- Planning guidance.
- Courses of actions.
- Tactical plan.

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- Enemy.
- Terrain.
- Troops.
- Weather.
- Threat (including medical threat).
- Operational conditions and constraints.
- Civilian populace in the AO.
- Medical personnel status.
- Equipment status of the medical platoon.
- Supply status including Class VIII.
- Communications capability.
- Nuclear, biological, and chemical defense including OEG.
- Nuclear, biological, and chemical casualty considerations.
- Training status.
- Casualty estimates.
- Medical evacuation requirements and capabilities.
- Nonmedical support requirements from the squadron.
- Area support requirements.
- Special operations support requirement
- Medical records and reports requirements.
- Phases of operations.
- Policy and procedure updates.

b. The foundation of the squadron CHS plan is the squadron commander's guidance and the brigade CHS plan.

D-11. Squadron Operation Plans and Operation Orders

a. The brigade headquarters gives mission orders to the squadron headquarters. The medical platoon may receive additional coordinating instructions from the BSS. These coordinating instructions are normally transmitted in a force text e-mail message via the tactical LAN. As part of the mission analysis and based on the squadron commander's intent and guidance, the medical platoon develops CHS estimates for supporting squadron operations. An understanding of the squadron RECON troop time lines or battle rhythm will assist the squadron medical platoon leader and field medical assistant in developing the CHS input through the squadron S1 to the squadron OPLAN/OPORD.

b. Squadron COA development/analysis and wargaming are accomplished after mission analysis. Course of action development and wargaming result in the production of the OPORD and the CHS annex.

c. Once the RSTA squadron receives the brigade WARNO, it begins mission analysis. Based on its analysis and the full brigade order that follows, the squadron determines its tactical plan. Part of determining its plan is the placement of medical treatment elements (squadron aid station/treatment team). The brigade CHS plan will include the plan for Echelon II support as well as any tasking of support to the squadron medical platoon. The RSTA squadron medical platoon leader will assess the platoon's adequacy as part of the mission analysis. He will bring any shortfalls to the squadron commander's attention during the mission analysis briefing. The platoon leader and/or the field medical assistant then participate in COA development and wargaming to produce the squadron plan. When the commander approves the OPLAN, it becomes the OPORD. The OPLAN and OPORD are developed by the S3 section, using input from each of the staff elements, with the S1 being the staff coordinating element for CHS. The RSTA squadron CHS plan is revised or updated based on mission analysis or changes in CHS requirements. The medical platoon leader maintains current information on the following subject areas that include—

- Patient status board (for example, awaiting evacuation).
- Dirty routes/patient decontamination sites.
- Location of squadron aid station/treatment team and of BAS or other MTF providing area medical support to RSTA squadron elements (current/projected).
- Area medical support responsibilities.

D-12. Rehearsal

For successful implementation of the CHS annex of the RSTA squadron plan, the CHS plan must be coordinated and synchronized with the squadron plan so that CHS requirements are met. To achieve optimal synchronization, the CHS plan is rehearsed as an integral part of the combined arms plan at the combined arms rehearsal. See Chapter 3 for definitive information on rehearsal.

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D-13. Combat Health Support for the Offense and the Defense

See Chapter 4 for definitive information on CHS for offensive and defensive operations.

D-14. Reconnaissance, Surveillance, and Target Acquisition Squadron Operations and Combat Health Support

a. The unique mission of the RSTA squadron will cause it to deploy its troops over a very large AO. These long distances will require careful planning and well-coordinated and aggressive CHS operations. This squadron will rely heavily on first aid and CLSs.

b. Many RECON and counter-RECON missions will occur at night. Combat health support for these missions must be planned in detail for limited visibility conditions. The acquisition and MEDEVAC of a RSTA squadron casualty will require a team effort on the part of the troops, the medical platoon, and the squadron staff. Often, trauma specialists will not be able to successfully execute this alone in the RSTA squadron AO. In most cases, it will require a combined arms effort.

D-15. Combat Health Support During Night Operations

The squadron surgeon and medical platoon members must anticipate that the brigade does a substantial amount of its work at night or in limited visibility. They must ensure that the platoon TSOP is available and used throughout the squadron for providing MEDEVAC and treatment at night. See Chapter 4, paragraph 4-4, for definitive information of night operations.

Section III. OVERVIEW OF MEDICAL FORCE STRUCTURE IN SUPPORT OF THE INTERIM BRIGADE

D-16. Combat Health Support for the Interim Brigade

a. Combat health support to the brigade is focused on the stabilization of wounds and injuries, and early evacuation of casualties out of the brigade's AO. Self-aid/buddy aid and the CLS is essential first aid, and early initial medical treatment provided by the trauma specialist is critical for reducing the morbidity and mortality rates. Additionally to reduce the morbidity and mortality rates, both EMT and ATM are performed at the BAS and the BSMC to ensure appropriate treatment and to stabilize the wounded or traumatized patient. After the initial first aid or medical treatment, an ambulance crew evacuates the patient to the supporting Echelon I treatment team/BAS.

b. The BSMC of the brigade support battalion is capable of providing Echelon I area medical support to BSA elements, back-up Echelon I support to forward maneuver battalions, and Echelon II CHS to all elements of the brigade. The BSMC is normally augmented with a surgical capability provided by an

attached corps FST. Casualties that cannot be returned to duty by the brigade medical assets will be evacuated to a corps hospital or supporting MTF. After the first 96 hours of brigade operations, the brigade may be augmented with a corps FSMT. When deployed forward to the BSA, the BSMC commander coordinates the air ambulance team's evacuation missions.

c. The BSMC, assisted by the support operations section, provides real-time tactical information to the air ambulance crew about evacuation missions from the brigade combat team units/elements to supporting brigade MTFs. When air ambulances operate forward of the BSA, they will execute the A2C2 plan through the maneuver brigade S3. The BSB support operations section provides planning and coordination between aeromedical evacuation and the supported maneuver brigade. The brigade S3 provides the A2C2 plan that includes the air corridors, air control points, and communications checkpoints. The brigade S3 will provide updates as required. Air ambulances deployed to the BSA provide MEDEVAC from forward areas (BAS) back to the BSA. Air ambulance evacuation from the point of injury will be METT-TC dependent. Corps air ambulances may also evacuate from the BSA to supporting corps MTF. Corps aeromedical elements will operate from BSA providing around the clock immediate response evacuation aircraft. To accomplish this, elements must maintain a close tie with the A2C2 system in the brigade. The brigade A2C2 element provides an airspace plan through the brigade OPORD/OPLAN A2C2 annex. The aircrew must also be familiar with the daily airspace control order and the airspace control plan. These documents contain all ACM, to include free fire areas, no-fly fire areas, restricted operations zones, and established and standard Army aircraft flight routes. These route and ACM change on a daily basis and cannot be integrated into the brigade OPORD. The BSS will ensure all A2C2 information is provided to corps aeromedical elements. The BSS does not generate A2C2 information, but does provide A2C2 planning information to division A2C2 elements.

D-17. Brigade Surgeon's Section

The BSS is assigned to the HHC of the brigade and operates out of the brigade TOC. It is the brigade's primary planning cell for CHS and works closely with the S3 and his staff in the planning process. The BSS staff is responsible to the brigade commander for staff supervision of CHS within the brigade. The BSS is also responsible for coordinating GS and DS relationships of organic medical units and medical units/elements whether under OPCON or attached to the brigade. The BSS also will—

- Advise the brigade commander on the health of the command.
- Monitor force health protection issues.
- Provide basic sick call support to headquarters personnel.
- Provide technical control/assistance to brigade medical personnel.
- Advise/make recommendations on risk reduction.
- Review/coordinate for either external support or augmentation.

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D-18. Brigade Support Medical Company

The BSMC provides Echelon II CHS to all the brigade units operating within the brigade's AO. It also provides/ensures Echelon I CHS to all the brigade units without organic medical support. The BSMC will be organized into a company headquarters, a treatment platoon, an ambulance platoon, a PVNTMED section, and a MH section. The area support section in the treatment platoon contains an area support treatment squad (two treatment teams), which operates the brigade clearing station located in the BSA. These treatment teams will utilize HMMWVs with trailers, or an acceptable variant consistent with the interim brigade concept. The holding squad provides a holding capability of 20 cots. The primary use of the cots is to hold those patients awaiting MEDEVAC out of the brigade AO. An additional mission for the patient holding squad is to hold and provide nursing care for soldiers expected to RTD within 24 to 72 hours. The area support squad provides limited dental support, as well as limited laboratory and x-ray support to the BSMC. The treatment platoon will include two treatment teams to provide mobile Echelon I support within the brigade AO. These treatment teams will utilize IAVs (treatment variant) with trailers. The ambulance platoon will consist of six ambulance teams in IAV ambulances, and four ambulance teams in HMMWV ambulances. The teams in IAV ambulances will be deployed in support of the medical platoons in the maneuver battalions. The IAV ambulances will be used to evacuate patients from BAS to AXP (located between the BAS and the BSMC) where the patients are transferred to BSMC HMMWV ambulances and evacuated to the brigade clearing station operated by the BSMC.

D-19. Forward Surgical Team

Corps-level initial surgical support will be provided by the FST. This team is comprised of 20 personnel and has two operating tables.

D-20. Medical Force Protection

The BSMC medical force protection assets include a PVNTMED section and a MH section. Both sections have two-man teams. The PVNTMED section has an environmental science officer and a PVNTMED specialist. The PVNTMED team provides medical force protection through technical advice to the commander. They ensure the health of the brigade by performing sanitary inspections of food service, field sites, latrine, bathing, and other activities. The team is also responsible for coordination and oversight of medical surveillance. This includes early recognition of potential epidemics or biological warfare agent employment; and monitoring field water supplies, to include sample collection for potential NBC contamination. The MH team includes a behavioral science officer and a MH specialist. The mission of this team is combat operational stress control; they focus on the medical force protection aspects of treatment and prevention of combat stress. This includes the rapid reversal of dysfunctional stress reactions (BF). These medical force protection capabilities are essential to enhancing soldier survivability across the spectrum of battlefield contingencies through continual health hazard assessment, stress reduction, and minimizing disease and injury.

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D-21. Medical Logistics (Class VIII/Blood)

The BSMC has limited Class VIII/ blood management capability. During deployment, lodgment, and early buildup phases, medical units operate from planned, prescribed loads and from existing pre-positioned war reserve materiel identified in applicable contingency plans. The BSMC will deploy with supplies to support a 72-hour, self-sustainment mission within the brigade (support for maneuver units is included). Resupply (Class VIII/blood requisitions) for the BSMC will be conducted via a functional module of MC4 electronic requisitions sent to the medical logistics management center, operating out of the AO. The medical logistics management center will send release orders for materiel to the appropriate MEDLOG activity. Class VIII resupply will flow via the battlefield distribution system under the direction of the brigade support battalion support operations section. Unique to the brigade is the range and complexity of MEDLOG support. The probability of corps-level CHS (surgery, hospitalization, intensive care, and extensive blood usage) within the brigade footprint will result in a significant increase in the variety and urgency of medical supplies and equipment. Priority of transportation of critical Class VIII materiel will have to be recognized and supported throughout the distribution pipeline. Blood support to the operation will follow the same procedures.

D-22. Infantry Battalion Medical Platoon

See paragraph D-1.

D-23. Reconnaissance, Surveillance, and Target Acquisition Squadron

See paragraphs D-4 through D-13.

D-24. Field Artillery Battalion

Combat health support for the FA battalion is provided by its medical section that is assigned to the battalion's headquarters service battery. The medical section has a combat medic section with a trauma specialist assigned to support each firing battery. There are three ambulance teams. Normally, one ambulance team is in DS of each firing battery and a treatment team. Echelon II care is provided by the BSMC.

D-25. Engineer Company

Combat health support for the engineer company is provided by its combat medic section. This section is under the supervision of a health care SGT and each platoon is supported by a trauma specialist. Echelon I medical treatment and MEDEVAC support will be provided on an area support basis from brigade medical assets. Echelon II care is provided by the BSMC.

D-26. Antitank Company

Combat health support for the antitank company is provided by its organic medical section that consists of a senior company medic and an individual trauma specialist for each platoon. The antitank platoons will be employed in the proximity of other brigade units that have organic medical treatment teams. Company personnel will receive additional Echelon I from brigade organic medical treatment teams. Echelon II CHS is provided by the BSMC of the brigade support battalion on an area support basis.

D-27. Units Without Organic Medical Personnel

Units without organic medical personnel will utilize self-aid/buddy aid and the CLS according to current directives. These units will normally operate in proximity to area medical support assets. Based on the concepts of employment for these units, personnel will receive Echelons I and II CHS on an area support basis from organic brigade medical assets.