

APPENDIX F

TACTICAL STANDING OPERATING PROCEDURE**F-1. General**

All medical platoon/sections assigned to combat arms, CS, and CSS units must establish a TSOP for conducting CHS operations supporting their units for all operational contingencies. These TSOP should be detailed and cover all aspects of unit CHS operations. This is an example TSOP that can be used by both the division and nondivisional medical platoons and sections to guide them in the development and refinement of their TSOP.

F-2. Sample Tactical Standing Operating Procedure

The sample shown is from a medical platoon assigned to an infantry battalion and it would be included in an annex of the battalion's TSOP. This TSOP supports the battalion for all operational contingencies and is written for wartime and other operations. There is not a standard format for all TSOP; however, it is recommended that the annex follow the format used by its higher headquarters.

DEPARTMENT OF THE ARMY
Headquarters and Headquarters Company
 _____ **Battalion,** _____ **Infantry**
 _____ **Division**
Fort _____, State/APO _____, ZIP CODE _____

ANNEX O
MEDICAL PLATOON
TACTICAL STANDING OPERATING PROCEDURES

I. PURPOSE

The purpose of this TSOP is to provide guidelines, policies, and procedures. The implementation of this document will enhance the effectiveness of training and provide specific procedures for routine tasks during CHS operations. This TSOP has been prepared to standardize operations and CHS procedures for the battalion medical platoon in time of war and other operations.

A. **Scope.** The scope of this TSOP addresses the mission, organization, equipment, and medical platoon operations.

B. **Applicability.** This SOP applies to all personnel assigned to the _____ Infantry Medical Platoon.

C. **Accountability.** All personnel assigned to the medical platoon as a part of their initial orientation are required to become familiar with and have a working knowledge of this TSOP. Thereafter, all medical platoon personnel in leadership positions will review the TSOP every 90 days and update or

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recommend changes as required. Personnel not in leadership positions are required to review the TSOP a minimum of every 6 months or as necessary when conducting operations.

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II. GENERAL

A. The medical platoon operates the BAS and provides Echelon I CHS for the battalion. Medical platoon personnel are under the command leadership of the battalion commander and the HHC commander. The battalion surgeon/medical platoon leader is a member of the battalion staff. He is responsible to the battalion commander for directing battalion CHS operations. The battalion surgeon/medical platoon leader is responsible to the brigade surgeon for technical oversight and supervision of all CHS activities within the battalion.

B. The medical platoon is dependent on the FSMC of the supporting FSB for Echelon II CHS. This includes medical evacuation from the BAS to the FSMC, patient holding, operational and CSC support, Class VIII resupply, PVNTMED support, medical maintenance, x-ray, laboratory, and operational dental care. The medical platoon requests augmentation/reinforcing support from the FSB's medical company.

III. ORGANIZATION AND MISSION

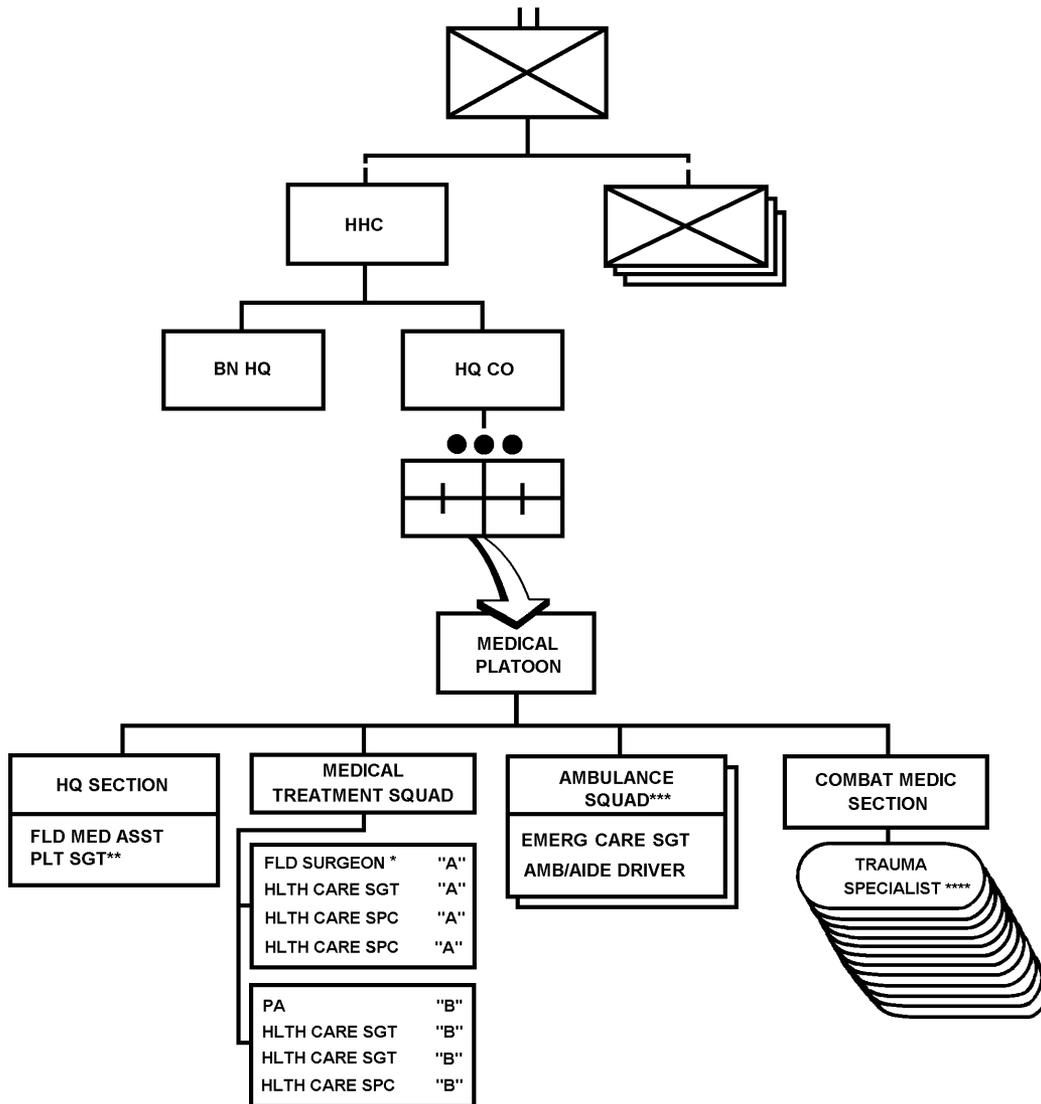
A. Organization. The medical platoon is organized as shown in Figures F-1.

1. Platoon headquarters.

a. The headquarters section, under the direction of the battalion surgeon, provides C3 and resupply for the platoon. The field medical assistant and the platoon SGT man the platoon headquarters. It is normally collocated with the treatment squad to form the BAS. The CP includes the plans and operations functions performed by the field medical assistant.

b. The field medical assistant, an MS Corps 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 CHS operations with the battalion S3 and S4 and coordinates patient evacuation with the FSMC. When a physician or PA are not assigned, he performs the duties of medical platoon leader.

c. The platoon SGT assists the platoon leader and supervises the operations of the platoon. He also serves as the ambulance section SGT. This NCO prepares reports; requests general supplies as well as medical supplies; advises on supply economy procedures; and maintains ASL of expendable supplies. He supervises the activities and functions of the ambulance section, to include operator maintenance of ambulances and equipment; OPSEC; and EMT.



- * ALSO BATTALION SURGEON
- ** ALSO SERVES AS AMBULANCE SECTION SGT
- *** 4 AMBULANCE TEAMS
- **** AIRBORNE BATTALIONS HAVE 12 TRAUMA SPECIALISTS ASSIGNED TO THE COMBAT MEDIC SECTION AND AIR ASSAULT BATTALIONS HAVE 10 TRAUMA SPECIALISTS ASSIGNED TO THE COMBAT MEDIC SECTION
- "A" ALFA TREATMENT TEAM
- "B" BRAVO TREATMENT TEAM

Figure F-1. Medical platoon, headquarters and headquarters company light infantry battalion.

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2. Treatment squad. This squad is staffed with an operational medical officer (primary care physician/battalion surgeon), a PA, two health care SGT, and four health care specialists. The squad's physician, PA, and health care SGT are all trained in ATM procedures, commensurate with their occupational positions/specialties.

3. Combat medic section. A total of 12 trauma specialists are assigned to the combat medic section. To foster good interpersonal relations and morale of combat troops, every effort should be made to attach the same trauma specialists to the same unit they habitually support each time the unit deploys. However, during lulls in combat operations, they should return to the medical platoon for consultation and proficiency training.

4. Ambulance squads. Medical platoon ambulance squads have two emergency care SGTs, two emergency care specialists, and four ambulance drivers/aides assigned. Four ambulances are assigned to the medical platoon's ambulance squads.

B. Mission. The mission of the medical platoon is to provide Echelon I CHS for the battalion. This includes medical treatment, medical evacuation, and clearing the battlefield. It includes PVNTMED activities to counter either disease or combat and operational stress disorders. It includes EMT and ATM to save lives, limbs, or sight and to stabilize the wounded or injured patient for further evacuation. This also includes maintaining accurate field health records as well as the permanent health record in a garrison setting.

IV. MEDICAL EVACUATION OF SICK AND WOUNDED

A. Purpose. This policy and these procedures established for evacuation of sick and wounded are consistent with doctrine published in the following manuals.

- FM 8-10-1, The Medical Company—Tactics, Techniques, and Procedures.
- FM 8-10-6, Medical Evacuation in a Theater of Operations—Tactics, Techniques, and Procedures.
- FM 8-10-26, Employment of the Medical Company (Air Ambulance).
- FM 8-55, Planning for Health Service Support.

B. General.

1. Evacuation is based on the principle that rear higher echelon medical units are responsible for evacuating patients from supported units. Lower echelon supported and supporting units must ensure evacuation support plans are complete and current by close, direct coordination. See FM 8-10-6 for an in-depth discussion of medical evacuation; for additional information, refer to FMs 4-02.4, 8-10, 8-10-1, 8-10-26, 8-42, 8-55, 63-20, and 63-21.

2. Patients are evacuated no further to the rear than that necessary to obtain the medical care that will return them to duty. Patients are evacuated by the means of transportation that most clearly meets the treatment demands of their wounds, injury, or illness.

3. Allied military personnel, treated or held in a division MTF within reasonable proximity of their own national facility, are classified and processed as follows:

a. Allied military personnel requiring further treatment, but in stable condition for immediate transfer, are returned to their own national medical facility, as coordinated through liaison with the corps or division surgeon.

b. Allied military personnel requiring further stabilization are retained in US medical channels until they can be safely transferred to their own national MTFs. Arrangements for reception of the patient by the gaining MTF are completed prior to the evacuation.

c. The preferred method for evacuation of neuropsychiatric and BF casualties who can be managed without medications or physical restraints is a nonambulance ground vehicle. If physical restraints and/or medications are required during transportation, ground ambulance is preferred. An air ambulance should only be used if no other means of evacuation is available. Physical restraints are used only during transport and medications are given only if needed for reasons of safety. Those neuropsychiatric and BF patients with life- or limb-threatening conditions are evacuated by the most expedient means available. See FMs 8-10-6 and 8-51 for additional information on medical evacuation of psychiatric patient and BF soldiers.

C. Responsibilities for Medical Evacuation.

1. The medical platoon leader—

a. Develops an evacuation plan which will best support the operations being conducted.

b. Prepares/obtains the necessary maps of the AO and overlays from the S3.

c. Does reconnaissance of MEDEVAC routes, either map or on the ground.

d. Provides ambulance teams with strip maps; briefs the plan; and rehearses the MEDEVAC plan with the ambulance section when time permits.

e. Identifies and coordinates with the battalion TOC on the location of primary and alternate helicopter landing sites that are established.

f. Coordinates with the FSMC on medical evacuation and location of the AXP.

g. Oversees medical evacuation operations to ensure expedient evacuation from the battlefield.

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2. The medical platoon SGT—

a. Ensures that evacuation wheeled assets are maintained and preventive maintenance checks and services (PMCS) are accomplished in accordance with 10/20 standards.

NOTE

The 10/20 indicate the technical manuals authorized for every item of equipment at unit level.

b. Ensures that ambulances are properly stocked with requisite Class VIII supplies and equipment.

c. Ensures ambulance communication and computer equipment is functional and that all personnel are familiar with SOI.

3. The evacuation squad leader—

a. Participates in route reconnaissance with the medical platoon leader or SGT.

b. Identifies locations of company aid post and CCP.

c. Ensures ambulances are maintained in a state of readiness to perform their evacuation mission.

d. Maintains vehicles in accordance with 10/20 standards and ensures PMCS are performed.

e. Ensures computers and communications equipment are functioning.

f. Keeps the squad updated on road conditions and the threat levels.

4. The senior (line) company trauma specialist—

a. Establishes a company aid post/CCP.

b. Requests medical evacuation of wounded or injured soldiers via the company's communications assets.

c. Coordinates with the BAS as required for additional medical evacuation assets.

d. Maintains aid bags in accordance with published packing lists.

- e.* Maintains prescribed Class VIII supplies on hand.
 - f.* Request Class VIII resupplies for CLS, as required.
5. Companies (A, B, C, and HHC)—
- a.* Collect and secure casualty's sensitive items.
 - b.* Remain custodian (1SG) of casualties' personal effects that do not accompany patient through the evacuation process.
 - c.* Ensure the casualty's protective mask accompanies the soldier when he is evacuated from the battalion.
 - d.* Ensure unit personnel are trained on manual carries and on the use of litter carries to transport casualties. Units must be prepared to assist medical personnel as required.
 - e.* Complete the DA Form 1156, Casualty Feeder Report, and DA Form 1155, Witness Statement on Individual, when required. (Medical personnel do not complete these forms.)
6. The battalion S4—
- a.* Is involved in developing the mass casualty plan and the use of nonstandard vehicles to evacuated casualties.
 - b.* Is responsible for coordinating with graves registration personnel for the transport of deceased personnel (BSA).
 - c.* Provides pouches for human remains (body bags).
 - d.* Provides transportation assets for deceased personnel.
- D. Procedures for Medical Evacuation.
- 1. One ground ambulance, M997, is normally placed in direct support of each company.
 - 2. One ground ambulance, M997, remains with the aid station for supporting the HHC and area support.
 - 3. The two cargo trucks, M998s, used to haul BAS equipment and supplies, may be used for medical evacuation with the augmentation of medical personnel to ride with the patients and provide en route care.
 - 4. Medical platoon ambulances are responsible for medical evacuation of patients from forward areas back to the BAS.

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5. The FSMC positions one ambulance, M997, forward with the BAS that is responsible for evacuating patients back to an AXP or to the FSMC in the BSA.

6. One technique used to reduce evacuation times is to pre-position ambulances with the supported company.

7. Another technique is to have on call ambulance support. For this technique, units submit medical evacuation request via radio or landline. The BAS will dispatch an ambulance, M997, to the company aid post/CCP to retrieve the casualty. In some cases, the senior company trauma specialist and the 1SG, using the 1SG's vehicle, may evacuate the casualty from forward areas back to the CCP.

a. Procedures for information collection and MEDEVAC request preparation are performed in accordance with the 9-line MEDEVAC request identified in FM 8-10-6. Air ambulances may not fly forward of the BAS because of threat antiaircraft capabilities. This mission will be performed by a ground ambulance and the following information is collected, to include—

- (1) What is the location of the pickup site?
- (2) Radio frequency and call sign.
- (3) Number of patients by precedence (URGENT, URGENT-SURGICAL, PRIORITY, ROUTINE, and CONVENIENCE).
- (4) Special equipment required.
- (5) Number of patients by type (litter or ambulatory).
- (6) Number and types of wounds (peacetime).
- (7) Security of pickup point (wartime).
- (8) Method of marking pick-up site if required.
- (9) Patient nationality and status.
- (10) Nuclear, biological and/or chemical contamination (wartime) or terrain description (peacetime).

b. Upon receipt of the mission, the ambulance team on call will—

- Obtain road clearance from the S3 for the MSR/evacuation route to the requesting unit.
- Perform a radio check with the BAS and/or field trains upon departure from BAS, upon arrival at pickup site, and upon departure from pickup site. Convey problems encountered en route and difficulties regarding en route patient care will also be forwarded.

- c.* Actions at the unit CCP include—
- Securing (if not already done) site with driver and other available personnel.
 - Parking vehicle facing the perimeter (doors to the rear).
 - Surveying patients and performing triage (this is accomplished by the senior company trauma specialist on location). Assigning evacuation categories (for example, URGENT, URGENT SURGICAL, PRIORITY, ROUTINE, and TACTICAL CONVENIENCE). Separating NBC-contaminated casualties. Practicing appropriate protective measures in an NBC environment.
 - Organizing litter teams (senior company trauma specialist).
 - Checking each DD Form 1380 (FMC) to ensure it is completed according to AR 40-66 (senior company trauma specialist).
 - Personnel at the CCP assisting with loading patients as directed by the ambulance driver in accordance with Chapter 10, FM 8-10-6.
- d.* Actions by the ambulance team upon departure of the CCP include—
- Notifying the BAS and/or the field trains as to the time of departure and ETA at the BAS. Stating number and type of patients, to include ambulatory and litter. Discussing potential en route medical complications with physician or PA.
 - Moving along prescribed movement routes, taking advantage of cover and concealment. Verifying evacuation routes as tactical situation dictates.
- e.* Actions of the BAS upon arrival of patients.
- Patients are off loaded and provided EMT/ATM as required; the physician or PA will determine if the patient requires further evacuation. Patient information is entered into the treatment and disposition log and also provided to the battalion S1. If the patient is an URGENT or URGENT-SURGICAL precedence, an air ambulance is requested.
 - If a ground ambulance is to be used, the ambulance team from the FSMC is notified of their mission. Normally to minimize the time that the supporting FSMC ambulance is away from the BAS, the FSMC will establish an AXP somewhere between the supported unit and the BSA. This AXP is where the FSMC ambulance team that is supporting the BAS evacuates the patient(s). At the AXP, the patient is transferred to another ground ambulance then evacuated the remaining distance to the FSMC. The medical platoon leader will inform the battalion staff and the patient's company commander on the disposition of his unit member.
 - From the BSA, corps ground or air ambulances are responsible for evacuating to the corps combat support hospital.

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- Aeromedical evacuations are conducted in accordance with FMs 8-10-6 and 8-10-26.

E. Control of Property and Equipment.

1. Soldiers evacuated from their unit to the BAS, as a minimum, have their protective mask and clothing.

2. Any property and equipment arriving with casualties other than the protective mask and clothing or individual weapon for ambulatory patients will be collected and turned in to the battalion S4 for return to the parent unit. The battalion S4 coordinates the return of property and equipment to the casualty's unit.

3. Under combat conditions, protective masks are kept in the immediate proximity of each patient throughout their period of evacuation and stay at any MTF. In other operations, the protective mask policy for patients will be based on the NBC threat and the policy established by higher headquarters.

F. Rules for Employment of Ambulance and Ambulance Personnel.

1. The use of MEDEVAC vehicles will be restricted to—
 - a. Transportation of sick or injured personnel.
 - b. Transportation of medical personnel.
 - c. Transportation of Class VIII supplies/equipment and blood.
2. Medical personnel assigned to the ambulances will—
 - a. Adhere to the tactical commanders' standards for uniform and camouflage and other requirements identified in the supported unit's TSOP.
 - b. Participate in the medical training being conducted at the supported medical element.
 - c. Assist with patient treatment as required.

NOTE

Caution should be exercised by officers-in-charge or noncommissioned officers-in-charge to ensure the ambulance crew has adequate rest in order that they can safely perform their evacuation duties.

- d. Perform PMCS on their vehicles.

e. Ensure their vehicle is restocked with required Class VIII supplies and equipment, full of fuel, and ready for the next evacuation mission.

3. Medical personnel assigned to the ambulances that are positioned with the supported medical element will not be required to—

- Perform duties as kitchen police.
- Perform EPW or perimeter guards.
- Perform driver duties for other than their assigned vehicle.

G. Use of Aeromedical Evacuation.

1. Aeromedical evacuation is the preferred method of evacuation and will be used when—
 - a.* Life, limb, or eyesight is in jeopardy (URGENT or URGENT-SURGICAL category).
 - b.* Speed, distance, and time are factors in assuring prompt and adequate treatment.
 - c.* There is a critical need for resupply of Class VIII supplies or whole blood/blood products.
 - d.* There is a critical need for movement of medical personnel and equipment.

2. Helicopter landing zones are established when and where tactical situations permit. A helicopter landing zone should be marked with a letter “H” or a letter “Y,” using identification panels or other appropriate marking material. See FMs 8-10-6 and 57-38 for a complete description and guidelines for establishing a helicopter landing zone.

3. Precedence for air ambulance evacuation is provided in FMs 8-10-6 and 8-10-26.

V. DECEASED PERSONNEL

A. Principles Governing Medical Disposition of Deceased Personnel.

1. Deceased personnel are segregated from other casualties.
2. The deceased, as determined by the senior medical authority, are not evacuated with other casualties, nor are they routinely evacuated on medical vehicles. This is especially true if the threat of biological or chemical contamination will render the vehicle unfit for subsequent medical evacuation missions. A FMC should be initiated and attached to the remains, if possible.

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3. Medical evacuation resources should not be used to transport deceased personnel.
 4. All deceased personnel should have an FMC that is signed by a medical officer prior to their departure from a graves registration collection point operating in forward areas.
- B. Coordinate with the Battalion S4 for Transport of Deceased Personnel.
1. The battalion S4 coordinates with mortuary affairs collection point personnel for the evacuation of deceased personnel to the graves registration site (normally near or in the BSA).
 2. The battalion S4 obtains and issues pouches for human remains (body bags) to the BAS.
 3. Battalion aid station personnel coordinate transport of deceased personnel with the battalion S4.
 4. For definitive information on mortuary affairs operations, see FM 10-64.

VI. ENEMY PRISONERS OF WAR

- A. All EPW will be provided medical care according to the articles of the GWS, dated 12 August 1949.
- B. Enemy prisoner of war patients will be segregated from allied and US personnel.
- C. Enemy prisoner of war patients will be reported through normal medical reporting procedures.
- D. Enemy medical personnel are considered retained personnel and shall receive the benefits provided by the Geneva Conventions. Retained enemy medical personnel will be used to the maximum extent possible to care and treat EPW patients.
- E. Enemy prisoner of war patients will be evacuated through medical channels.
- F. Enemy prisoner of war patients will be under armed guard at all times. Guards are the responsibility of the echelon commander. Medical personnel will not be used as guards for EPW according to the Geneva Conventions.
- G. Enemy prisoner of war patients will be searched prior to each move in the MEDEVAC system.
- H. Information on EPW patients will be coordinated with the prisoner of war information center to maintain accountability of captives in medical channels. See FM 19-4 for additional information on EPW.

VII. CLASS VIII SUPPLY

A. Class VIII Supply Procedures in the Field. In the field, the medical platoon maintains a 2-day (48-hour) stockage of Class VIII supplies within its MES. The following MES are authorized for the medical platoon treatment section:

- Chemical Agent Patient Decontamination, NSN 6545-01-176-4612 (1).
- Chemical Agent Patient Treatment, NSN 6545-01-141-9469 (2).
- Sick Call Field, NSN 6545-01-228-1886 *(2).
- Trauma Field, NSN 6545-01-228-1667 *(2).

* Indicates the numbers of MES authorized for each treatment team.

B. Authorized Stockage and Controls. Medical supply items authorized for use by the medical platoon are normally those items that are identified as part of the MES. Items that are not in the MES must be approved for stockage by the division surgeon. This includes both expendable items and pharmaceuticals. For perishable and dated items that are found in the MES, a DA Form 4998-R, Quality Control and Surveillance Record for TOE Medical Assemblage, is initiated for all expendable and durable items in the medical assemblage. For a medical item that has a shelf life and demands are expected, a DA Form 4996-R will be prepared and maintained in accordance with AR 40-61. These items are referred to as potency and dated items. Controlled pharmaceutical such as R and Q items (see NOTE below) are stored in the most secure container. A record of controlled medical items will be kept on DA Form 3862 (Controlled Substances Stock Record).

NOTE

Controlled substances are drugs so designated by the Drug Enforcement Administration. A list of these drugs and changes are published in the Federal Register and in the SB 8-75 series. Standard controlled substances are identified by Note R and Q in the notes column of the Federal Supply Catalog, DOD Section, Medical Materiel and by controlled inventory items codes R and Q in the Army Master Data File.

QUALITY CONTROL AND SURVEILLANCE RECORD FOR TOE MEDICAL ASSEMBLAGES								
For use of this form, see AR 40-61; the proponent agency is OTSG								
NO	LOCATION	MANUFACTURER	CONTRACT NO. (if available)	LOT/BATCH NUMBER	EXP/MFR DATE (if available)	QTY ON HAND	DATE LAST INSPECTION	DATE NEXT INSPECTION
NSN		DESCRIPTION			UNIT OF ISSUE	NOTES	INSPECTION FREQUENCY	SHELF LIFE/ ESTIMATED SHELF LIFE

DA FORM 4998-R, APR 1994 REPLACES DA FORM 4998-R, AUG 1981, WHICH IS OBSOLETE USAPA V1.00

Figure F-2. Quality Control and Surveillance Record for TOE Medical Assemblage, DA Form 4998-R.

NSN		DESCRIPTION			INSP FREQ	DATE LAST INSP	DATE NEXT INSP
QUALITY CONTROL CARD							
For use of this form, see AR 40-61; the proponent agency is OTSG							
NO	MANUFACTURER	LOT NUMBER	EXP DATE	DATE MFG	SHELF LIFE	DATE RECD	
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
NSN		DESCRIPTION			INSP FREQ	DATE LAST INSP	DATE NEXT INSP

DA FORM 4996-R, APR 1994 REPLACES DA FORM 4996-R, AUG 1981, WHICH IS OBSOLETE USAPA V1.00

Figure F-3. Quality Control Card, DA Form 4996-R.

C. Class VIII Requisitioning Procedures in the Field.

1. Routine Requisitions. Routine requisitions for Class VIII supplies are submitted to the FSMC using a DA Form 2765-1, Request for Issue or Turn-in, for each item in accordance with DA Pam 710-2-1. The FSMC may fill these requests from its MESs or forward them to the DMSO. The DMSO will fill the requests and send items forward to the supporting FSMC via LOGPAC. The FSMC coordinates the delivery of Class VIII supplies to the requesting unit through the FSB support operations section. Requisitions may also be sent via radio or by using a sneaker net method. Prior to deployment, individuals should know the Class VIII resupply requirement and procedures.

2. Emergency Requisitions. Emergency requisitions for Class VIII supplies are sent to the FSMC via radio or telephone. Any item not filled is immediately forwarded to the DMSO. Delivery of emergency requests will be by the most expedient mode of transportation, based on METT-TC factors. Normally, a requisition with a 03 or higher priority will require the approval of the commander.

D. Class VIII Supply Procedures in Garrison.

1. Medical Treatment Facility Operations. Operations of the BAS/MTF at the home station are normally under the control of the medical center (MEDCEN)/MEDDAC commander. For MTF (garrison) operations, Class VIII items may be requisitioned directly from the MEDDAC. Under other situations, the BAS/MTF orders from the DMSO or supporting MEDLOG battalion. The installation medical supply activity is operated by either the MEDDAC or the MEDLOG battalion.

2. Class VIII Requirements. The MEDCEN/MEDDAC commander establishes requirements for MTF operations in garrison. A list of Class VIII items required and authorized at the MTF is identified by hospital SOP or regulation. Medications are identified in the hospital formulary. When operating MTF in a garrison environment, medical platoons are subject to the same standards as any of the MEDCEN/MEDDAC treatment facilities.

3. Requisitioning Information. Requisitioning information includes—

- a.* Department of Defense activity address code. Example: YNAMTF
- b.* Serial numbers. The serial number is issued by the document register maintainer and this number is preceded by the Julian date on each request for issue or turn-in. Serial number example: W35MW2.
- c.* Account processing code. This code is issued by the supporting MEDLOG element and identifies the unit. An example is AWhA.
- d.* Signature cards will be on file with the MEDCEN/MEDDAC and a copy maintained by the platoon SGT or his designated person for supply actions.
- e.* The platoon SGT or his designated person for supply activities maintains the document register.

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4. Supply Matrix. A supply matrix will be posted in the supply 3-ring binder with the following information:

- a. Quantity maintained.
- b. Quantity needed to be ordered.
- c. Date medication was ordered.
- d. Expiration dates of pharmaceuticals (checked each month).

5. Expired Medications. If from the MTF, they are turned in to the MEDCEN/MEDDAC. If from the TOE MES, they are turned in to the DMSO.

6. Multidose Vials. When opened, they are dated and initialed by the user.

7. Medication Refrigerator. Will be cleaned and defrosted monthly.

8. Medication Locker and Safe. Medication lockers are unlocked during sick call but are locked if the care provider leaves the room. The safe with code R and Q items is secured except for removal of medication to fill a prescription. Keys will be maintained by the physician, PA, or platoon SGT. Only the physician, PA, or platoon SGT will have the combination to the safe.

9. Inventories. A 100 percent inventory of all assets belonging to the medical platoon is performed on an annual basis according to DA Pam 710-2-1 and DA Pam 710-2-2.

10. Point of Contact. The telephone number of the MEDCEN/MEDDAC logistics division's is _____.

VIII. MEDICAL MAINTENANCE

A. Garrison Medical Treatment Facility. Operator maintenance is performed on medical equipment according to MEDCEN/MEDDAC SOP and in accordance with manufacture's instructions. Medical equipment is turned in to the MEDCEN/MEDDAC medical maintenance shop or a work order is phoned in according to MEDCEN/MEDDAC SOP.

B. Medical Maintenance in the Field. Medical maintenance will consist of operator-/user-level maintenance. See FM 4-02.1 for additional information. Medical platoon personnel will exercise their responsibilities by performing operator PMCS. This includes maintaining equipment by performing routine services like cleaning, dusting, washing, and checking for frayed cables, loose hardware, and cracked or rotting seals. In addition, medical platoon personnel will—

- Perform equipment operational testing.

- Replace operator-level spares and repair parts that will not require extensive disassembly of the end item, critical adjustment after the replacement, or extensive use of tools.

IX. MANAGEMENT OF MASS CASUALTIES

A. Mass casualty situations occur when the number of casualties exceed the available medical capability to rapidly treat and evacuate them. The battalion surgeon working with the S4 and the S3 advises the commander on integrating all available resources into an effective mass casualty plan.

B. All companies must have procedures in place to respond effectively to mass casualty situations. The potential of disasters in war and other operations requires that the medical element be prepared to support mass casualty situations. They must be able to receive, triage, treat, and evacuate large numbers of casualties within a short period of time. Contingency plans for supporting mass casualty operations must be developed by all units in coordination with their battalion surgeon and battalion S3. Unit mass casualty plans, as a minimum, will address the following subject areas:

1. Planning and training requirements.
2. Medical duty positions.
3. Nonmedical personnel positions and duties, including litter teams, perimeter guards crowd control, and information personnel.
4. Location of treatment areas, to include triage, immediate care, minimal care, delayed care, and expectant care areas.
5. Support requirements beyond the unit's capability.
6. Medical evacuation.
7. Use of nonmedical transportation assets.
8. Nuclear, biological, and chemical casualties.
9. Return to duty procedures.
10. Medical records and reports.
11. Locating deceased personnel away from and out of sight of all patients.

C. Upon notification of large number of casualties, the medical platoon will request augmentation support from the FSMC. The division or brigade surgeons should be informed of any mass casualty situation by the most expedient means available. As a minimum, information provided should include location, anticipated number of casualties, and additional support required. For additional information, see FMs 8-10, 8-10-1, 8-55.

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D. The DSS directs and coordinates CHS requirements for the requesting unit. Supporting corps and division medical units in the chain of evacuation are alerted of the situation.

E. Mass casualty management in garrison is accomplished according to the MEDCEN/MEDDAC SOP.

X. PREVENTIVE MEDICINE

A. The battalion surgeon oversees all PVNTMED activities in the battalion.

B. The division PVNTMED cell located in the MSB (or for Force XXI, the DSB) is responsible for supervising the division's PVNTMED program as described in AR 40-5. This cell ensures PVNTMED measures are implemented to protect division personnel against food-, water-, and arthropodborne diseases, as well as environmental injuries (for example, heat and cold injuries). This cell provides advice and consultation in the areas of environmental sanitation, epidemiology, sanitary engineering, and pest management.

C. Preventive medicine support for the battalion is requested through the FSMC and formal tasking is accomplished through the division or brigade headquarters.

D. All companies in the battalion will establish unit field sanitation teams. Preventive medicine personnel will assist in the training of these teams in the aspects of environmental sanitation and the limited control of animal reservoirs and disease vectors.

E. Company commanders will—

1. Use trained field sanitation team members to assist in preserving the health of the unit and reducing the incidence of DNBI which will hinder mission accomplishment (FM 21-10).

2. Ensure the field sanitation team members take to the field all required field sanitation equipment and supplies to perform their duty (AR 40-5).

3. Enforce food and water safety standards. Unless otherwise stated, water will be treated to at least 5 parts per million chloride residual and will be obtained from approved sources only. Safe handling, storage, and preparation of food will be according to AR 30-21, AR 40-5, FMs 10-23, and 21-10.

4. Plan for the construction of hygienic devices, such as handwashing devices in the unit area. Company commanders will also enforce personal hygiene measures to reduce the threat of disease.

5. Motivate subordinates to execute individual preventive measures (such as carrying an extra pair of dry socks; and/or eating or drinking from approved sources only).

6. Enforce the use of the DOD repellent systems requiring the use of repellents on skin (DEET [75 percent N,N-diethyl-M-toluidide]) and clothing (permethrin).

7. Develop and enforce the unit sleep plan that provides soldiers with a minimum of 4 hours of uninterrupted sleep in a 24-hour period. If sleep is interrupted, then 5 hours should be given. During continuous operations when uninterrupted sleep is not possible, blocks of sleep which add up to 6 hours in a 24-hour period are adequate for most people. Remember, 4 hours each 24-hour period is far from ideal. Do not go with only 4 hours sleep each 24 hours for more than 2 weeks before paying back sleep debt. Recovery time should be approximately 8 to 10 hours sleep each 24 hours over a 5- to 7-day period. If at all possible, give the individuals (such as ambulance drivers) whose key tasks are vulnerable to sleep loss 6 hours of sleep a day.

8. Plan for measures to prevent environmental injuries (such as heat or cold) (see FM 21-10).

9. Obtain and disseminate information on the medical threat so soldiers can reduce their risk of DNBI.

10. Request PVNTMED consultation/assistance. Requests can be submitted to the DSS, the BSS, or any medical company/element in the division.

XI. DENTAL SERVICES

A. Dental treatment facilities are located in each FSMC and in the MSMC (or DSMC for Force XXI). Each medical company establishes dental sick call hours; supported units are notified of the sick call hours.

B. Operational dental care will be provided in the field. This dental care consists of emergency and essential care.

C. Battalion personnel report to the BAS for dental sick call. Dental patients are sent back to the FSMC for dental services.

D. The goal by battalion personnel for dental patients is to relieve pain, to get them back for dental treatment, to get them seen, and to return them to duty.

XII. MENTAL HEALTH/COMBAT STRESS CONTROL

A. Under the guidance of the division psychiatrist and the FSMC MH section, the battalion surgeon is responsible for the battalion's CSC programs.

1. Conduct or request classes on stress control.

2. Identify and eliminate unnecessary stress on unit personnel.

3. Ensure personnel and leaders are familiar with stress-reducing techniques.

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4. Ensure all leaders understand the problems associated with sleep deprivation and the consequences of not following the unit sleep plan.

B. The battalion surgeon requests after-action stress debriefings for battalion personnel involved in operations where numerous injuries or loss of life has occurred. He coordinates for critical-events debriefing following a catastrophic incident in the unit. See FMs 8-51 and 22-51 for definitive guidance on stress control.

XIII. EYEWEAR

A. Battalion personnel requiring corrective eyewear will deploy with two pairs of eyewear plus one set of inserts for their protective mask.

B. Personnel authorized to wear contact lenses will deploy with two pair of standard eyewear.

C. The following procedures are followed for repair or replacement of eyewear including—

1. Maintaining the latest prescription on the soldier's field medical record.
2. Sending eyewear that is broken or in need of repair to the division optometry section located in the MSMC (or DSMC for Force XXI).
3. Requesting the replacement of lost eyewear.

XIV. GENEVA CONVENTIONS COMPLIANCE

A. Medical Facilities.

1. All US medical facilities and units, except veterinary, will display the distinctive flag of the Geneva Conventions. This flag consists of a red cross on a white background. It is displayed over the unit or facility and in other places as necessary to adequately identify the unit or facility. Nondisplay of the flag can be ordered by a brigade or higher level commander.

2. Camouflage of the medical facility (medical units, medical vehicle, and medical aircraft on the ground) is authorized when a lack of camouflage might compromise the tactical operation.

3. The order to camouflage can be given by a brigade-level or higher commander.

NOTE

As used in this context, camouflage means to cover up or remove the Geneva Conventions emblem. The black cross on an olive background is not a recognized emblem of the Geneva Conventions.

B. Defense of Medical Units.

1. Medical personnel may carry small arms for personal defense of themselves and defense of their patients. Self-defense of medical personnel or defense by medical personnel of their patients is always permitted. This does not mean that they may resist capture or otherwise fire on the advancing enemy. It means that, if civilian or enemy military personnel are attacking and ignoring the marked medical status of medical personnel, medical transportation, or the medical unit, the medical personnel may provide self-protection. If an enemy military force merely seeks to assume control of a military medical facility or a vehicle for the purpose of inspection and without firing on it, the facility or vehicle may not resist.

2. An overall defense plan may not require medical units to take offensive or defensive actions against enemy troop at any time. If a medical force is part of a defensive area containing nonmedical units, medical personnel may not be responsible for manning part of the overall perimeter. If located in isolation, the medical unit may provide its own local and internal security if other support is not available. However, all soldiers (medical and nonmedical) providing this internal and local security must comply with the requirements in subparagraph 1 above.

XV. MEDICAL REPORTING

Medical reporting requirements for the battalion should be listed in the battalion TSOP. Medical reporting requirements are established by the division and brigade surgeons. Listed below are documents used for reporting or from which information is obtained for reporting purposes.

A. Field Medical Card. A FMC will be initiated for each new patient and for cases required to be carded-for-record only. This will be accomplished according to AR 40-66 and FM 8-10-6. Field Medical Cards will be conspicuously attached to the patient's clothing.

B. Daily Disposition Log. The Daily Disposition Log is maintained by all Echelon I and Echelon II MTFs assigned or attached to the division. Information from this log is extracted, when required, and provided to the S1 or the supported unit requesting the information. The log is also the primary source document for information needed in the preparation of the Patient Summary Report and the Patient Evacuation and Mortality Report.

C. Medical Reports Format. Medical reporting will be accomplished using the FBCB2, FAX, or voice, transmitted via radio/MSE. A manual backup system will be developed. Formats for medical reports are required to maintain consistency and continuity in reporting procedures for information submitted to the BSS and the DSS. Data contained in these reports are required to support the DSS's capability projections and to assist the BSS, HSSO, and FSMC commander in coordinating and planning CHS operations. Data is also extracted for consolidated reporting to higher headquarters. The guidelines presented below should be followed exactly.

1. Each line of information is divided into a number of fields. Each field has a minimum number of alphanumeric characters as indicated in the sample format provided.

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2. Each field is separated by a single slash(/).
3. The end of each set of fields is indicated by a double Slash (/).
4. If information from a prior report has not changed, "NC" will be entered in that field (/NC/).
5. Reports are formatted according to special instructions and reports format.

D. Medical Situational Report, Battalion Aid Station. The MEDSITREP, BAS is a daily patient summary report. This report is used to inform the commander of the battalion's patient, Class VIII, and medical equipment status. This report is submitted daily, covering the events in a 24-hour time period based on time lines provided by the higher headquarters. It is submitted to the supporting medical company. The battalion surgeon (platoon leader) or platoon SGT is responsible for this report. This report could be dispatched via courier, FAX, and/or teletype.

E. Medical Situational Report, Medical Companies. The MEDSITREP, medical companies is a daily patient summary report. This report is submitted daily to the DSS according to time lines provided by higher headquarters. The following information will be included in line six of this report:

1. Status of all assigned and attached ambulances, to include—
 - a. Total number of ambulances.
 - b. Number of ambulances that are operational.
 - c. Number of ambulances that are nonoperational.
2. Status of personnel; identify shortages by AOC or MOS.
3. Treatment of any EPW will be entered in this section.
4. Identify all patients seen during the reporting period with a number and provide the following information in the order provided below:
 - a. Nationality.
 - b. Name.
 - c. Rank.
 - d. Service number.
 - e. Unit.
 - f. Date of birth.

- g.* Diagnosis.
- h.* Disposition.
- i.* Date of disposition.
- j.* Gaining unit.

5. A hard copy of each aid station's MEDSITREP must accompany the submitting medical company's report.

F. Medical Situational Report, Medical Operations. The MEDSITREP, medical operations is a consolidated patient summary report. This report is consolidated by the DSS and pertains to the previous 24 hours. It is submitted from the DSS daily to the division based on time lines established by the division surgeon.

G. Patient Evacuation and Mortality Report. All Echelons I and II MTFs assigned or attached to the division prepare the Patient Evacuation and Mortality Report. The purpose of this report is to provide a status of patients seen by division MTFs. This is a weekly report compiled as of 2400 each Sunday and distributed each Monday to supported units.

H. Patient Summary Report. The Patient Summary Report provides the status of patients seen by division medical companies and includes their subordinate elements (dental, optometry, MH, or attached units). This report is a weekly report compiled as of 2400 each Sunday. It is prepared by all Echelons I and II MTFs operating in the division AO. It is submitted each Monday to the DSS.

I. Blood Report. The Blood Report is a required report for requesting blood support. Echelon II MTFs will request only Group O Positive and Group O Negative liquid red blood cells.

J. Team Movement Report. The Team Movement Report is used to track the status and location of teams (PVNTMED, CSC, veterinary, ambulance, and treatment teams).

XVI. AUTHORIZED ABBREVIATIONS AND REPORT CODES FOR MEDICAL REPORTS

AUTHORIZED ABBREVIATIONS

ARMS AND SERVICES:

AVN	AVIATION	EMPLOYED MEANS:
ABN	AIRBORNE	MORTARS
AD	AIR DEFENSE	POISON
AMINF	ARMED INFANTRY	ROCKETS
AMPB	AMPHIBIOUS	SABOTAGE
ARMED	ARMORED	TUBEARTY
ARTY	ARTILLERY	MISSILES

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AT	ANTITANK
ATAGM	ANTITANK GUIDED MISSILE

COMMAND LEVEL:

AG	ADJUTANT GENERAL
ARMY	ARMY
BDE	BRIGADE
BN	BATTALION
CO	COMPANY
CORPS	CORPS
DIV	DIVISION
GP	GROUP
HQ	HEADQUARTERS
PLT	PLATOON
RGT	REGIMENT

NATIONALITY:

BE	BELGIAN
CA	CANADIAN
GE	GERMAN
NL	NETHERLANDS/HOLLAND
UK	BRITISH
US	AMERICAN

CAUSE OF CASUALTY TO BE USED FOR MASS CASUALTY REPORTING.

ACCIDENT:	AIRCRAASH
ACCIDENT:	MARITIME
ACCIDENT:	MOTOR VEHICLE
ACCIDENT:	RAILWAY
ACCIDENT:	FIRE
ACCIDENT:	INDUSTRIAL
ACCIDENT:	POISON
ACCIDENT:	NATURAL DISASTERS
ACCIDENT:	OTHER CAUSES
BATTLE:	CONVENTIONAL
BATTLE:	NUCLEAR
BATTLE:	BIOLOGICAL
BATTLE:	CHEMICAL