

## CHAPTER 2

**DIVISION COMBAT HEALTH SUPPORT****Section I. OVERVIEW OF DIVISION AND CORPS MEDICAL ASSETS****2-1. Tables of Organization and Equipment**

The TOE provides a model for fielding a unit at full capability, or at a reduced capability if resource constraints so mandate. The TOE also specifies the capabilities that the unit has to accomplish its mission. Tables of organizations and equipment are scheduled for revision when changes in doctrine occur, upon introduction of new or improved equipment, or to incorporate more effective organizational design. New TOEs are developed to accommodate the requirements of new organizations. If the TOE is not scheduled for revision or replacement by a new TOE, it will be scheduled for cyclic review every 3 years. There are different editions of TOE that are identified as under the TOE modernization system. For example, A-Edition TOE were developed to identify restructuring initiatives for existing L-Edition TOE. Example of TOE editions based on modernization of the Army include—

- Division 86, H-Edition TOE.
- Army of Excellence (AirLand Battle/Medical Force 2000), L-Edition TOE.
- Medical Reengineering Initiative (MRI), A-Edition TOE.
- Force XXI (Digitized Division), F-Edition TOE.

The MTOE is the document that is seen at the unit level. The MTOE is a modified version of a Headquarters, Department of the Army (DA)-approved TOE that prescribes the unit organization, personnel, and equipment necessary to perform a mission in a specific geographical or operational environment. At unit level, the MTOE is the base document for requesting personnel and equipment; distributing personnel and equipment resources; unit status reporting; and reporting supply and maintenance status. In addition to the TOE, some organizations have a table of distribution and allowances (TDA). The TDA prescribes the organizational structure for a unit having a support mission for which a TOE does not exist and which may include civilian positions. For the remainder of this chapter only the Army of Excellence/AirLand Battle and the Force XXI/Digitized Division TOE (with some information pertaining to MRI units) will be discussed.

**2-2. Division Medical Assets, L-Edition TOE (Army of Excellence/AirLand Battle)**

The Army of Excellence/L-Edition TOEs were developed to support the AirLand Battle/Medical Force 2000 doctrine. They will be in the Army's inventory until the Army completes its Army XXI and other modernization initiatives. Medical assets that are organic to the division with units under the L-Edition TOE include—

- Division surgeon's section (DSS) that has a surgeon and three additional medical personnel.
- Division support command, division medical operations center (DMOC), which could have up to 18 personnel assigned, depending on type of communications equipment the DMOC is using.

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- Main support battalion, health service support officer (HSSO).
- Main support medical company.
  - Headquarters section.
  - Treatment platoon.
  - Ambulance platoon.
  - Division medical supply office.
  - Mental health section.
  - Preventive medicine section.
  - Optometry section.
- Forward support battalion, HSSO.
- Forward support medical company.
  - Headquarters section.
  - Treatment platoon.
  - Ambulance platoon.
- Aviation brigade flight surgeon's section

In addition, medical platoons/section are assigned to the following combat arms battalions or squadrons:

- Armored.
- Mechanized infantry.
- Airborne infantry.
- Air assault.
- Light infantry.
- Armored cavalry.
- Artillery.

- Reconnaissance, surveillance, and target acquisition (RSTA) squadron.
- Air defense artillery battalion.

Also, medical personnel may be assigned to the following units.

- Engineer battalion.
- Signal battalion.
- Antitank company.
- Military police company.

### 2-3. Division Medical Assets, F-Edition TOE (Force XXI/Digitized Division)

The F-Edition TOEs were developed to support the Force XXI/Division Redesign Initiative and Force XXI doctrine. Digitization of the new Force XXI Division is a high priority.

#### NOTE

Digitization is defined as the application of information to acquire, exchange, and employ timely battlefield information. It will *enhance situational understanding* and provide the means for information dominance by enabling friendly forces (ten divisions, Reserve Components, and joint/combined forces) to *share a common picture of the battlefield* while communicating and targeting in real or near real-time. Digitization will reduce the “fog of war” and *decrease decision-making time* by *optimizing the flow of information*. It will allow the “orchestration” of combat power at critical times and places faster than an adversary can. It will contribute *increased lethality, survivability, and operational tempo* while *reducing the potential for fratricide* to ensure *seamless digital communications* from the sustaining base to the tactical and strategic levels.

Medical assets that are organic to the division with units under the F-Edition TOE include—

- Division surgeon’s section (a surgeon and 12 additional medical personnel).
- Division support command medical operations branch, including an officer and an NCO.
- Division support command medical materiel management branch (MMMB) (one officer and one NCO).

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- Division support battalion HSSO.
- Division support medical company (DSMC).
  - Headquarters section.
  - Treatment platoon.
  - Ambulance platoon.
  - Mental health section (a division psychiatrist, an NCO, and one MH specialist are assigned to this section).
  - Preventive medicine section (one environmental science officer and a PVNTMED NCO are assigned to this section).
  - Optometry section.
- Forward support battalion, CHS cell/HSSO (an officer and an NCO are assigned to this section).
- Forward support medical company.
  - Headquarters section.
  - Treatment platoon (one less treatment squad than the L-Edition TOE).
  - Ambulance platoon.
  - Mental health section (a division psychiatrist, an NCO, and one MH specialist are assigned this section).
  - Preventive medicine section (one environmental science officer and a PVNTMED NCO are assigned to this section).
- Maneuver brigade surgeon's section (BSS) (six personnel assigned).
- Medical platoons/sections are assigned to the following combat arms and CS battalions:
  - Armored.
  - Mechanized infantry.
  - Artillery.

- Engineer.
- Signal.
- Medical personnel may be assigned to the following units:
  - Engineer company.
  - Antitank company.

#### **2-4. Division Surgeon, L-Edition TOE (Army of Excellence/AirLand Battle)**

The division surgeon is an Medical Corps (MC) officer, area of concentration (AOC) 60A. He is a special staff officer and normally coordinates his CHS activities through the G1. Generally, the surgeon's duties are administrative; the division commander charges him with full responsibility for the technical control of all medical activities in the command. The division surgeon's staff is assigned to the DSS of the division HHC. Personnel assigned to this section include an operations NCO (MOS 91W40), a clerk typist (MOS 71L10), and a patient administration specialist (MOS 71G10). These personnel along with the DMOC staff located in the DISCOM, assist the division surgeon in the performance of his duties. The division surgeon's responsibilities include—

- Advising on the health status of the command and of the occupied or friendly territory within the commander's area of responsibility.
- Briefing the division commander and/or his representative during all routine and emergency division briefings on CHS operations.
- Participating in the preparation of division OPLAN and contingency plans and identifying potential medical hazards associated with geographical locations and climatic conditions.
  - Determining reporting requirements and frequencies.
  - Advising on the health effects of the environment.
  - Advising on the health effects of NBC devices/weapons, to include OEG.
  - Exercising technical supervision of subordinate brigade surgeons, physicians, and PAs.
  - Providing consultation and mentoring to subordinate brigade surgeons, physicians, and PAs.
  - Advising on the health effects of directed-energy devices/weapons.
  - Determining requirements for the requisition, procurement, storage, maintenance, distribution management, and documentation of Class VIII supplies within the division.

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- Monitoring critical Class VIII items and keeping the division commander informed.
- Determining requirements for medical personnel and making recommendations concerning their assignments.
- Coordinating with medical unit commanders, to include leaders of medical platoons and sections, for continuous CHS.
- Submitting to higher headquarters those recommendations on professional medical problems that require research and development.
- Recommending use of captured medical supplies in support of EPW and other recipients.
- Advising on medical intelligence requirements (including the examination and processing of captured medical supplies as directed by the corps surgeon).
- Providing recommendations on allocation and redistribution of AMEDD personnel, CHL, and CHS during the reconstitution process.
- Advising commanders about the PVNTMED aspects of reconstitution and availability and use of CSC teams.
- Forwarding the Command Health Report (RCS MED-3 [R7]) according to Chapter 3, AR 40-5.
- Advising commanders on the effects of accumulated fatigue, radiation exposure, possible delayed effects from exposure to chemical warfare (CW) or biological warfare (BW) agents, and use of countermeasures and pretreatments.
- Advising commanders on disposition of personnel exposed to lethal, but not immediately life-threatening, doses of radiation or CW and BW agents.
- Ensuring the division's CHS annex is developed for all contingency plans. For CHS planning factors, see FM 8-55.
- Initiating, through the division commander and the G3, medical training, first aid training, and CLS training programs for the division.
- Overseeing the continuing health education program for the division and ensuring compliance with AR 351-3.
- Ensuring that all physicians and nonphysician health care providers have gone through a credentialing committee according to AR 40-68 to validate clinical privileges.
- Ensuring that clear and accurate patient records are maintained of all clinical encounters for supported/deployed personnel through the use of appropriate forms as directed by AR 40-66. See Appendix B

for management of individual health records in the field. For additional information on the division surgeon, see FMs 8-10-3 and 8-10-5.

#### **2-5. Division Surgeon, F-Edition TOE (Force XXI/Digitized Division)**

The division surgeon, an MC officer (Lieutenant Colonel [LTC], AOC 60A00), is a division-level special staff officer. He normally works under the staff supervision of the division Chief of Staff. The division surgeon is responsible for the technical control of all medical activities in the command. He oversees and coordinates CHS activities through the DSS. The division surgeon advises the division commander on all medical or medical-related issues. The division surgeon's responsibilities are the same as those identified above except for—

- Briefing the division commander and/or his representative during all routine and emergency division briefings on CHS operations. This is normally accomplished using the Combat Service Support Control System (CSSCS).
- Monitoring the status of critical Class VIII items list and providing the G4 a list of medical items that should be a part of the commander's tracked items list.
- Developing the division's CHS annex for all contingency plans. For CHS planning factors, see FM 8-55.
- Ensuring that clear and accurate patient records are maintained of all clinical encounters for supported/deployed personnel through the use of appropriate forms as directed by AR 40-66. See Appendix B for management of individual health records in the field. Also, digital patient records at the division and brigade level will be available through the fielding of Medical Communications for Combat Casualty Care (MC4) and the Theater Medical Information Program (TMIP); see Chapter 3. For additional information on the division surgeon, see FM 4-02.21.

#### **2-6. Division Surgeon's Section, F-Edition TOE (Force XXI/Digitized Division)**

The DSS is normally located with the division main and consists of a medical plans and operations cell, a CHL cell, a patient disposition and reports cell, and a PVNTMED cell. Figure 2-1 shows the typical organization and staffing of the DSS.

*a. Medical Plans and Operations Cell.* The medical plans and operations cell is responsible for coordinating, planning, synchronizing, rehearsing, and conducting CHS for the division. For definitive information on the organization, functions, and operations of this section, see FM 4-02.21.

*b. Combat Health Logistics Cell.* The CHL cell is responsible for planning, coordinating, and prioritizing CHL and medical equipment maintenance programs for the division. The CHL cell is staffed with a health service materiel officer (HSMO). The HSMO (Major, AOC 70K67) works closely with the DISCOM MMB and medical logistics (MEDLOG) company. The HSMO coordinates and oversees the CHL support for the division.

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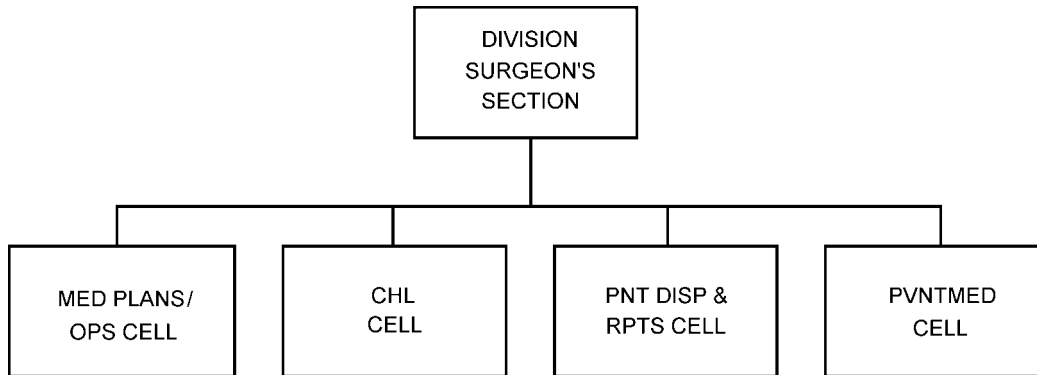


Figure 2-1. Division surgeon's section.

c. *Patient Disposition and Reports Cell.* The patient disposition and reports cell is responsible for coordinating patient disposition throughout the division. The branch obtains and coordinates disposition of patients with the medical plans and operations cell and the corps medical regulating office(r) (MRO). It prepares and forwards appropriate medical statistical reports as required. The patient disposition and reports cell is staffed with a patient administration NCO and two patient administration specialists.

d. *Preventive Medicine Cell.* The division PVNTMED cell is responsible for—

- Supervising the command PVNTMED program, to include health assessment and medical surveillance; see AR 40-5 and FM 4-02.17.
- Ensuring PVNTMED measures are implemented that protect division personnel against food-, water-, and vectorborne diseases, as well as environmental injuries (for example, heat and cold injuries).
- Monitor disease trends within the division.

The PVNTMED missions are accomplished according to the division CHS plan and coordinated by the PVNTMED officer through the medical plans and operations cell with the DSMC and FSMCs. Division PVNTMED personnel provide advice and consultation in the areas of environmental sanitation, epidemiology, and entomology, as well as limited sanitary engineering services and pest management. Additional information pertaining to the PVNTMED personnel and their specific functions is discussed in FMs 4-02.17, 8-10, 8-10-1, and 8-10-3. The PVNTMED cell is staffed with a PVNTMED officer. The PVNTMED officer (Major, AOC 60C00) is responsible for the implementation of the command PVNTMED program.

### 2-7. Corps Medical Assets in Support of Divisions

Corps medical units in GS and DS of the division are normally assigned to the corps medical command (MEDCOM) or medical brigade. The MEDCOM/brigade will provide subordinate units to support the



division by establishing a command relationship of OPCON or attachment. The MEDCOM/brigade could also choose to maintain only a support relationship of DS or GS to support the division. The division surgeon and DSS (Force XXI) and the DMOC under Army of Excellence interface with corps medical units according to the MEDCOM/brigade tactical standing operating procedures (TSOP). The DSS or DMOC and other division staff elements must be prepared to integrate corps-level medical units/elements into the medical, as well as the logistical, support structure. The MEDCOM/brigade will normally deploy a liaison officer to the division to coordinate and synchronize corps CHS. Information concerning the organization, functions, and responsibilities of the corps MEDCOM/brigade is found in FM 8-10.

*a. Corps Medical Command and Medical Brigade.* The corps MEDCOM and medical brigade provide C2, including—

- Staff planning.
- Supervision of operations.
- Administration of the assigned and attached units.

*b. Medical Logistics Battalion.* The MEDLOG battalion is organic to the corps medical brigade. The MEDLOG battalion provides C2 for assigned MEDLOG companies and the blood support detachment. The MEDLOG battalion is responsible for receiving, storing, and distributing medical materiel; single and multivision optical fabrication and repair; medical maintenance; blood and blood product collection, manufacturing, and distribution; medical gas production and distribution; and building of medical assemblages/push packages. The MEDLOG battalion will employ standard state-of-the-art MEDLOG information management and communications systems, to include satellite links.

(1) *Medical logistics company.* The MEDLOG company provides Class VIII supplies, DS/GS medical maintenance, and optical support. The MEDLOG company will use line-item requisitioning to support customers and will have the capabilities of building and maintaining preconfigured push packages in support of forward deployed medical units.

(2) *Blood support detachment.* The MEDLOG battalion's blood support detachment serves as the Army's blood supply unit (BSU). Blood and blood products will be stored and distributed under rigid specifications and managed by standard automated systems. Air movement will be the mode of choice for transporting blood and blood products. Army blood support in the AO will be the responsibility of the supporting MEDLOG battalion. The MEDLOG battalion's blood support detachment will collect, manufacture, receive, store, and distribute blood and blood products on an area basis.

*c. Medical Evacuation Battalion.* The headquarters and headquarters detachment, MEDEVAC battalion serves as the central manager of ground and air evacuation assets in the corps. Its mission is to provide C2 of ground and air MEDEVAC units within its AO. Information pertaining to the organization, functions, and capabilities of this unit is discussed in FM 8-10-6; air ambulance operations in support of the division are discussed in FMs 4-02.21, 8-10-3, and 8-10-26. A ground ambulance and one air ambulance company are normally placed in support of a division. The air ambulance company provides aeromedical evacuation on a DS basis. This company may be attached for support (less OPCON) to the division aviation

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brigade. Air ambulances will operate from the DSA and BSA, providing 24-hour immediate response MEDEVAC capability.

*d. Medical Detachment, Combat Stress Control.* The CSC detachment provides DS to a division's maneuver brigades and GS/reinforcing support to the DSA, including corps units in those areas. The detachment must function with its elements widely dispersed, some working in and for the supported division and others working in the corps. For definitive guidance on the medical detachment, CSC, see FM 8-51.

*e. Veterinary Elements.* The division will have corps veterinary team/personnel positioned at Class I supply points. They may also be deployed to the division to monitor and evaluate zoonotic diseases and environmental data, to include food exposed to NBC agents. Veterinary personnel will provide animal care for military working dogs and may perform investigations and postmortem examination of reported animal deaths. For additional information see FM 8-10-18.

*f. Preventive Medicine Elements.* Corps PVNTMED team/personnel may be deployed into the division when requested to augment division PVNTMED sections. Corps PVNTMED personnel provide advice and consultation in the areas of environmental sanitation, epidemiology, and entomology, as well as sanitary engineering services and pest management. Additional information pertaining to corps PVNTMED units and their specific functions is discussed in FM 4-02.17.

*g. Dental Services.* In planning the concept of operations, unit-level dental support is dependent upon corps-level area dental support assets in numbers sufficient enough to support the manpower requirement criteria for operational dental care. Unit dental support relies on corps-level area dental support units for assistance in providing operational care. Modules of area dental support units also augment or reconstitute unit dental elements when required. Corps-level dental units provide dental modules to reinforce or reconstitute the division dental modules when necessary and to operate field dental clinics. See FM 4-02.19 for definitive information on dental services.

## Section II. DIVISION SUPPORT COMMAND MEDICAL UNITS AND ELEMENTS

### 2-8. Division Support Command, L-Edition TOE (Army of Excellence/AirLand Battle)

The DISCOM is organized to provide the maximum amount of CSS within prescribed strength limitations while providing the most effective and responsive support to tactical units in a combat environment. In order to provide responsive support to the tactical commander, logistics, medical, and personnel services support must be effectively organized and positioned as far forward as necessary to support the tactical plan. Division-level CHS for the Army of Excellence division is coordinated and provided by the DISCOM medical elements listed below:

- Division medical operations center, DISCOM HHC, located in the DSA.

- Main support battalion.
- Main support medical company, MSB, located in the DSA.
- Forward support battalion.
- Forward support medical company, FSB, located in the BSA.

*a. Division Medical Operations Center.* The DMOC's mission is to plan, coordinate, and synchronize the division's CHS with technical medical advice from the division surgeon. The division surgeon and the DMOC chief have joint responsibilities for CHS operations in the division. Their staff positions in the division and DISCOM require a close working relationship and coordination of their CHS activities. The DMOC staff is responsible to the DISCOM commander for staff supervision of CHS within the DISCOM. The division surgeon and DMOC chief will develop operating procedures that will enhance the flow of information and facilitate the synchronization of CHS operations within the division. It is imperative that the division surgeon and the DMOC chief work as a team. Both share equal responsibility for planning and overseeing CHS operations. The DMOC is responsible for monitoring CHS activities within the division area and keeping the DISCOM commander informed of the status of CHS. The division surgeon is informed of the DISCOM's CHS status through reports prescribed by the TSOP. For definitive information on the DMOC, see FMs 8-10-3 and 63-2.

*b. Main Support Battalion.* Information pertaining to the structure and operations of the MSB is provided in FM 63-21. The DMOC will interface with elements of the MSB, as required and approved by the DISCOM commander. The DMOC may interface with elements of the MSB through the DISCOM support operations section. The interactions and coordination between the DMOC and the MSB are driven by CHS requirements of the division and changes with the tactical situation. The chief, DMOC, and the MSB commander must develop policies and procedures that clearly delineate responsibilities and coordination requirements for an effective working relationship. Tasking of the MSMC elements by the DISCOM will be through command channels.

*c. Main Support Medical Company.* The MSMC provides division- and unit-level CHS and medical staff advice and assistance on an area basis to units operating in the DSA. Combat health support operations are coordinated by the DISCOM DMOC medical operations branch through technical channels. The DISCOM will task elements of the MSMC through command channels to provide division-level CHS. The interface between the MSMC and the DMOC is essential for providing required division CHS. For definitive information of the MSMC, see FMs 8-10-1, 8-10-3, and 63-21.

*d. Forward Support Battalion.* The DMOC will interface with elements of the FSB as required and approved by the DISCOM commander. The DMOC may interface with elements of the FSB through the DISCOM support operations section. This interface between the DMOC and elements of the FSB is driven by CHS requirements in the forward areas. This information will assist the DMOC in planning, coordinating, and managing division medical elements and resources in support of the battle. Communications and coordination between elements of the DMOC and the FSB are essential for successful accomplishment of the DMOC's and FSB's CHS mission. For additional information, see FM 63-20.

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*e. Forward Support Medical Company.* The FSMC provides CHS for the brigade as well as area medical support for the brigade rear. Combat health support operations are coordinated by the FSMC commander and the FSB HSSO. The DISCOM tasks elements of the FSMC through command channels to provide division-level CHS. The FSMC commander positions are documented 05A, AMEDD immaterial, meaning any qualified AMEDD officer can assume command. When the FSMC commander is not a physician, medical decisions and technical supervision of physicians is performed by the senior physician assigned to the FSMC. The FSMC commander keeps the FSB commander informed on the CHS aspect of FSB operations and the health of the command. He regularly attends FSB staff meetings to obtain information to facilitate the execution of medical operations. He provides staff estimates and assists the FSB and brigade staffs with development of the CHS plan. For additional information on the FSMC commander, see FMs 8-10-1 and 63-20.

### 2-9. Division Support Command, F-Edition TOE (Force XXI/Digitized Division)

The DISCOM is a multifunctional organization capable of providing, coordinating, and synchronizing logistical support to the division. The DISCOM's mission of sustaining the divisions combat power is more critical than ever. The DISCOM consists of an FSB, a division support battalion (DSB), a division aviation support battalion, and the HHC. The DISCOM provides CSS for the division. It provides arming through its Class V operations, fueling through Class III operations, repairing through its maintenance operations, transportation through the truck company and the supply and transportation sections in the FSB, and sustaining, through the provision of rations, individual equipment and medical support. The manning function is provided by the personnel sections throughout the division. The DISCOM organization shown in Figure 2-2 identifies DISCOM units in support of maneuver brigades and to the division.

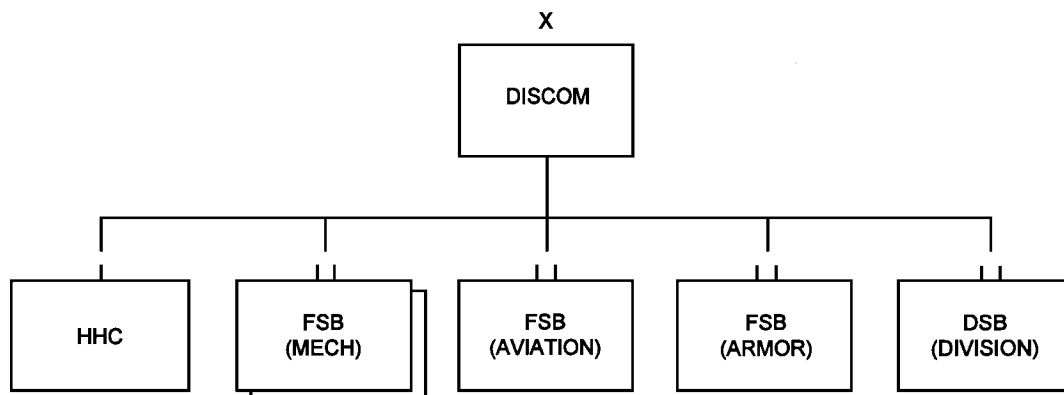


Figure 2-2. Division support command organization, Force XXI.

Division support command medical assets are organic to all of the subordinate battalions except for the division aviation support battalion (DASB). These medical assets include—

- Medical operations branch, DISCOM headquarters.
- Medical materiel management branch, DISCOM headquarters.
- Division support battalion, CHS cell.
- Division support medical company.
- Forward support battalion, CHS cell.
- Forward support medical company.

*a. Medical Operations Branch (Division Support Command Headquarters).* The medical operations branch is assigned to the distribution management center (DMC). The DMC has four branches—plans branch, operations branch, procurement branch, and medical operations branch. The DMC provides the division support operations the overall total asset visibility and the in-transit visibility of all commodities, movements, and units within, assigned, or inbound to the division AO. The primary responsibility of the medical operations branch is to assist with synchronization of the division CHS plan. The medical operations branch works with the DSS and the DISCOM staff in assisting with the development of the division CHS plan. This branch briefs the DISCOM commander and staff on CHS initiatives, as required. The medical operations branch and the DSS plan and coordinate for the employment of division medical assets and relocation of DISCOM CHS elements. The medical operations branch coordinates the CHS plan with synchronization of the division CHS plan. This branch collects medical information of intelligence value from reporting medical assets and forwards it to the appropriate division and DISCOM staff elements. The medical operations branch coordinates the placement of DS corps medical assets with supported DISCOM units, either in the DSA or BSA. The branch is responsible for—

- Briefing the DISCOM commander on the CHS planning and operations required.
- Providing current information that will assist the DSS with development of staff estimates and the division CHS plan.
- Coordinating the attachment of corps medical units/elements with DISCOM units.
- Providing information to the DSS on the DISCOM commander's intent for logistics and CHS operations.
- Coordinating the division CHS plan with all DISCOM staff elements.
- Coordinating operations information with the DSS and making recommendations to ensure synchronization of CHS activities in support of the division.

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- Ensuring CHS information from the DSS is staffed to all DISCOM elements in a timely manner.
- Coordinating with the BSS, as required, for synchronization of division CHS.

*b. Medical Materiel Management Branch.* The MMMB is assigned to the general supply office (GSO). The GSO coordinates and supervises the supply management for water and Classes I, II, III(B), and III(P) supplies and recommends priorities for the allocation and other controls of supplies. The MMMB provides advice on the receipt, storage, and distribution of supplies within its area of responsibility. This office consists of a Class I branch, Classes II/III(P)/IV branch, Class III and water supply branch, Class V branch, Class VIII branch (MMMB), and Class IX branch. The MMMB manages the Class VIII supply system in the division. The branch coordinates and recommends the prioritization of medical supplies and blood products. It also coordinates for the disposition of captured enemy medical materiel. Under the technical control of the HSMO of the DSS, the MMMB monitors and coordinates Class VIII resupply for division medical units/elements. Using the CHL functional module of the TMIP/MC4 system, the Theater Army Medical Management Information System (TAMMIS), Joint Total Asset Visibility, Transportation Coordinators' Automated Information for Movement System II, and/or other automated logistics management systems, the MMMB manages all Class VIII requisitions submitted from the division to the supporting MEDLOG company. The MMMB maintains a record of the requisition until it is filled. The MMMB coordinates shortfalls in throughput distribution with the DSS and division support operation section. The MMMB may update priorities with the MEDLOG company to correct deficiencies in the delivery system. The MMMB provides Class VIII situational understanding to the DISCOM staff and the DSS according to the TSOP. For definitive information on division Class VIII resupply operations, see FMs 4-02.1, 4-02.21, 8-10-9, and 63-2-2. The MMMB, in coordination with the CHL cell of the DSS, manages the distribution of blood and blood products for division medical units. It also coordinates through the DSS with the G5 for disposition of captured enemy medical material.

*c. Division Support Battalion Health Services Support Officer.* The HSSO is assigned to the command section and is the medical plans and operations officer. The HSSO coordinates internal medical support. He coordinates the schedules, locations, and capabilities of medical support with the DSMC. He prepares and provides an area medical plan to the subordinate units. The HSSO is also responsible for coordinating the placement of supporting corps medical elements attached to the DSB within the battalion's assigned area of the DSA. For additional information on the DSB HSSO, see FM 63-23-2.

*d. Division Support Medical Company.* The DSMC has the overall mission of providing Echelons I and II CHS to units located in the DSA and division rear areas. It provides C2 for organic elements and attached medical units. The DSMC is dependent on appropriate elements of the corps and division for patient evacuation (including air ambulance), CHS operations planning, guidance, legal, finance, and personnel and administrative services. It is also dependent on the headquarters and headquarters detachment of the DSB for food service and religious support. The DSMC is organized into a company headquarters, a treatment platoon, an ambulance platoon, an optometry section, a PVNTMED section, and a MH section.

*e. Forward Support Battalion Combat Health Support Cell.* The CHS cell is assigned to the support operations section. It is staffed with a medical planner/HSSO who is the FSB commander's special

staff officer for CHS and a member of the FSB battle staff and a medical operations NCO who is the primary assistant to the HSSO. This cell is responsible for—

- Providing the CHS input for logistics preparation of the battlefield for the FSB.
- Providing the CHS estimates and medical threat input for inclusion in the FSB commander's estimate.
- Coordinating and synchronizing FSB medical operations for the supported brigade.
- Coordinating the delivery of Class VIII supplies via logistics packages (LOGPAC).
- Overseeing all FSB CHS planning activities to ensure such planning is synchronized laterally and vertically.
- Developing the CHS portion of the FSB's OPLAN in coordination with the FSB staff, the FSMC commander, and the DISCOM medical operations branch.
- Coordinating the placement of supporting corps medical elements attached to the FSB within the BSA. Identifying CHS support requirements for the BSA including space requirements for the FST (tents, equipment, vehicles, and trailers), the forward support MEDEVAC team (FSMT) (includes fuel truck and forward area refueling equipment [FARE], aircraft parking, tents for billeting), and the supporting corps ground ambulance teams and ambulances.
- Coordinating communications access for supporting corps elements as required.
- Coordinating through the BSS with the brigade S3 (Air) for current Army airspace command and control (A2C2) information that is provided to the FSMT crews. Also provides a copy of the brigade OPORD/OPLAN A2C2 annex that provides the air corridors for medical evacuation.
- Coordinating CHS taskings from the DISCOM medical operations branch with the FSB staff and the FSMC commander. Tasking may include area medical/dental, PVNTMED, CSC, and CHS reinforcement, or reconstitution support.
- Coordinating for the training and use of nonmedical personnel for patient decontamination in the event of an NBC or weapons of mass destruction attack. (See FM 8-10-7.)
- Coordinating and synchronizing CHS requirements with the BSS and the DISCOM medical operations branch.
- Monitoring the status of the FSB and brigade medical elements via the medical situational reporting on Force XXI Battle Command Brigade and Below (FBCB2).
- Monitoring the status of division medical units/elements via medical reporting on CSSCS.

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- Advising the FSB commander on CHS operations in the BSA and brigade rear.
- Maintaining situational understanding of lateral and supporting medical units.
- Submitting and forwarding status reports in accordance with DISCOM and brigade

TSOP.

*f. Forward Support Medical Company.* The FSMC has the overall mission of providing Echelon I and Echelon II CHS on a DS basis for the supported maneuver brigade. It provides C2 for organic elements and attached medical units. The FSMC is dependent on appropriate elements of the corps, division, brigade, and FSB for patient evacuation (including air ambulance), CHS operations planning and guidance, and for legal, finance, and personnel and administrative services. It is also dependent on the headquarters and distribution company of the FSB for food service and religious support and the base support company for maintenance. The FSMC is organized into a company headquarters, a treatment platoon, an ambulance platoon, a PVNTMED section, and a MH section (see Figure 2-3). For more detailed information on the operations and functions of the medical company, see FM 8-10-1. The FSMC performs these functions:

- Treatment of patients with DNBI, battle fatigue (BF), and trauma injuries. It provides routine sick call, triage of mass casualties, ATM, surgical resuscitation/stabilization (when the FST from the corps is deployed/collocated with the FSMC), and preparation of patients incapable of returning to duty for further evacuation.

- Ground ambulance evacuation for patients from BAS and designated casualty collection points (CCP).

- Operational dental care (emergency and essential dental care).

- Class VIII resupply and medical equipment maintenance for supported units.

- Medical laboratory and radiology services commensurate with Echelon II/division-level treatment.

- Outpatient consultation services for patients referred from unit-level MTF.

- Patient holding for up to 40 patients able to RTD within 72 hours.

- Limited reinforcement and augmentation to supported maneuver battalion medical platoons.

- Coordination with the UMT for required religious support.

- Preventive medicine consultation and support.

- Combat stress control, to include management of BF and stress-related casualties.



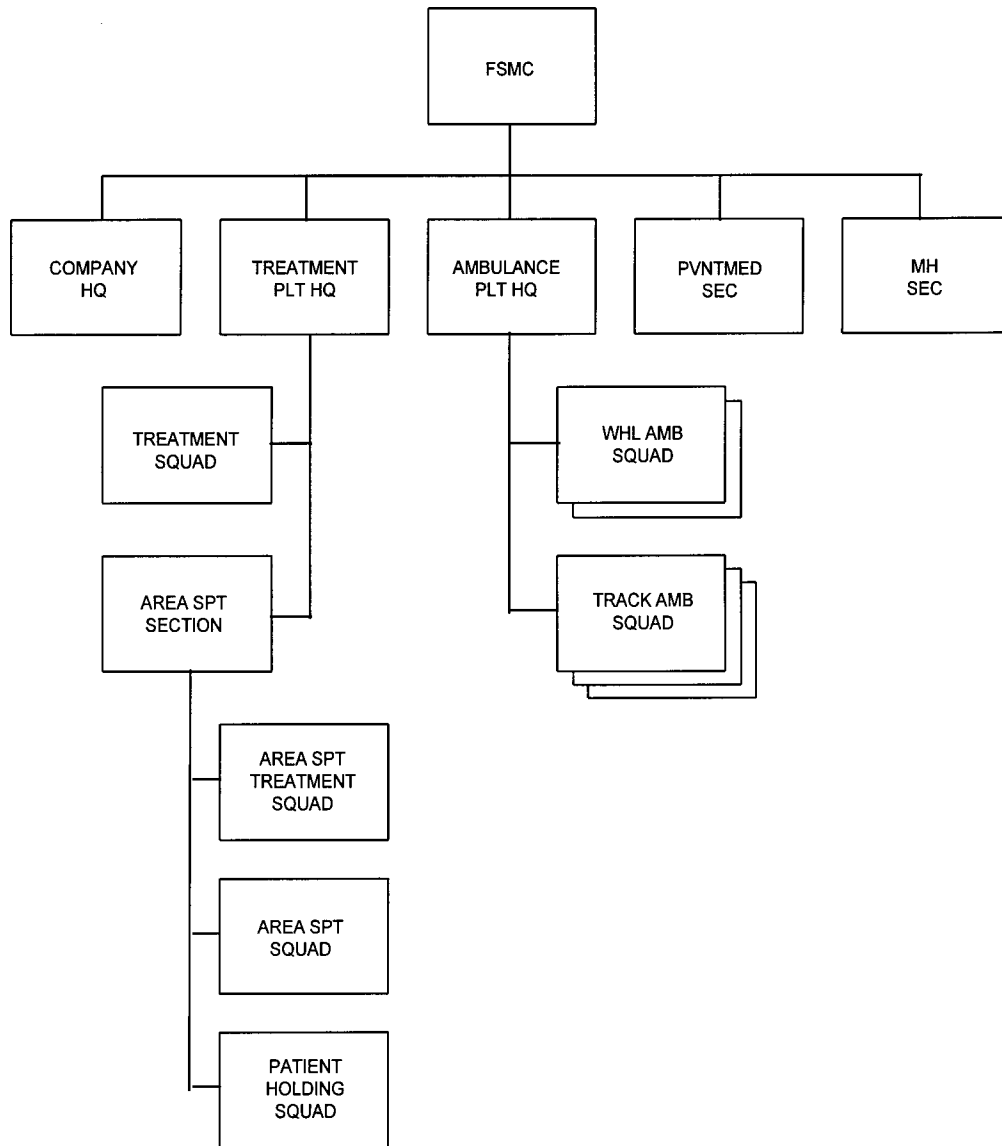


Figure 2-3. Forward support medical company.

### Section III. BRIGADE HEADQUARTERS MEDICAL ASSETS

#### 2-10. Brigade Surgeon, F-Edition TOE (Force XXI Digitized Division)

The brigade surgeon is an MC officer (Major, AOC 62B00). He is a special staff officer who plans and coordinates brigade CHS activities with the brigade staff. The brigade surgeon is assigned to the HHC of the maneuver brigade. The surgeon is responsible for the technical control of all medical activities in

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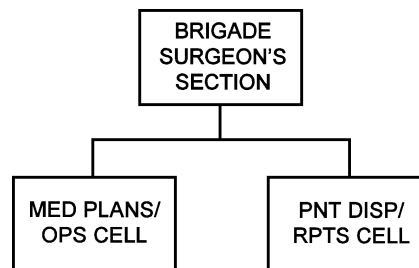
the command. The brigade surgeon oversees and coordinates CHS activities through the BSS and the brigade S3. The brigade surgeon keeps the brigade commander informed on the status of CHS for brigade operations and the health of the command. He provides input and obtains information to facilitate medical planning. His specific duties in this area include—

- Ensuring implementation of the CHS section of the brigade TSOP.
- Determining the allocation of medical resources within the brigade.
- Supervising technical training of medical personnel and the CLS program within the brigade.
- Determining procedures, techniques, and limitations in the conduct of routine medical care, emergency medical treatment (EMT), and ATM.
- Monitoring aeromedical and ground ambulance evacuation.
- Monitoring the implementation of automated medical systems.
- Informing the division surgeon on the brigade's CHS situation.
- Monitoring the health of the command and advising the commander on measures to counter disease and injury threats.
- Exercising technical supervision of subordinate battalion surgeons and PAs.
- Providing consultation and mentoring for subordinate battalion surgeons, physicians, and PAs.
- Providing the medical estimate and medical threat for inclusion in the commander's estimate.
- Monitoring the command PVNTMED program (includes health assessment and medical surveillance); see AR 40-5 and FM 4-02.17.
- Ensuring field health records are maintained by primary care providers according to AR 40-66.

### **2-11. Brigade Surgeon's Section, F-Edition TOE (Force XXI/Digitized Division)**

The BSS is assigned to the HHC of the brigade and operates out of the brigade TOC. The section, in coordination with the HSSO of the FSB support operations section and the FSMC commander, is responsible for the development of the medical portion of the brigade OPLAN/OPORD and takes part in the brigade 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 brigade commander is updated as required on the status of CHS in the brigade. Figure 2-4 shows the typical organization and staffing of the BSS. It consists of a medical plans and operations cell and a patient

disposition and reports cell. The staff of the BSS assists the brigade surgeon in planning and conducting brigade CHS operations.



*Figure 2-4. Brigade surgeon's section.*

## 2-12. Brigade Surgeons, L-Edition TOE (Army of Excellence/AirLand Battle)

The FSMC commander positions are documented 05A, AMEDD immaterial, meaning any qualified AMEDD officer can assume command. When the FSMC commander is not a physician, medical decisions and technical supervision of physicians is performed by the senior physician/treatment platoon leader. When a brigade surgeon is not assigned to the brigade headquarters, the treatment platoon leader, who is always a physician, will perform the brigade surgeon's duties. His duties and responsibilities as the brigade surgeon require that he work closely with the FSMC commander and include, but are not limited to—

- Ensuring the implementation of the CHS section of the division TSOP.
- Determining the allocation of CHS resources within the brigade.
- Supervising the technical training of medical personnel and the CLS program within the brigade.
- Developing and monitoring the MEDEVAC plan (ground and air) which supports the brigade's maneuver plan.
- Writing the CHS portion of brigade TSOP, OPLAN, and OPORD.
- Monitoring requests for aeromedical evacuation from supported units.
- Monitoring the health of the command and advising the commander on measures to counter the medical threat.
- Monitoring and advising units on their mild to moderate BF cases and determining the capability to restore BF casualties within the brigade's AO.

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- Informing the division surgeon and the DMOC of the brigade's CHS situation.
- Supervising corps medical elements within the brigade's AO when directed.
- Exercising technical control over subordinate battalion surgeons.
- Assuming technical supervision of PAs organic to subordinate units in the absence of their assigned physicians.
- Advising PAs assigned to artillery and engineer battalions, as required.

### **2-13. Armored Cavalry Regiment and Separate Brigade Surgeons (Army of Excellence)**

The duties of the regimental surgeon and the separate brigade surgeon are the same as those identified in paragraph 2-10.

### **2-14. Armored Cavalry Regiment Medical Troop**

The mission of the ACR medical troop is to provide Echelons I and II medical care within the ACR. The capabilities of this unit are to—

- Provide C2 of attached medical elements (including CHS planning; policies and procedures; support operations; and MEDEVAC coordination for movement of patients within and out of the regiment AO).
- Advise the regiment commander and support squadron commander on the health of the command and other CHS activities affecting the regiment.
- Develop, prepare, and coordinate the CHS portion of OPLAN and OPORD.
- Allocate medical resources (personnel and equipment) to all assigned and attached units of the regiment.
- Perform triage, initial resuscitation and stabilization, and preparation for further evacuation of patients generated in the regiment rear area.
- Provide ground evacuation for patients from Echelon I MTFs.
- Employ treatment squads to perform reinforcement/augmentation to maneuver squadrons' medical platoons. (These squads/teams are routinely placed OPCON to supported maneuver squadrons.

They are normally attached to the squadron medical platoon under technical control of the squadron surgeon.)

- Provide CHL and medical equipment maintenance repair parts and support to the regiment on an area support basis. (The regiment medical supply section maintains a 5-day stock of emergency *push* packages and individual medical items. Emergency supply requests are sent to the supporting MEDLOG battalion or the nearest medical unit.)
- Provide dental support (including treatment of maxillofacial injuries; operational dental care that includes emergency and essential dental treatment).
- Provide laboratory service commensurate with the regiment's Echelon II facility.
- Perform patient holding for up to 40 patients awaiting evacuation or RTD within 72 hours.
- Provide outpatient consultation services for patients referred from Echelon I MTFs.

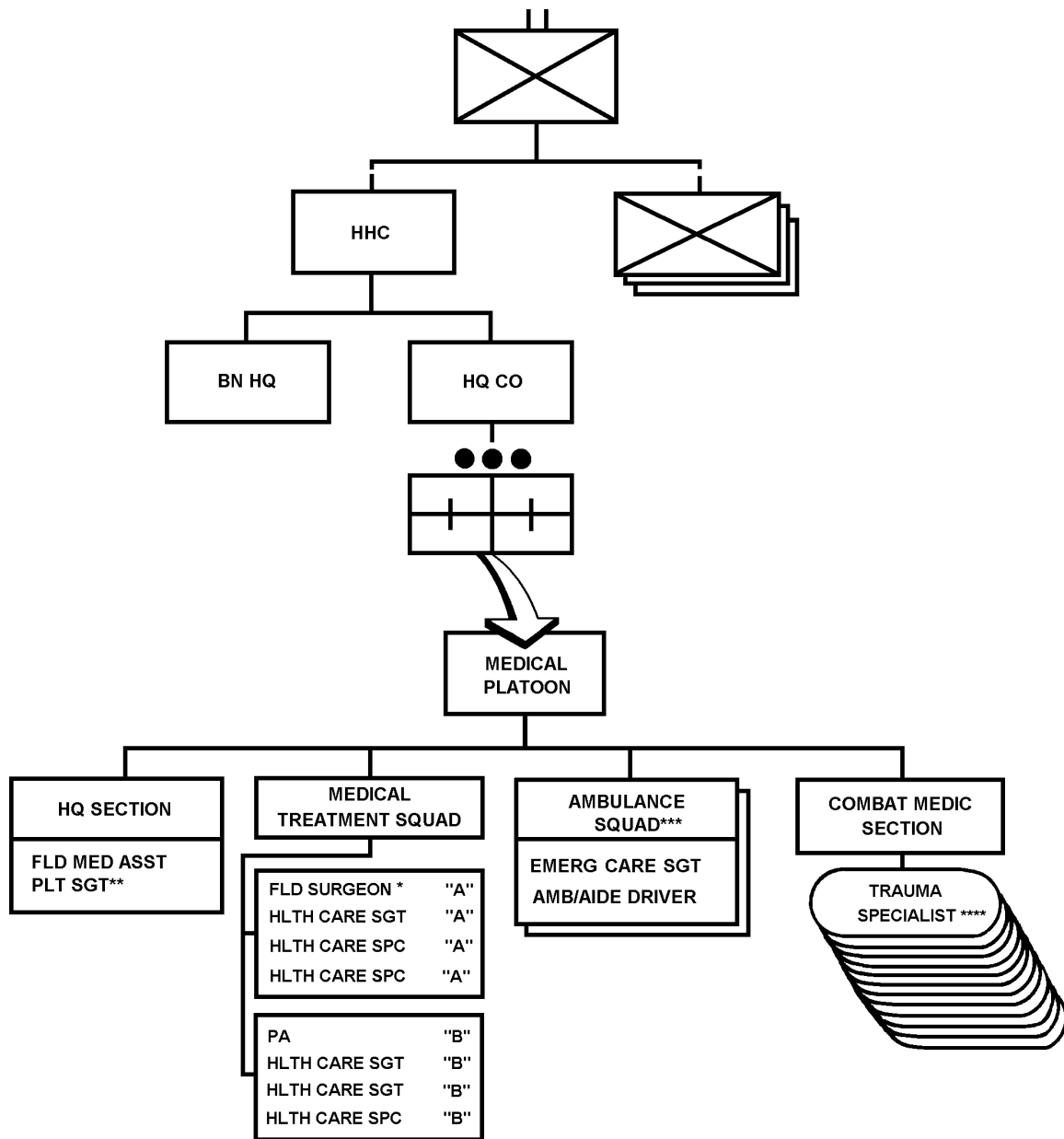
## **Section IV. MEDICAL PLATOONS (ARMY OF EXCELLENCE/AIRLAND BATTLE)**

### **2-15. Assignment**

A medical platoon is organic to each combat battalion HHC. Under the Army of Excellence TOE, the platoon is organized with a headquarters section, a treatment squad (two treatment teams), an ambulance squad, and a combat medic section. The medical platoon is organized as shown in Figures 2-5 and 2-6.

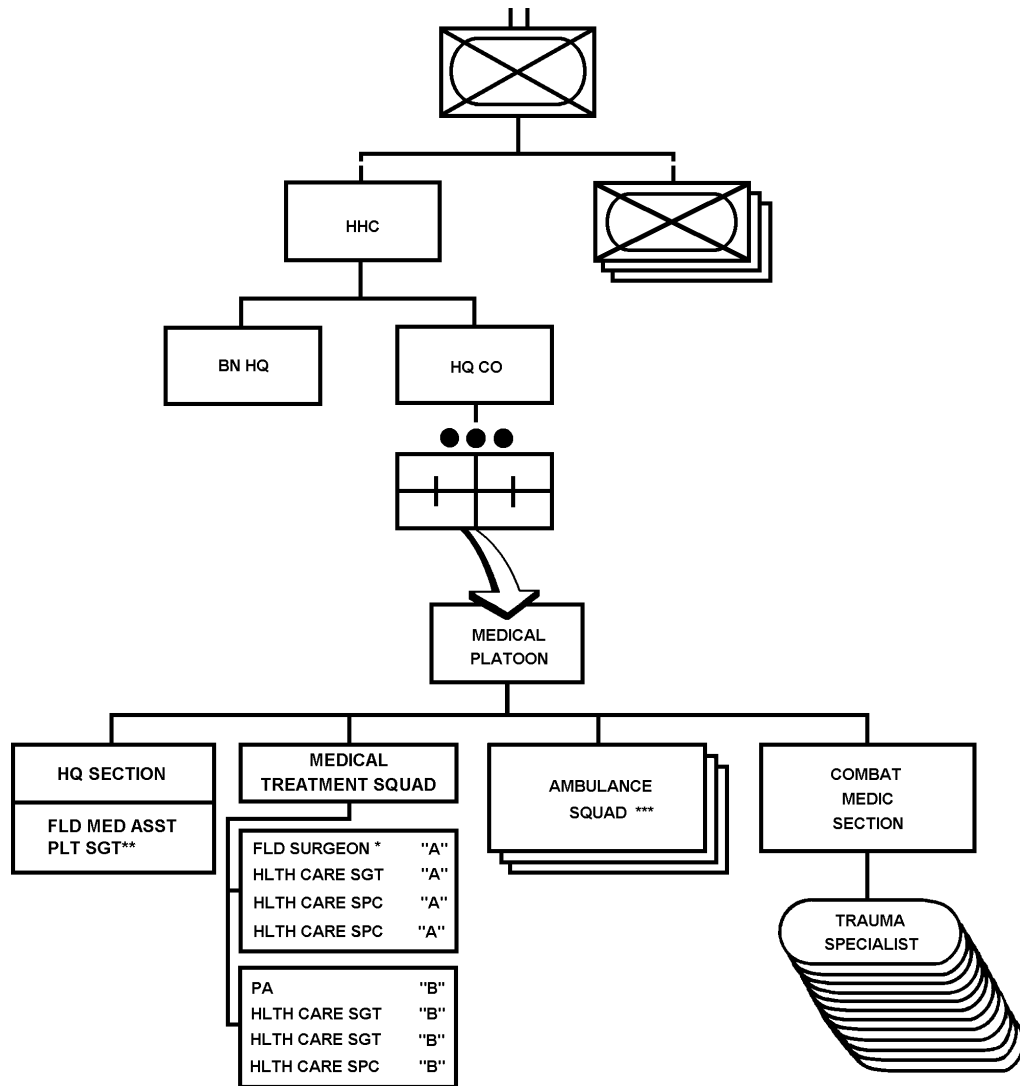
### **NOTE**

Mechanized infantry and armor units have four ambulance squads consisting of two ambulance teams each assigned to their medical platoon ambulance squads. Airborne and air assault medical platoons have 12 trauma specialists assigned to their combat medic section, while light infantry has 9 trauma specialists assigned to their combat medic sections. The armor medical platoons have 3 trauma specialists assigned to their combat medic section and the mechanized infantry medical platoons have 3 health care SGTs (91W30) and 9 trauma specialists (91W10) assigned to their combat medic section.



- \* 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 2-5. Medical platoon, headquarters and headquarters company light infantry battalion.



\* ALSO BATTALION SURGEON

\*\* ALSO SERVES AS AMBULANCE SECTION SGT

\*\*\* MECHANIZED INFANTRY BATTALIONS HAVE 3 AMBULANCE SQUADS AND ARMOR BATTALIONS HAVE 4 AMBULANCE SQUADS

"A" ALFA TREATMENT TEAM

"B" BRAVO TREATMENT TEAM

Figure 2-6. Medical platoon, mechanized infantry battalion.

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### 2-16. Battalion Surgeon/Medical Platoon Leader, L-Edition TOE

The battalion surgeon/medical platoon leader (MC, AOC 62B00) 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 Echelon I CHS 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 nonmedical personnel for patient decontamination teams.
- Training CLS.
- Supervising the battalion MH/CSC program, to include training troop leaders in the preventive aspect of stress on soldiers.
- Supporting humanitarian assistance programs when directed.
- Overseeing the common task training, continuing medical education, and clinical training of subordinate medical personnel.
- Monitoring the command PVNTMED program, to include health assessment and medical surveillance; see AR 40-5 and FM 4-02.17.
- Ensuring field health records are maintained by primary care providers according to AR 40-66.

### 2-17. Platoon Headquarters, L-Edition TOE

*a.* The headquarters section, under the direction of the battalion surgeon/medical platoon leader, provides for the C3 and resupply for the platoon. The platoon headquarters is manned by the field medical assistant and the platoon SGT. 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. 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 CHS operations (Figure 2-7). The headquarters section serves as the net control station (NCS) for the platoon.



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/medical platoon leader 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.

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 authorized stockage levels (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.

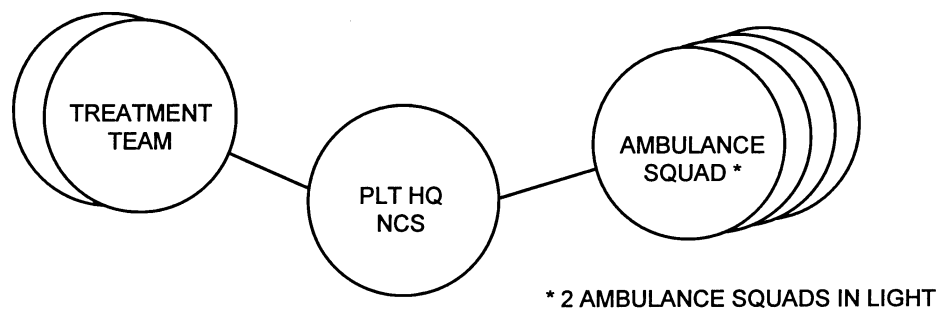


Figure 2-7. Medical platoon operations net.

d. The PA performs general technical health care and administrative duties. The PA is ATM-qualified and works under the clinical supervision of the medical officer. This officer serves as the medical platoon leader in the absence of an assigned physician. He performs the following duties:

- Establishes and operates a BAS or BAS minus (one 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, as required.
- Conducts training for battalion personnel in first aid procedures (self-aid/buddy aid), CLS, field sanitation, evacuation of the sick, injured, and wounded, and the medical aspects of injury prevention. For additional information on the CLS Program, see Appendix C.
- Assists in the conduct of the battalion preventive psychiatry program, to include training troop leaders in the preventive aspects of stress on soldiers.

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- Trains medical personnel in emergency medical procedures and, in the absence of a physician, ensures common task training, continuing medical education, and clinical training of subordinate medical personnel.

### 2-18. Treatment Squad, L-Edition TOE

The treatment squad is the basic medical treatment element of the BAS. It provides routine sick call services, emergency medical care, triage, and ATM. This squad is staffed with an operational medicine officer (primary care physician/battalion surgeon), a PA, two health care SGTs, and four health care specialists. The squad's physician and PA are trained in ATM procedures.

### 2-19. Battalion Aid Station/Treatment Squad Operations, L-Edition TOE

Battalion aid station is the generic term used in designating the unit-level/Echelon I MTF.

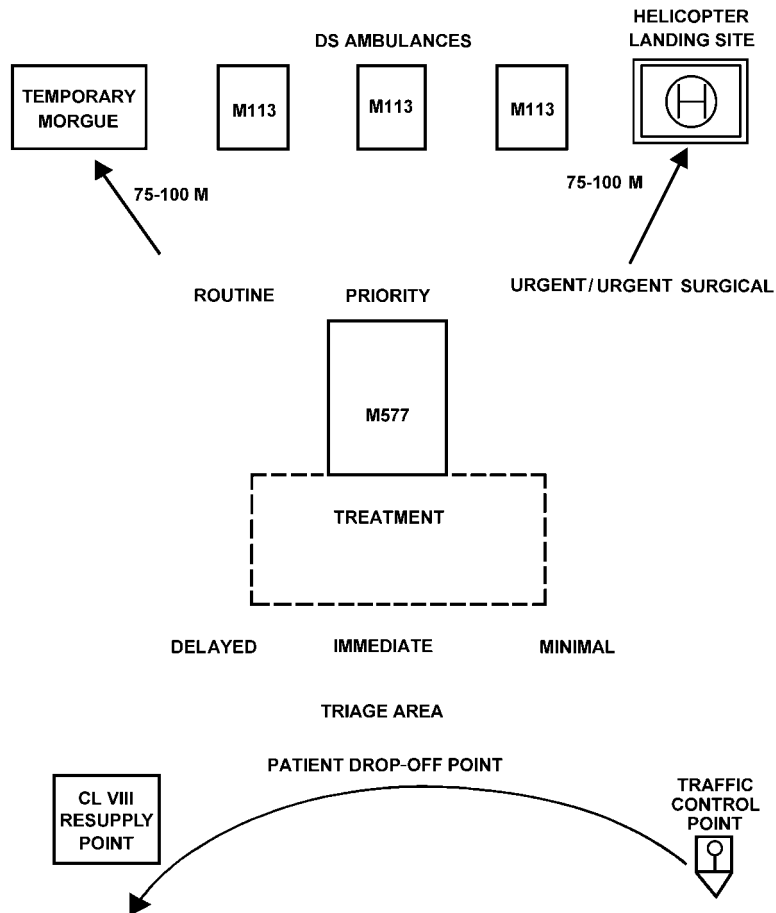
*a.* The treatment squad can split into two treatment teams and operate as two separate aid stations (BAS minus), normally not to exceed 24 hours. In continuous operations, when operating for longer periods, personnel efficiency and unit capability will tend to deteriorate. Each team employs treatment vehicle(s) with two medical equipment sets (MES)—one trauma field MES, and one sick call field MES.

*b.* For communications, each treatment team uses an 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 2-8 and 2-9 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 forces. Coordination ensures that CSS elements are not placed in the way of friendly maneuvering forces, in line of fires, or in areas subject to be overrun by rapidly advancing enemy forces. Treatment teams situated close to (within 1,000 meters of) maneuvering companies in contact must be prepared to withdraw to preplanned, alternate positions on short notice.

*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 OPCON of the battalion surgeon/medical platoon leader. A suggested scheme of employment is to place a team in close support of each maneuvering company while locating one treatment team in the combat trains. Medical treatment facilities should not be placed near targets of opportunity such as ammunition, petroleum, oils and lubricants (POL), distribution points, or other targets that may be considered lucrative by the opposing force. Considerations for the location of the BAS should include—

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



NOTE: A PATIENT DECONTAMINATION SITE MUST BE IDENTIFIED. SEE FM 8-10-7.

Figure 2-8. Layout of a battalion aid station (heavy).

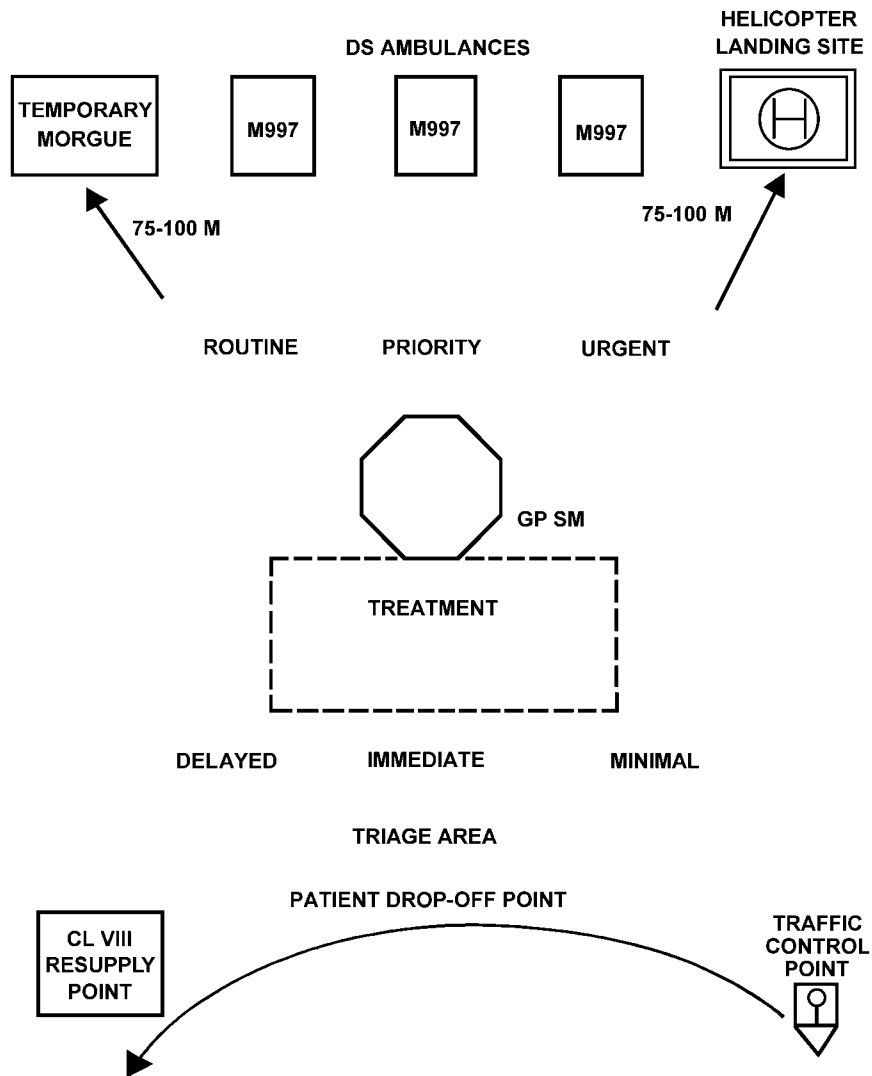


Figure 2-9. Layout of a battalion aid station (light).

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

*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 (FMC) (Department of Defense [DD] Form 1380), as required. See FM 8-10-6 for information on completion and disposition of the form.
- Verifying information contained on the FMC of each patient evacuated to the BAS.
- Requesting and monitoring MEDEVAC of patients.
- Monitoring personnel, when necessary, for NBC contamination prior to medical treatment.
- Supervising patient decontamination and treating NBC patients (refer to FMs 8-10-7, 4-02.283, 8-284, and 8-285).

#### NOTE

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

*f.* Medical evacuation from the BAS is performed by ground ambulances from the FSMC 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 standing operating procedures (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 when evacuated to the next echelon of care, as long as they are in the combat zone. Based on the threat, they may retain the protective mask until evacuated out of the theater.

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

*j.* Patients requiring optometry 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, MSMC, located in the DSA.

**2-20. Combat Medic Section, L-Edition TOE**

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. Functions of trauma specialists are as follows:

- Performs triage and EMT for the sick and wounded.
- Arranges MEDEVAC for litter patients and directs ambulatory patients to CCP or to the BAS.
- Initiates a FMC for the sick and wounded and, as time permits, prepares a FMC on deceased personnel.
- Screens, evaluates, and treats, within his capabilities, those patients suffering minor illnesses and injuries.
- Keeps the company commander and the battalion surgeon/medical platoon leader informed on matters pertaining to the health and welfare of the troops.
- Manages Class VIII resupply for the unit's CLS.
- 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).

**2-21. Ambulance Squads, L-Edition TOE**

*a.* Medical platoon ambulance squads provide evacuation within the battalion. Ambulance teams provide medical evacuation and en route care from the soldier's point of injury or a CCP to the BAS. In mass casualty situations, nonmedical vehicles may be used to assist in casualty evacuation (CASEVAC) as directed by the commander. Plans for the use of nonmedical vehicles to perform CASEVAC should be included in the battalion's TSOP.

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

(1) The emergency care SGT—

patients.

- Performs triage and EMT procedures in the care and management of trauma

- Assists in the care and management of BF patients.

- Prepares patient for movement.

- Provides patient care en route.

- Maintains contact with supported units.

- Collects casualties.

- Performs NBC detection procedures.

(2) The ambulance/aide driver is trained in EMT procedures. He operates and maintains the ambulance and all onboard equipment. He assists the aide/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.

- Direct or guide ambulatory patients to the BAS.

- Perform triage when necessary.

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- Provide Class VIII resupply to trauma specialists.
- Serve as messengers within medical channels.
- Maintain operational readiness of assigned vehicle.

*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 HMMWV ambulances. The mechanized infantry and the armored battalions ambulance sections have four ambulance squads equipped with M-113 tracked ambulances.

### 2-22. Employment and Functions of the Ambulance Team, L-Edition TOE

*a.* The ambulance team is a mobile trauma specialist team. Its function is to collect, treat, and evacuate the sick and wounded to the nearest treatment station or ambulance exchange point (AXP). For communications, the ambulance team employs an FM tactical radio mounted on its assigned ambulance. The team uses the medical platoon's internal operations net; however, in certain circumstances it may operate in the battalion administration/logistics net or as established by the battalion signal operating instructions (SOI).

*b.* In the heavy maneuver battalions, the track ambulance team routinely deploys with the maneuver company trains; however, it operates as far forward as the tactical situation permits and evacuates patients from the point of injury, if possible. In the light maneuver battalion, the wheeled ambulance team is either dispatched from the BAS, pre-positioned as close to the supported units as the tactical situation permits, or positioned with the maneuver company trains. Ambulance teams operating in a company's AO are normally under the tactical control of the company XO or 1SG, but remain under the technical and OPCON of the medical platoon. An ambulance team from the BAS will habitually support the same 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 backup 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 company trains area), find, treat, and move patients to safety, and later evacuate them to the BAS. When moving patients to the ambulance location, CCP, or company aid post, the team is normally assisted by nonmedical personnel.

### 2-23. Medical Evacuation, L-Edition TOE

*a.* Optimum patient care and treatment is dependent upon an evacuation system that provides a continuous movement of patients. Medical evacuation is the process of moving patients from the point of injury or illness to an MTF, while providing en route medical care, 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 echelon of CHS to which the patient is to be evacuated (see Figure 2-10). Ambulances go forward, pick up patients, and move them to the supporting MTFs.

- (1) Ambulance teams of the medical platoon evacuate patients from the company aid post or CCP to the BAS.
- (2) Ambulance squads of the FSMC evacuate patients from the BAS to the division clearing station.

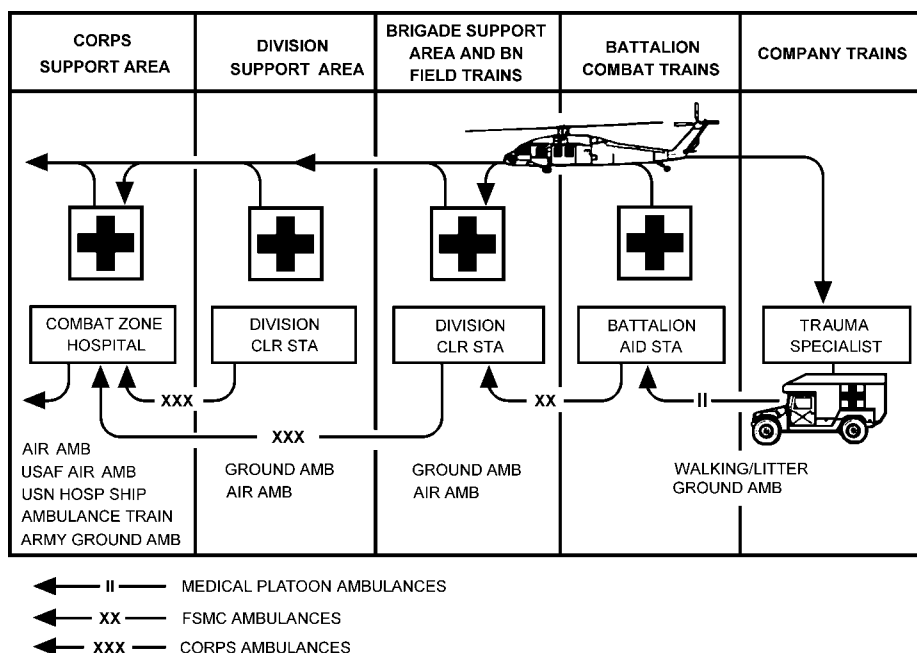


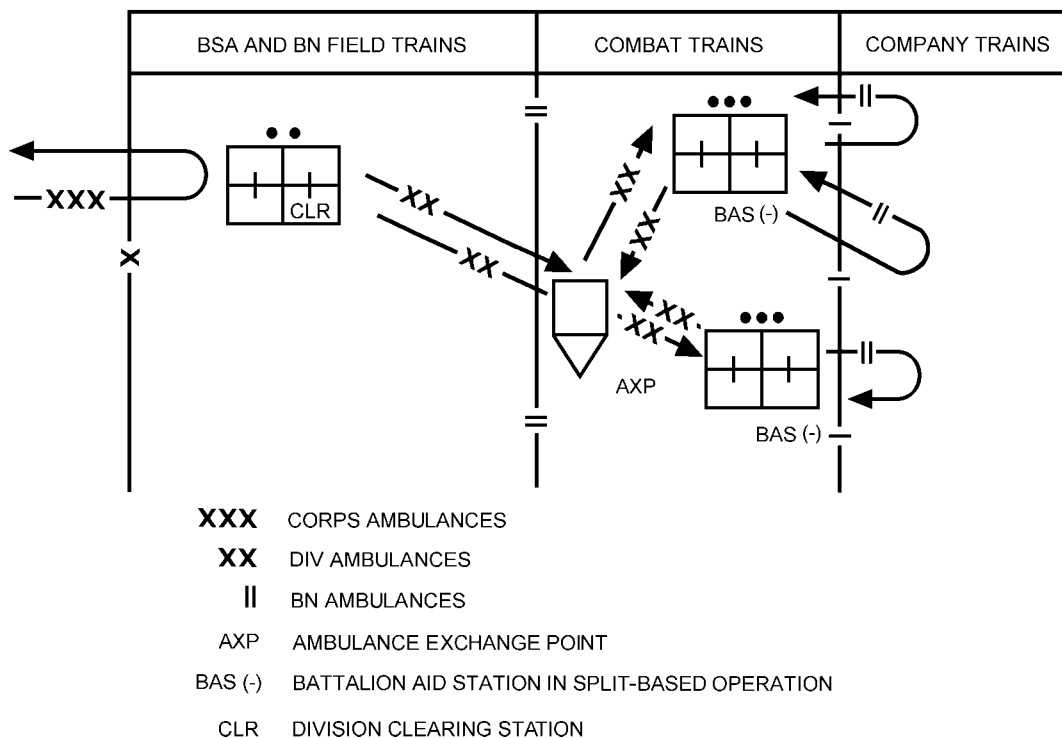
Figure 2-10. Patient evacuation flow.

b. An ambulance shuttle system may be set up between the FSMC division clearing station and the BAS. An AXP is established (Figure 2-11) 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.

c. Aeromedical evacuation in the combat zone should be used to the maximum extent possible for critically ill or wounded patients. See FMs 8-10-6 and 8-10-26 for additional information on aeromedical evacuation. Refer to FM 8-10-6 for MEDEVAC request procedures. Normally, ground ambulances are used to evacuate the minimally ill or wounded and those patients who cannot be evacuated by air. The specific mode of evacuation is determined by the patient's condition, aircraft/vehicle availability, the

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tactical situation, and weather conditions (METT-TC 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 trauma specialist 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.



*Figure 2-11. Ground ambulance shuttle system.*

**2-24. Evacuation and Disposition of Remains**

*a.* The transportation and disposition of remains is a Quartermaster function. Air and ground ambulance personnel do not clear the battlefield of remains nor do they carry remains in their dedicated medical vehicles or aircraft. Medical units do not accept remains or provide temporary morgues in which to hold remains for other units. Other units are responsible for evacuation of remains to mortuary affairs collection points.

*b.* The only remains that medical units/elements handle are those of its own unit members or of patients who are dead on arrival (DOA) or who died of wounds (DOW) while in their care. Whenever a

medical unit/element establishes a temporary morgue, it should be out of sight of the triage and treatment areas. The temporary morgue/holding area can be established behind a natural barrier, such as a stand of trees or it can be shielded from the view of others by using either tents or tarpaulins.

**2-25. Class VIII Resupply, L-Edition TOE**

a. 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 and they include—

- Chemical Agent Patient Decontamination, National Stock Number (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.

Normal medical resupply of the platoon is performed by the DMSO through LOGPACs, backhaul, or in coordination with the movement control office(r) (MCO). Medical resupply may also be by preconfigured Class VIII packages (push packages) throughput from the MEDLOG battalion located in the corps support area (Figure 2-12).

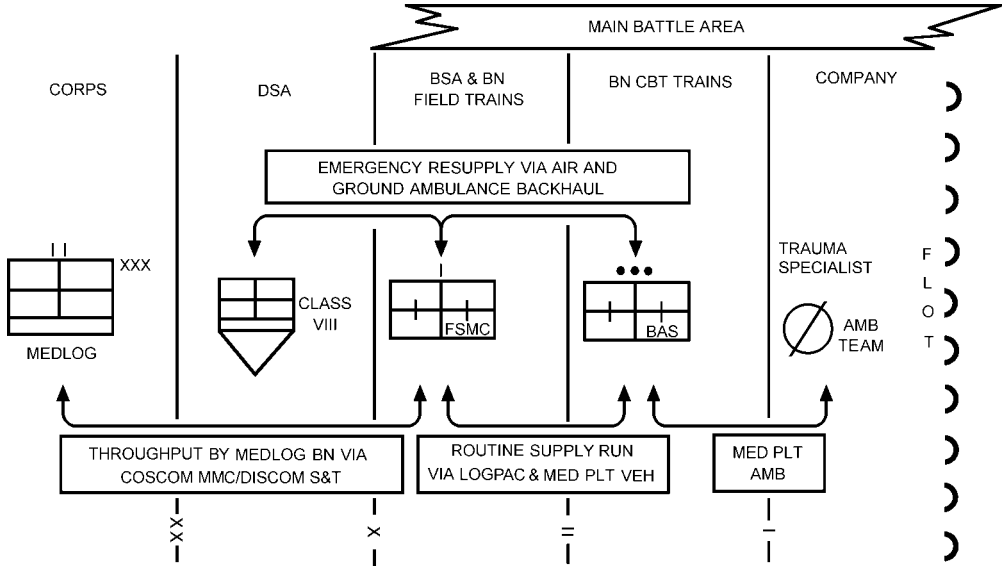


Figure 2-12. Flow of Class VIII supplies.

*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 BAS. Class VIII resupply of trauma specialists are performed by ambulances of the medical platoon. The trauma specialist can also be resupplied from the ambulance crew from supplies onboard the ambulance.

## **Section V. MEDICAL PLATOONS, FORCE XXI/DIGITIZED DIVISION**

### **2-26. Medical Platoon Assignment, F-Edition TOE**

The medical platoon is organic to all maneuver battalions. In the armored battalions and mechanized infantry battalions, the platoon is organized with a headquarters section, a treatment section, ambulance squads, and a combat medic section.

#### **NOTE**

1. One 91W10 per armor company and one 91W30 and three 91W10s per mechanized infantry company.
2. One ambulance team per maneuver company supported.

The medical platoon receives Echelon II CHS from the supporting FSMC.

### **2-27. Platoon Headquarters, F-Edition TOE**

The headquarters section, under the direction of the platoon leader, provides the C3 and logistics for the platoon. The platoon headquarters is manned by the field medical assistant and the platoon SGT. It is normally collocated with a treatment team/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 HHC and the maneuver battalion wire communication network for communications with all major elements of supported and 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 CHS operations, to include telemedicine and teleconsultation procedures. The headquarters section serves as the NCS for the platoon. Each of the medical platoon vehicles have CSS functions for the FBCB2 system. The FBCB2 is a hardware/software suite that digitizes C2 at brigade level and below. The FBCB2 concept provides a seamless battle command capability for performance of missions throughout the operational continuum at

the tactical level. The FBCB2 is the implementation of information age technology to provide increased battlefield operational capabilities. The system, positioned on the ambulance and treatment vehicles, will perform combat, CS, and CSS functions for the planning and execution of operations. The FBCB2 represents a major paradigm shift for the CSS and CHS communities. For the first time, the CSS organizations are digitally linked to the platforms and organizations that they support and the CHS elements are digitally linked to brigade and FSB medical elements. The FBCB2 provides a common operations picture enabling CHS and CSS providers to maintain the operational tempo set by maneuver commanders and to have near-time situational understanding of what is taking place on the battlefield.

## **2-28. Battalion Surgeon/Medical Platoon Leader, F-Edition TOE**

The battalion surgeon/medical platoon leader (MC, AOC 62B) is a working physician on Treatment Team “Alpha.” He is the medical advisor to the supported battalion 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—

- Planning and directing CHS for the supported maneuver battalion.
- Advising the supported maneuver 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 assigned or attached personnel.
- Examining, diagnosing, and treating (or prescribing courses of treatment) for patients, to include telementoring (TMEN) and ATM.
- Training CLS.
- Supervising the battalion 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.
- Coordinating the medical evacuation of patients, as required.

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 forward support company (FSC) support operations, the supported TF S1 and S4, and MEDEVAC with the FSMC. The platoon SGT assists in supervising the operations of the platoon. He also serves as the ambulance section SGT. Physician assistants are assigned to the Bravo and Charlie treatment teams. The PA (AOC 65D) performs general technical health care and administrative duties. He is ATM-qualified and works under the clinical supervision of the medical officer. The PA performs the following duties:

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

### 2-29. Treatment Section, F-Edition TOE

The three treatment teams (Teams Alpha, Bravo, and Charlie) are the basic medical treatment elements of the BAS. They provide Echelon I medical care and treatment. This includes sick call, EMT, ATM, and triage for the management of mass casualty situations. Each treatment team is staffed with a primary care physician or a PA, one health care SGT (E-5 or E-6) and two health care specialists (E-4 or E-3). The physician, PA, and health care personnel are all trained in ATM procedures, commensurate with their positions and skill levels.

### 2-30. Combat Medic Section, F-Edition TOE

Trauma specialists are allocated to mechanized infantry companies on the basis of one trauma specialist per platoon and a senior health care SGT for each company. In armored units, the allocation is one health care SGT and, normally, one ambulance team per company.

*a. Trauma Specialist Location.* The mechanized infantry platoon trauma specialist 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. This formation is the platoon's primary movement formation. When the platoon is mounted, the trauma specialist will normally ride in the same vehicle as the platoon SGT.

*b. Health Care Sergeant.* The company health care SGT or specialist with the armor company 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 provide medical treatment and prepare patients for MEDEVAC. The ambulance team supporting the company works in coordination with

the trauma specialists supporting the platoons. When a casualty occurs in a tank or an armored fighting vehicle, the ambulance 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. They move the patient to the treatment team or to a CCP to await further MEDEVAC. The company health care SGT normally remains with the company CP, but may be used anywhere in the company, assisting the ambulance teams in some situations.

### 2-31. Ambulance Squads, F-Edition TOE

There are three ambulance squads assigned to the medical platoon. Each squad has two ambulance teams. Armored ambulance teams have three emergency care personnel while wheeled ambulances have two emergency care personnel. The platoon ambulances provide medical evacuation within the supported maneuver battalion/TF. 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 CASEVAC as directed by the supported commander. Plans for the use of nonmedical vehicles to perform CASEVAC should be included in the maneuver battalion's TSOP and OPORD.

### 2-32. Property Exchange

*a. United States Army Medical Evacuation Operations.* Whenever a patient is evacuated from one MTF to another or is transferred from one ambulance to another, medical items of equipment (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 Army element exchanges like property with the transferring element. This reciprocal procedure will be practiced to the fullest extent possible through all phases of evacuation from the most forward element through the most rearward hospital.

**This subparagraph implements STANAG 2128 and QSTAGs 435 and 436.**

*b. Medical Property of Allied Nations (NATO and ABCA Armies).* Medical property accompanying patients of allied nations will be returned at once, if possible. If it is not possible, like items will be exchanged as in paragraph *a* above.

*c. Medical Property of Coalition Forces or Allied Nations Without Ratified Standardization Agreements.* Absence of a formal agreement, such as an Acquisition and Cross-Servicing Agreement, medical property accompanying patients of coalition and allied forces without ratified STANAGs will be returned to the parent nation as soon as practicable. Commanders should consult with their Staff Judge Advocate early in the planning process to ensure appropriate policy and procedures are developed and disseminated.

## **Section VI. TREATMENT TEAMS, MEDICAL SECTIONS, AND SPECIAL PURPOSE MEDICAL PLATOONS (ARMY OF EXCELLENCE/ AIRLAND BATTLE)**

### **2-33. Combat Support Unit and Division Headquarters Treatment Team, L-Edition TOE**

Treatment teams are organic to CS units and the division headquarters. With the exception of the combat engineer battalion, a medical support element in the light division normally consists of one treatment team. This treatment team is designed to provide Echelon I CHS for personnel of supported units. A treatment team normally with two ambulance teams is relatively small in comparison to a medical platoon; therefore, it will require augmentation from a supporting medical company in mass casualty situations.

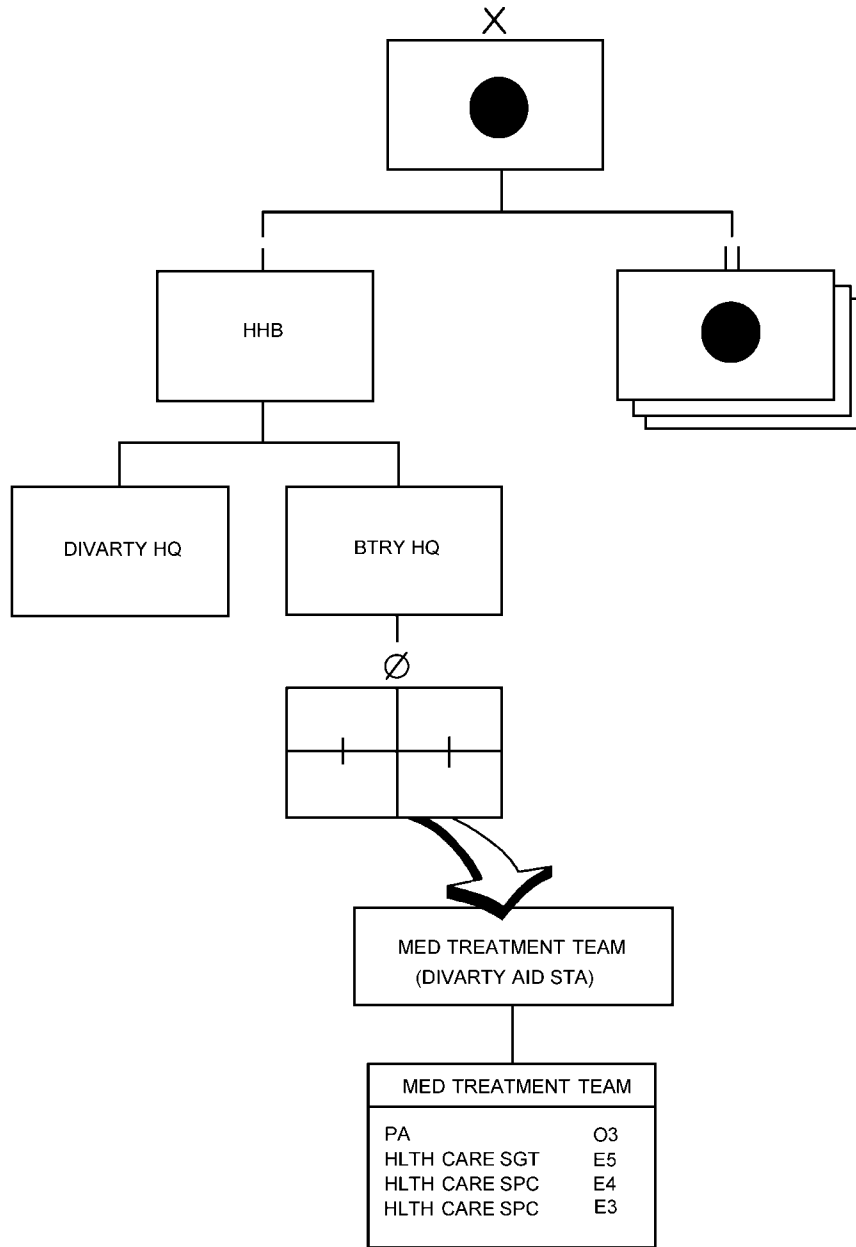
### **2-34. Medical Section, Headquarters and Headquarters Battery, Division Artillery, L-Edition TOE**

*a. Organizations and Functions.* The DIVARTY medical element includes a treatment team and an ambulance team. It is organized as shown in Figure 2-13. Personnel staffing of this section includes a PA, health care SGT, two health care specialists and an ambulance team.

(1) *Division artillery physician assistant.* The PA is the medical advisor to the DIVARTY commander and his staff. The PA works under the supervision of a physician, normally the division surgeon or treatment platoon leader of the MSMC. He coordinates with the division and brigade surgeons to ensure that all PAs/medical element leaders in the subordinate FA battalions, are working under the clinical supervision of a physician. 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 PA is responsible to the supervising physician for the 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 Echelon I CHS for members of the DIVARTY headquarters and FA battalions.
- Arranging for Echelon II CHS.
- Arranging for patient evacuation to the supporting medical company.
- Supervising the administration and maintenance of equipment, the supply function, technical training, and the employment of medical personnel.
- Examining, diagnosing, and treating (or prescribing courses of treatment for) patients, to include ATM for the trauma patient under the clinical supervision of a physician.
- Coordinating patient evacuation.





NOTE: THE LIGHT INFANTRY AND AIRBORNE DIVISION ARTILLERY DO NOT HAVE AN AMBULANCE TEAM.

Figure 2-13. Medical section, headquarters and headquarters battery, division artillery.

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(2) *Health care sergeant.* The health care SGT assists the PA in accomplishing his duties; he supervises personnel on the treatment and ambulance teams. He prepares reports, requests general and medical supplies, maintains supply economy procedures, and maintains the ASL of expendable supplies. This NCO also performs triage and assists with ATM procedures in the care of trauma and NBC-insulted patients, and care and management of BF patients. He also performs routine patient care and NBC detection procedures. His duties also include—

- Establishing and assisting with operating the DIVARTY aid station.
- Maintaining the patient accountability/casualty reporting system.
- Maintaining MES.
- 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.
- Maintaining field health records of all patients seen according to AR 40-66.

(3) *Health care specialists.* These specialists assist the health care SGT 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 an aid station near the DIVARTY headquarters and provides Echelon I CHS for members of the DIVARTY headquarters and headquarters battery (HHB).

(1) The section employs a treatment HMMWV, a cargo trailer, and two MESs (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 Echelon II CHS.

*c. Operations.* The preceding paragraphs describe BAS operations; these are equally applicable to the DIVARTY BAS. Figures 2-8 and 2-9 show suggested layouts of a BAS.

*d. Medical Evacuation.* The DIVARTY HHB, depending on the type, may have one ambulance team to provide medical evacuation support. Those units assigned to the DIVARTY without an ambulance team are dependent on the supporting medical company. Evacuation of patients to and from the DIVARTY aid station is provided by the MSMC in the DSA.

*e. Class VIII Supplies.* The medical section maintains a 2-day (48-hour) stock level of Class VIII supplies for the HHB. Routine requests for medical supplies are submitted through command channels to the DMSO that is assigned to the MSMC. Class VIII 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 2-25.

*f. Property Exchange.* See paragraph 2-32.

## **2-35. Treatment Team, Headquarters and Headquarters Battery, Field Artillery Battalion, L-Edition TOE**

Organic to the HHB of the FA battalion is a treatment team, an ambulance team, and a combat medic section. The treatment team operates the BAS and the ambulance team provides limited ground ambulance medical evacuation support for the battalion. Trauma specialist from the combat medic section, are deployed with each firing platoon and with the service battery. Medical elements of the HHB, FA battalion are organized as shown in Figure 2-14. Personnel staffing for the treatment team include a PA, a health care SGT, two health care specialists, MOS 91W20, and one health care specialist, MOS 91W10.

*a. Physician Assistant.* In the absence of a physician, the PA is the principal advisor to the battalion commander and his staff in the areas of health and medical readiness. Working under the clinical supervision of a physician, he is the primary medical care provider for the battalion and supervises all activities of battalion medical personnel. The PA is trained in ATM procedures and as stated, 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 Echelon I CHS and coordinating with the supporting medical company for Echelon II CHS 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 CLSs in emergency medical procedures.

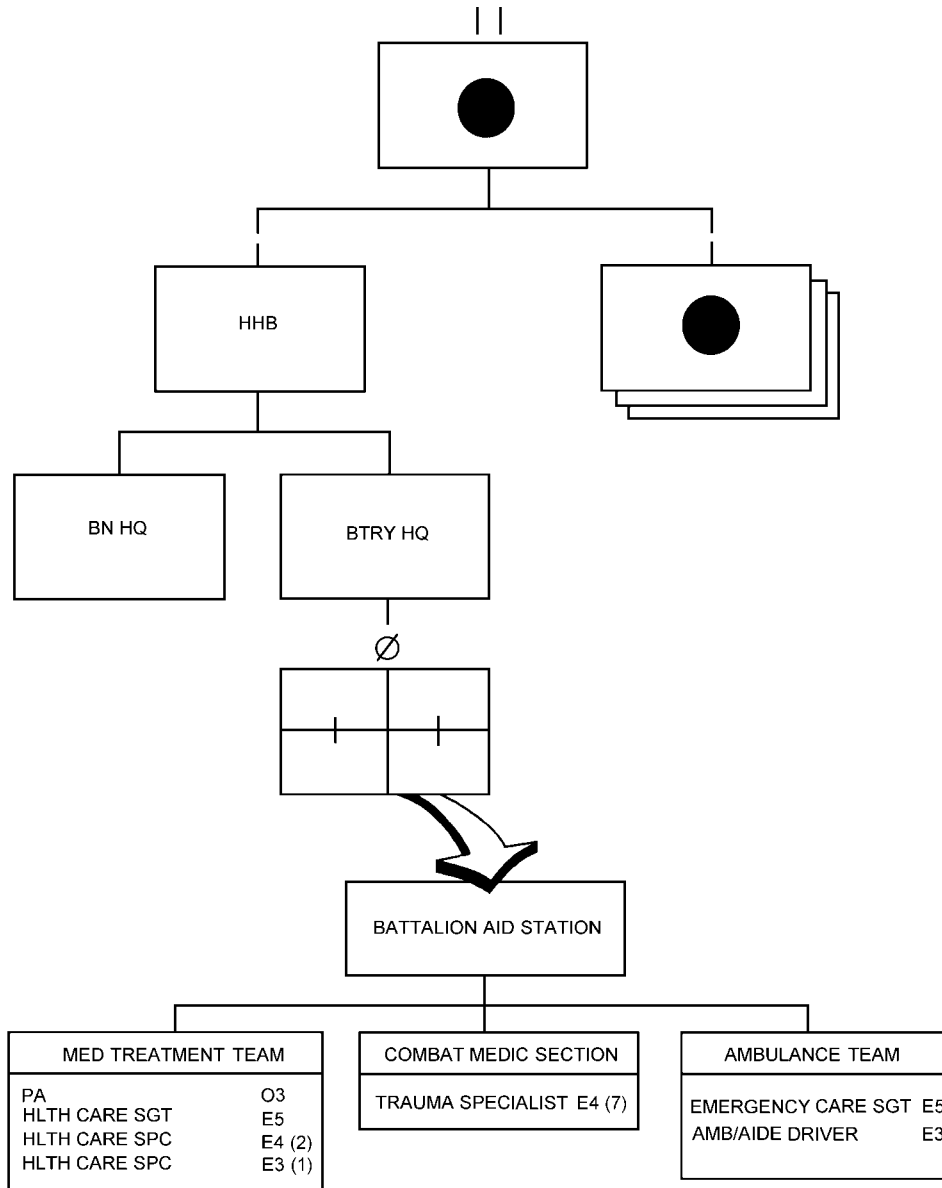


Figure 2-14. Medical elements, headquarters and headquarters battery, field artillery battalion.

*b. Health Care Sergeant.* This NCO assists the PA in accomplishing his duties. The specific duties of this NCO are the same as those described for the health care SGT in the DIVARTY HHB (refer to paragraph 2-34a[2]).

*c. Health Care Specialists.* The duties and functions of these specialists are the same as those discussed in paragraph 2-34a(3).

*d. Trauma Specialists.* Trauma specialists are allocated to a DS FA battalion on the basis of one to each firing platoon and the service battery. The duties and functions of trauma specialists are described in paragraph 2-20.

*e. Employment.* The treatment team establishes a BAS near the battalion headquarters and provides Echelon I CHS.

(1) The section employs a treatment HMMWV, a cargo trailer, and two MESs (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 battalion SOI. This section also has access to the supporting medical company's tactical operations net to request Echelon II CHS.

*f. Operations.* Paragraphs 2-19 describes a BAS operation; these are equally applicable to the FA BAS. Figures 2-8 and 2-9 show suggested layouts of a BAS.

*g. Medical Evacuation.* The HHB ambulance team evacuates patients to the BAS and to the supporting medical company if Echelon II ground ambulance support is not available.

*h. Property Exchange.* See paragraph 2-32.

## **2-36. Medical Treatment Team, Headquarters and Headquarters Company, Division Aviation Brigade/Combat Aviation Squadron, L-Edition TOE**

*a. Organization and Functions.* The division aviation brigade/combat aviation squadron medical treatment team is organized as shown in Figure 2-15. Personnel staffing for this section include a flight surgeon, a health care SGT, and two health care specialists. The flight surgeon (brigade surgeon) is the medical advisor to the aviation brigade commander and his staff. He is the primary care physician of the brigade. The flight surgeon is responsible for treatment provided by the medical treatment team (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.

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- Planning and directing Echelon I CHS for members of the brigade headquarters.
- Coordinating for evacuation of patients to the division clearing station.
- Coordinating for division CHS augmentation, as required..
- 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.

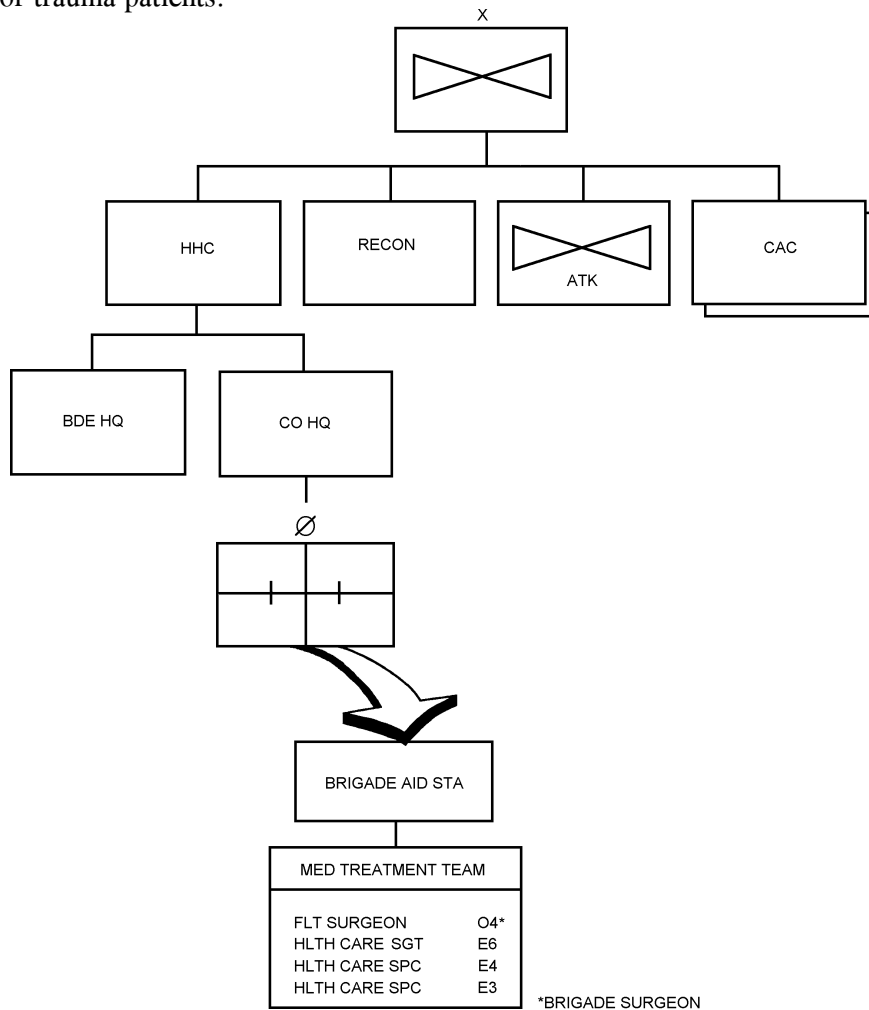


Figure 2-15. Medical treatment team, headquarters and headquarters company, division aviation brigade.

*b. Operations.* Paragraph 2-19 describes aid station operations; these are equally applicable to the DIVARTY BAS. Figures 2-8 and 2-9 show suggested layouts of a BAS.

*c. Medical Evacuation.* The brigade HHC medical section has no MEDEVAC assets. Evacuation of patients is provided by the supporting medical company.

*d. Class VIII Resupply.* See paragraph 2-25.

*e. Property Exchange.* See paragraph 2-32.

**2-37. Medical Section, Headquarters and Headquarters Company, Attack Helicopter Battalion, Division Aviation Brigade, L-Edition TOE**

*a. Organization and Functions.* The attack helicopter battalion medical section is organized as shown in Figure 2-16. Personnel staffing this section include a flight surgeon, a health care SGT, and two health care specialists. For further explanation, see paragraph 2-36a.

*b. Property Exchange.* See paragraph 2-32.

**2-38. Medical Platoon, Headquarters and Headquarters Troop, Reconnaissance Squadron, Division Aviation Brigade, L-Edition TOE**

*a. Organization and Functions.* The headquarters and headquarters troop (HHT) RECON squadron, division aviation brigade medical section is organized as shown in Figure 2-17. The medical section has a medical treatment squad, an ambulance squad, and a combat medic element.

(1) The patient treatment squad includes a flight surgeon (AOC 61N00), a PA, a section SGT/health care SGT (MOS 91W30), two health care SGTs (MOS 91W20), and three health care specialists (MOS 91W10).

(a) For flight surgeon responsibilities, see paragraph 2-36.

(b) The PA 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.

- Performing general technical health care and administrative duties (refer to paragraph 2-17d).

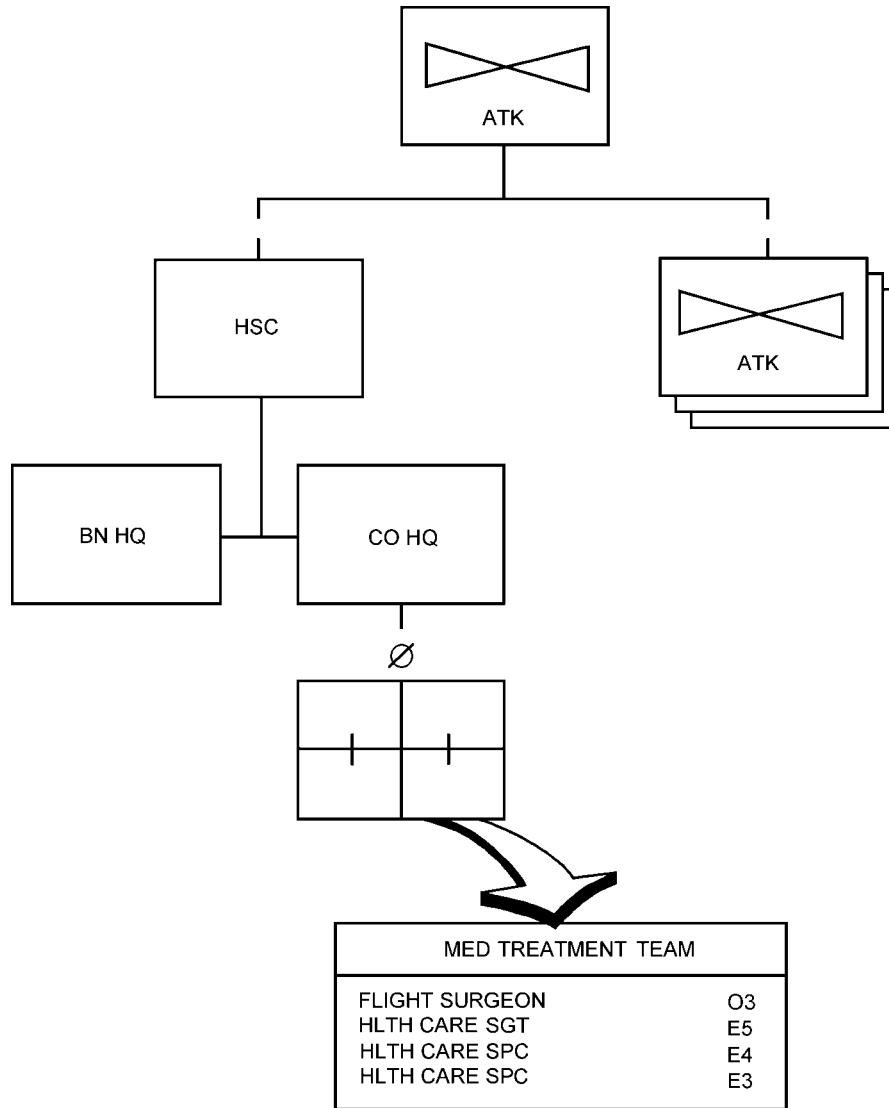


Figure 2-16. Medical section, headquarters and headquarters company, attack helicopter battalion.



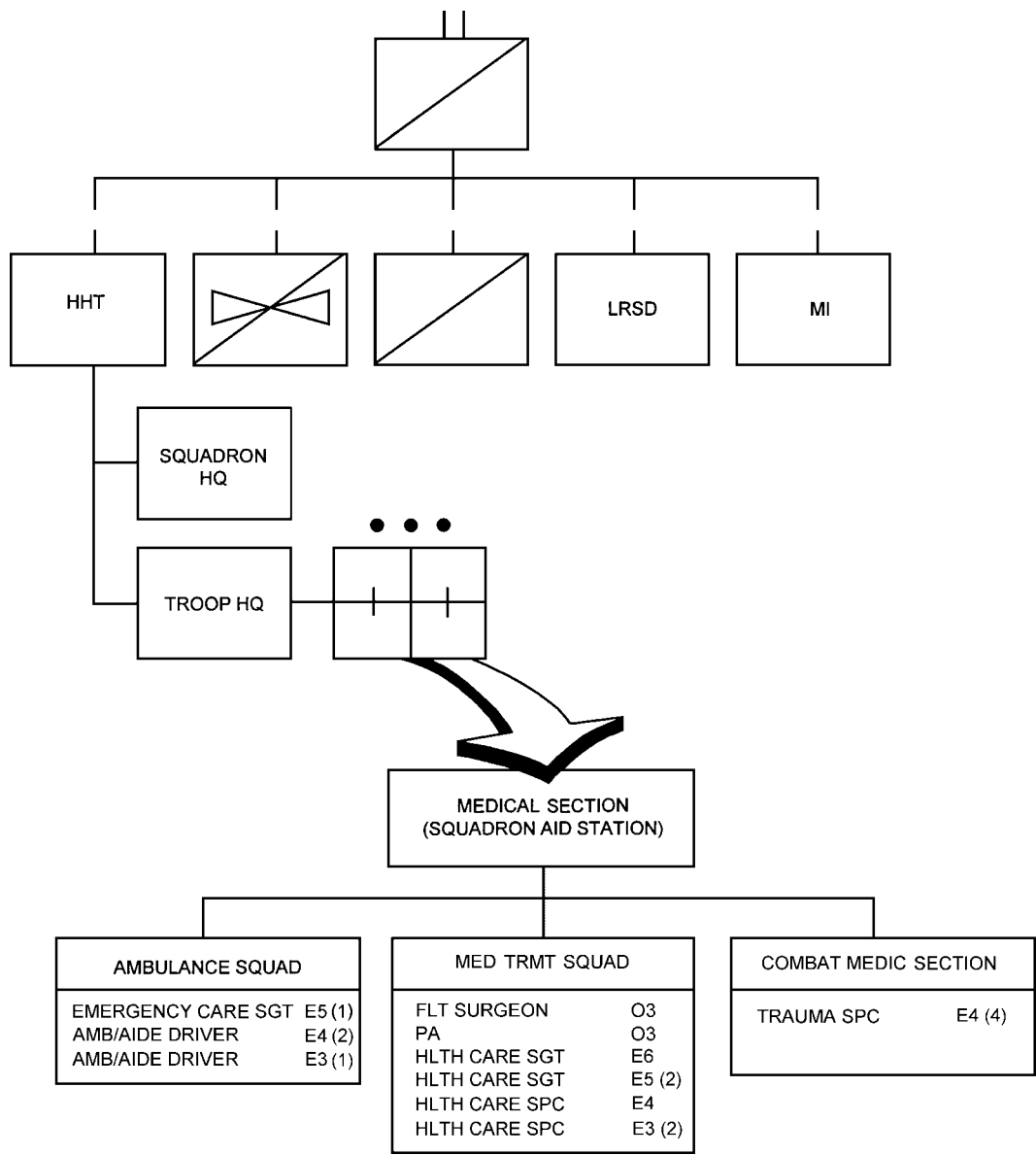


Figure 2-17. Medical platoon, headquarters and headquarters troop reconnaissance squadron.

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(2) The ambulance squad has one emergency care SGT (MOS 91W20) and three ambulance/aide drivers (MOS 91W10).

(3) The combat medic element has one trauma specialist, MOS 91W10.

*b. Section Sergeant.* This NCO, also a health care SGT, assists the flight surgeon in accomplishing his duties. The specific duties of this NCO are the same as those described for the health care SGT in the DIVARTY HHB (refer to paragraph 2-34).

*c. Health Care Specialists.* The duties and functions of these specialists are the same as those discussed in paragraph 2-34.

*d. Trauma Specialists.* The duties and functions of trauma specialists are described in paragraph 2-20.

*e. Ambulance Squad.* Paragraph 2-21 describes duties of ambulance squad members.

*f. Employment.* The medical section establishes a BAS near the squadron headquarters and provides Echelon I CHS for members of the squadron.

(1) The section employs a treatment HMMWV, a cargo trailer, and two MESs (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 headquarters and headquarters support company's wire communications net. It also employs an FM tactical radio and is deployed in the net designated by the squadron SOI. This section has access to the supporting medical company's tactical operations net for requesting Echelon II CHS.

*g. Operations.* Paragraphs 2-19 describes a BAS operation; these are equally applicable to the squadron BAS. Figures 2-8 and 2-9 show suggested layouts of a BAS.

*h. Medical Evacuation.* Evacuation of patients from the squadron aid station 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 Class VIII resupply 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 2-25.

*j. Property Exchange.* See paragraph 2-32.

### **2-39. Medical Section, Headquarters and Headquarters Company, Division Headquarters, L-Edition TOE**

*a. Organizations and Functions.* The HHC division headquarters medical treatment team is organized as shown in Figure 2-18. Personnel staffing of this section includes a PA, a health care SGT, and two health care specialists.

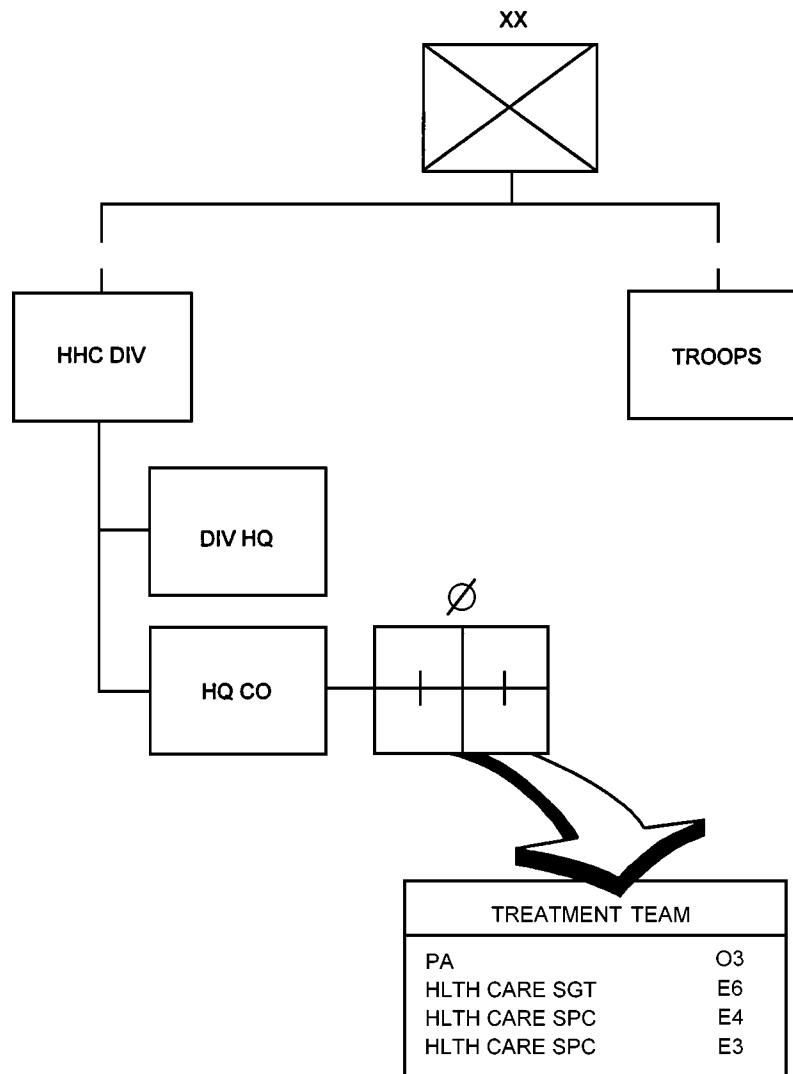


Figure 2-18. Medical section, headquarters and headquarters company, division headquarters.

(1) *Physician assistant.* The PA is responsible for the medical treatment provided by HHC medical personnel. He works under the clinical supervision of the division surgeon. In the division treatment team, the PA is the principal advisor to the division surgeon in the areas of PA affairs, executive medicine issues, and quality assurance/implementation. The specific duties of the PA are the same as those described in the DIVARTY HHB (refer to paragraph 2-34).

(2) *Health care sergeant.* Refer to paragraph 2-34.

(3) *Health care specialists.* Refer to paragraph 2-34.

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*b. Employment.* The medical treatment team establishes an aid station near the division headquarters and provides Echelon I CHS for members of the division HHC.

(1) The section employs a treatment HMMWV, a cargo trailer, and two MESs (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 HHC wire communications net. It also employs a FM tactical radio and is deployed in the net designated by the division SOI. This section has access to the MSMC's tactical operations net to request Echelon II CHS as required.

### **2-40. Combat Medic Section, Headquarters and Headquarters Company, Combat Engineer Battalion, L-Edition TOE**

*a. Organization and Functions.* The combat medic section of the combat engineer battalion is organized as shown in Figure 2-19. Personnel staffing of this section includes a section SGT and ten trauma specialists. The combat medic section provides EMT and treatment of minor wounds and injuries. It coordinates for and/or requests MEDEVAC support as required.

*b. Section Sergeant.* The section SGT, MOS 91W30, prepares reports, requests general and medical supplies, maintains supply economy procedures, and maintains the ASL of expendable supplies. He supervises combat medic section personnel. He coordinates Echelon I CHS from supported maneuver battalion medical platoon and Echelon II CHS from the supporting medical companies. His duties also include—

- Assigning tasks to trauma specialists.
- Providing and/or coordinating for Class VIII resupply for trauma specialists when deployed with engineer platoon or squad.
- 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.
- Coordinating and conducting CLS training for the battalion.
- Providing medical planning input to the S1 on battalion operations.

*c. Trauma Specialists.* The duties and functions of trauma specialists are described in paragraph 2-20.

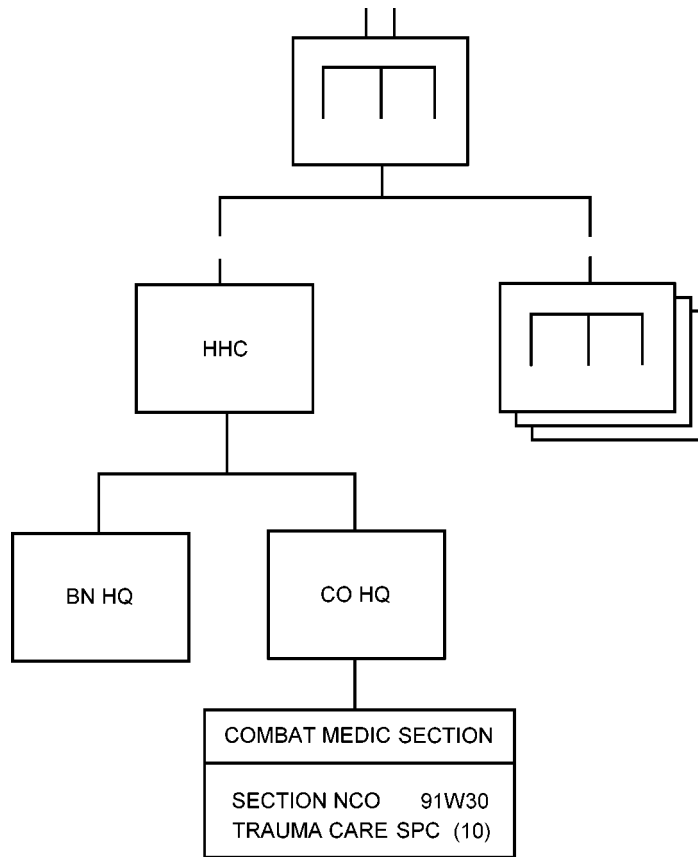


Figure 2-19. Medical platoon, headquarters and headquarters company, engineer battalion.

**Section VII. ADDITIONAL MEDICAL ASSETS OPERATING IN THE BRIGADE AREA OF OPERATIONS (FORCE XXI/DIGITIZED DIVISION)**

**2-41. Treatment Squads/Teams from the Forward Support Medical Company, F-Edition TOE**

The treatment squad provides emergency and routine sick call treatment to soldiers assigned to supported units. These teams can perform their functions while located in the FSMC area, or can operate independently of the FSMC for limited periods of time. The squad has the capability to split and operate as separate treatment teams (Teams Alpha and Bravo) for limited periods of time. While operating in these separate modes, they may operate two separate treatment stations. Normally, a squad or team deploys

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forward to augment or reinforce maneuver battalion medical platoons. Ambulance squads/teams may be deployed to AXP especially when there are extended evacuation routes. It can be assigned to reinforce or reconstitute battle losses of maneuver battalion medical platoons.

### 2-42. Forward Surgical Team, A-Edition TOE (Force XXI/Medical Reengineering Initiative)

Corps-level initial surgical support will be provided by the FST. The FST (Corps), TOE 08518LA00, and the FST (Airborne/Air Assault Division/ACR [Light]), TOE 08518LB00, are clinically standardized modules regardless of their assignment. These teams are comprised of 20 personnel and each has two operating room (OR) tables. The FST is organized into four functional areas—triage-trauma management, surgery, recovery, and administrative/operations. The mission of the FST is to provide a rapidly deployable immediate surgical capability enabling patients to withstand further evacuation. The requirement to project surgery forward increases as a result of the extended battlefield. This small, lightweight surgical team is designated to provide surgical augmentation to the FSMCs in support of the maneuver brigades, brigade TF, or the Interim Brigade Combat Team (IBCT). The FST is capable of continuous operations with divisional or nondivisional medical companies/troops for up to 72 hours; the ability to continue operations is limited by personnel fatigue/exhaustion and available supplies. The FST provides urgent, initial surgery for otherwise nontransportable patients. The FST's surgical capability is based on two OR tables with a surgical capacity of 24 OR table hours per day. Other capabilities include—

- Emergency medical treatment, to include assets to receive, triage, and prepare incoming patients for surgery.
- Surgery, including initial surgery and continued postoperative care for up to 30 critically wounded or injured patients over a period of 72 hours with the FST's organic MESs prior to resupply.
- Nursing care. Postoperative acute nursing care for up to eight patients, simultaneously, prior to further medical evacuation.
- Rapid strategic deployability. The team's personnel and equipment (less vehicles) are capable of deploying in one C-130 aircraft for initial entry missions, when required. The FST is capable of subsequent movement by helicopter sling-load operations.
- Tactical mobility. The team is 100 percent mobile with organic vehicles; it has a total of six HMMWVs.

For definitive information of the FST, see FM 8-10-25.

### 2-43. Forward Support Medical Evacuation Team, L-Edition TOE (Force XXI/Medical Reengineering Initiative )

The brigade may be augmented with a corps FSMT. When deployed forward to the BSA, the FSMT leader coordinates the air ambulance team's evacuation missions. The FSMT, 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 FSB 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 medical evacuation from forward areas (BAS) back to the BSA. Air ambulance evacuation from the point of injury will be METT-TC-dependent. Corps air ambulances providing GS evacuate from the BSA to supporting corps MTF. Aeromedical elements provide around the clock immediate response evacuation from either the BSA or their location based on METT-TC. 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 division 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 airspace control measures (ACM), to include free fire areas, no-fly fire areas, restricted operations zones, and established and standard Army aircraft flight routes. These routes and ACM change on a daily basis and cannot be integrated into the division 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. For definitive information on the corps air ambulance company and its FSMT that deploy forward into the brigades' AO, see FM 8-10-26.

**2-44. Corps Ground Ambulance Company, Either the L-Edition TOE or the A-Edition TOE Supporting Force XXI/Medical Reengineering Initiative**

The corps ground ambulance company is assigned to the corps MEDEVAC battalion. The basis of allocation within the combat zone is one per division supported. The current Army of Excellence ambulance company has four ambulance platoons with each platoon having 10 ambulances each. Under the MRI, the new MRI ground ambulance company will have a total of 24 ground ambulances. When deployed to the division, the ground ambulance company is attached to the MSB or division support battalion for Force XXI. The mission of the ground ambulance company in the division is to provide medical evacuation support to the division's maneuver brigades and to other divisional units and corps units operating in the division, as required. Normally, corps ground ambulances provide medical evacuation from the FSMC located in the BSA and from either the MSMC or the DSMC (Force XXI) to the supporting corps combat support hospital. The corps ground ambulance will reinforce the MEDEVAC assets in the medical companies of the division, as required.

**2-45. Corps Combat Stress Control Augmentation, A-Edition TOE (Force XXI/Medical Reengineering Initiative)**

The division may be augmented with additional CSC personnel, if requested. The base of allocation for the CSC medical detachment is one per division supported by the corps. The CSC medical detachment provides complete MH and combat stress preventive and treatment services in DS of division and corps personnel deployed forward. The new MRI detachment is a 43-person unit composed of a headquarters, a CSC preventive section and a CSC fitness section. The old Medical Force 2000 CSC medical detachment

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had 23 personnel and was designed to be a corps-level package to augment the organic MH sections of the divisions. Whereas, the new MRI CSC medical detachment retains the mission of providing DS to a division's maneuver brigades and general/reinforcing support to the DSA, including corps units in those areas. In addition, the detachment now augments area support in the corps immediately behind the division. The detachment must function with its elements widely dispersed, some working in and for the supported division and others working in the corps for the medical command/brigade. The CSC medical detachment personnel provide CSC planning, consultation, training, and staff advice to C2 headquarters and the units to which they are assigned/attached regarding—

- Combat and operational stressors affecting the troops.
- Mental readiness.
- Morale and cohesion.
- Potential for BF casualties.

The detachment and its personnel are dependent on units that they are attached for support, to include—

- Food service.
- Water distribution.
- Medical treatment.
- Logistical support including Class VIII items.
- Patient administration (detachment has one patient administration specialist, MOS 71G10, that works with the supporting unit).

For definitive information on the CSC medical detachment, Medical Force 2000 and MRI, see Change 1, FM 8-51.