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Army Health System Command and Control Organizations

Headquarters, Department of the Army

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Headquarters
Department of the Army
Washington, DC, 26 May 2010

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Preface

This field manual (FM) establishes command and control (C2) doctrine for the provision of Army Health System (AHS) support in echelons above brigade (EAB). It discusses all roles of care within the theater. The AHS is the overarching concept of support for providing timely medical support to the tactical commander. This publication is designed for use by medical commanders and their staffs that are involved in the planning and execution of medical operations in the EAB.

This publication implements or is in consonance with the following North Atlantic Treaty Organization (NATO) International Standardization Agreements (STANAGs) and American, British, Canadian, Australian, and New Zealand (ABCA) standards and publication:

TITLE	STANAG	ABCA Standard	ABCA Publication
Coalition Health Interoperability Handbook			256
Identification of Medical Material for Field Medical Installations	2060	248	
Emergency War Surgery	2068		
Multilingual Phrase Book for Use by the NATO Medical Services—AMedP-5(B)	2131		
Documentation Relative to Medical Evacuation, Treatment and Cause of Death of Patients	2132	470	
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The proponent of this publication is the United States (US) Army Medical Department Center and School (USAMEDDC&S). This publication applies to the Active Army, the Army National Guard (ARNG)/Army National Guard of the United States (ARNGUS), and the United States Army Reserve (USAR) unless otherwise stated. Send comments and recommendations in a letter format directly to **Commander, USAMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-5052** or to e-mail address: medicaldoctrine@amedd.army.mil. All recommended changes should be keyed to the specific page, paragraph, and line number. A rationale should be provided for each recommended change to aid in the evaluation of that comment.

The organizational structures presented in this publication reflect those established in the G-edition tables of organization and equipment (TOEs) in effect on the date of this publication. For a copy of your modified TOE, contact the Authorizations Documentation Directorate, 9900 Belvoir Road, Suite 120, ATTN: MOFI-FMA, Fort Belvoir, Virginia 22060-2287.

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

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Chapter 1

Army Health System in Echelons Above Brigade

The AHS is a complex system of interrelated and interdependent systems comprised of ten medical functions. The synchronization of these systems is essential to ensure that all of the capabilities resident in the AHS can be optimally employed to provide a seamless health care continuum from the point of injury or wounding, through the successive roles of essential care within the area of operations (AO) to the continental United States (CONUS)-support base for definitive, rehabilitative, and convalescent care. The medical functions align with medical disciplines and specialty training and the capabilities required to provide state-of-the-art care to Soldiers regardless of where they are physically assigned. These functions include: medical C2, medical treatment (area support), hospitalization, dental services, preventive medicine (PVNTMED) services, combat and operational stress control (COSC), veterinary services, medical evacuation, medical logistics (MEDLOG), and medical laboratory services. The ability of AHS commanders and leaders to coordinate health service support (HSS) and force health protection (FHP) requirements and to synergistically task-organize and augment lower roles with medical specialties and medical materiel, when required, maximizes the utilization of scarce medical resources, enhances patient care capabilities, and ensures the AHS is responsive to the tactical commander's concept of operations.

SECTION I — OPERATIONAL ENVIRONMENT

1-1. Operational environments are a composite of the conditions, circumstances, and influences that affect the employment of capabilities and bear on the decisions of the commander. The myriad of factors that combine and interact to define the operational environment in which forces are deployed is always changing and will continue to change during the deployment. Our forces are engaged in an era of persistent conflict—a period of protracted confrontation among state, nonstate, and individual actors increasingly willing to use violence to achieve their political and ideological ends.

THREATS

1-2. There are four categories of threat which are defined. An adversary may use elements from within each of the threat groups to achieve an end. For a discussion on the health threat refer to Figure 1-1. The four categories of threat are—

- Traditional threats emerge from states employing recognized military capabilities and forces in understood forms of military competition and conflict.
- Irregular threats are posed by an opponent employing unconventional, asymmetric methods and means to counter traditional US advantages, such as terrorist attacks, insurgency, and guerrilla warfare.
- Catastrophic threats involve the acquisition, possession, and use of chemical, biological, radiological, and nuclear (CBRN) weaponry, often referred to as weapons of mass destruction.
- Disruptive threats involve an enemy using new technologies that reduce US advantages in key operational domains.

MITIGATION

1-3. Regardless of the type of threat faced, the supporting AHS organizations can assist the commander in mitigating the adverse health effects of deployed Soldiers. The Army Medical Department (AMEDD) generating force conducts continuous medical research to field technologically advanced medical equipment and medications/vaccines to counter the health threats faced by the deployed force. The regional medical centers and educational programs train health care providers to provide state-of-the-art care to trauma casualties and devise new and innovative treatment protocols to enhance care and reduce morbidity, mortality, and long-term disability. Prior to deployment, AHS personnel have a key role in ensuring a healthy and fit force through training, promotion of a healthy lifestyle, individual medical readiness activities (such as immunizations, dental examination and treatment, vision readiness examinations, eyewear, and protective mask inserts), and health risk communications. During deployments through the use of comprehensive medical and occupational and environmental health (OEH) surveillance activities, the specific health threats posed by the deployment are identified and corrective actions are taken to prevent or to mitigate the exposure and/or the effects of the particular threats. Medical treatment assets within the deployed AO provide essential care to Soldiers who become wounded or ill during the operation.

1-4. The most critical AMEDD function across all threats and full spectrum operations is medical C2. Medical C2 provides the synchronization, coordination, and synergy required to effectively harness and manage the HSS (casualty care, MEDLOG, and medical evacuation) and the FHP (casualty prevention) aspects of operations. Leader-developed medical professionals are required to deconflict separate and often disparate priorities across the complex system of systems and leverage the resources resident, not only in the AHS, but across all Services and often from the civilian medical and educational communities, to ensure our Soldiers receive timely and effective medical care, regardless of the type of injury or illness or the Soldier's location. Figure 1-1 is a graphic representation of the threats with an example of the critical medical areas for initial consideration. However, since the AHS is a composite of subsystems, all 10 medical functions must be considered to ensure that effective and comprehensive care is provided throughout the continuum of care.

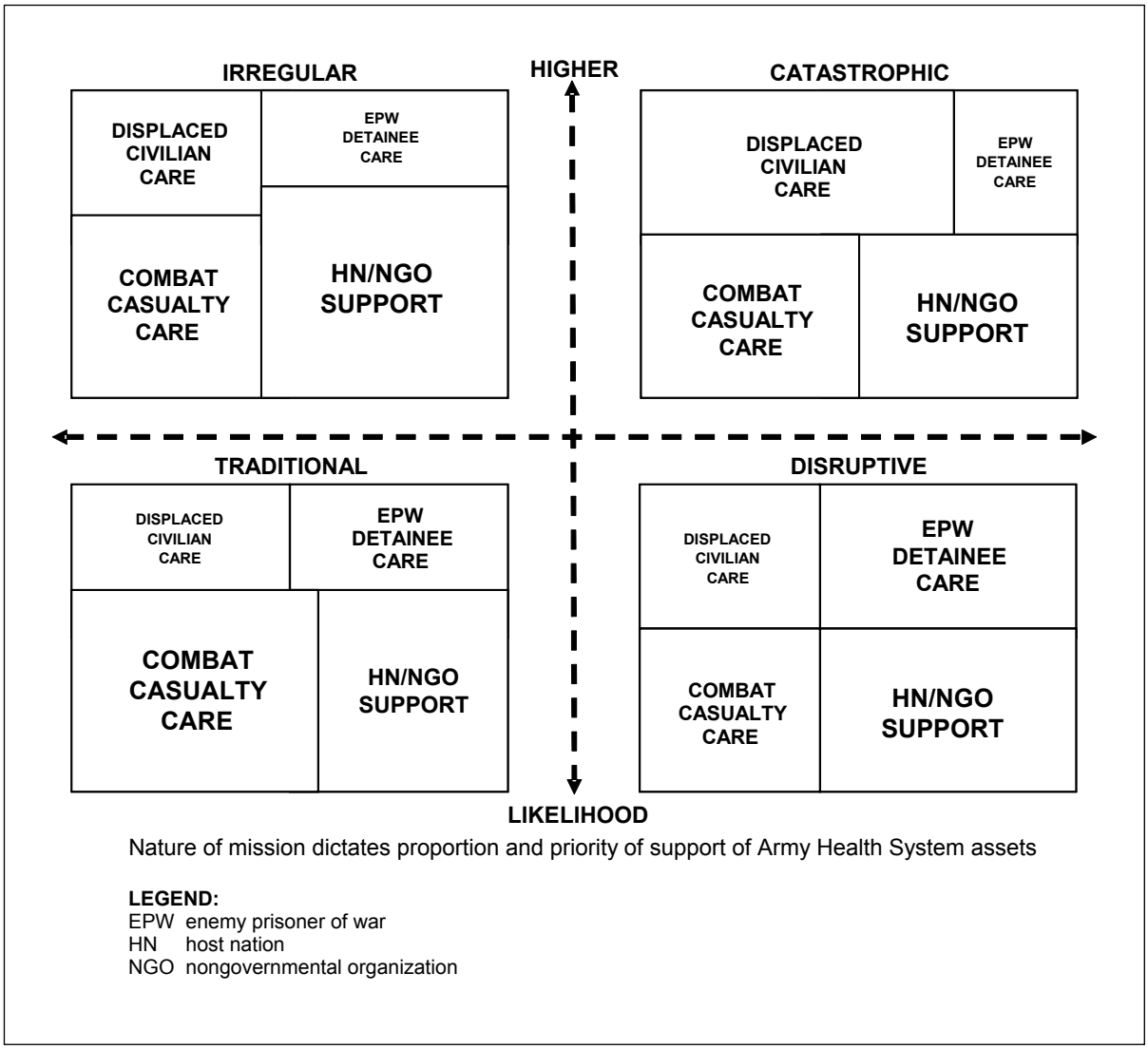

Figure 1-1. Threats and medical capabilities

OPERATIONAL VARIABLES

1-5. The joint force commander and component commanders devote considerable efforts to analyzing the operational environment and providing that analysis to their subordinates. Subordinate headquarters continue the analysis of the operational variables (using the memory aid of PMESII-PT [**P**olitical, **M**ilitary, **E**conomic, **S**ocial, **I**nformation, **I**nfrastructure, **P**hysical environment, and **T**ime]) concentrating on the variables that most influence their plans. Analysis of the operational variables develops a broader understanding of the operational environment and equips commanders to visualize the unit's role in the larger operation. This makes it much easier to understand the higher commanders' intent. It also prepares commanders and staffs to extract out of PMESII-PT the information that is most important given the situation that exists at the time they receive an order. The commander and staff can then go through the decisionmaking process for that mission focused on the situation in terms of the mission variables, or mission, enemy, terrain and weather, troops and support available, time available, and civil considerations (METT-TC).

1-6. The AHS planners of the regionally focused medical command (deployment support) (MEDCOM [DS]) (paragraph 2-4) can use this construct to provide an in-depth analysis of underlying health care issues within the geographic combatant commander's (GCC's) area of responsibility. This enables the medical commander to develop plans to target the underlying social, economic, and environmental issues impacting the health of a region in support of the GCC's theater engagement plan.

MISSION VARIABLES

1-7. The mission variables (METT-TC factors) used by the tactical commander are influenced, to a degree, by the operational variables used in strategic planning. As the operational variables describe the human aspects of the operational environment, they must be carefully considered by the medical commander and the AHS planner. In addition to supporting the tactical commander during major operations, AHS assets are often simultaneously engaged in providing humanitarian care during stability operations.

1-8. The AHS planner must accurately anticipate and forecast the medical requirements of the full spectrum of military operations. If the AHS planner at the tactical level is not aware of or conversant with the characteristics of the operational environment within the AO, the additional workload generated by emerging civilian medical requirements will adversely impact the support provided to the tactical commander. The humanitarian nature of medical care and assistance and the potential of the enemy exploiting the human suffering of the civilian population to his own purposes could result in some of the medical resources being diverted from their primary mission of supporting the deployed forces to supporting civilian health care emergencies. The AHS planner, in conjunction with the regionally focused MEDCOM (DS), must ensure that a thorough analysis has been accomplished of the existing health threat and the host nation's ability to mitigate or reduce the threat and that threat analysis is used in the development of the medical requirements for a given operation. Most importantly, the AHS planner must ensure that his actions and plans are integrated and synchronized with the task, purpose, and intent of the tactical commander.

SECTION II — INTRODUCTION TO THE ARMY HEALTH SYSTEM IN ECHELONS ABOVE BRIGADE

SYSTEM OF SYSTEMS

1-9. The AHS (Figure 1-2) promotes wellness and provides the tactical commander with a medically fit and ready force. Pre- and postdeployment health assessments document the Soldier's health baseline and create a mechanism to document OEH hazard exposures encountered during deployments. The state-of-the-art medical care provided the Soldier and his Family while at home station build the Soldier's trust and confidence in the military health care delivery system, so that he knows that if he is injured in battle he will receive the same responsive, dedicated medical care in the deployed setting. The confidence instilled by knowing that responsive medical care is always available translates to increased morale and *esprit de corps* in our Soldiers. Additionally, knowing that his Family will be medically cared for while he is deployed effectively reduces some of the stress of deployment and Family separation.

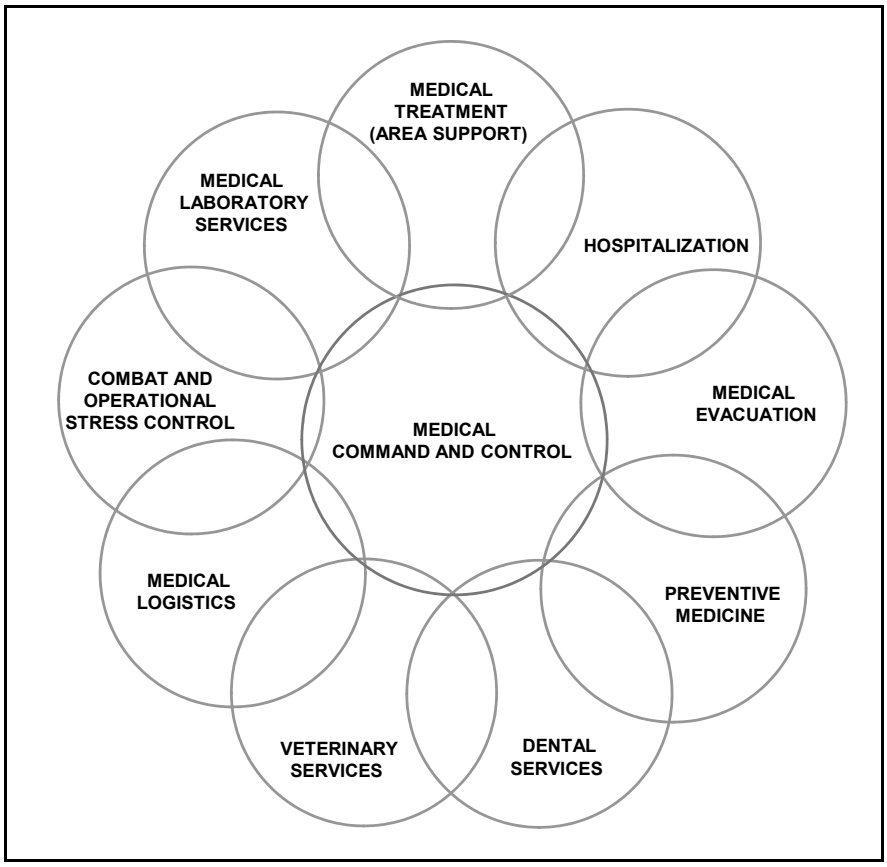

Figure 1-2. The Army Health System—a system of systems

1-10. To ensure a seamless, continuum of care from the point of injury or wounding to the CONUS-support base exists, in order to decrease morbidity and mortality and to reduce disability, a synergistic effort is required between Army TOE and generating force medical organizations and resources and those found in other sectors of the CONUS-support base. The ability of the deployed medical commander to reachback into the CONUS-support base for medical technical, clinical, and materiel support is paramount to optimizing the medical outcomes of our Soldiers who become wounded, injured, or ill while on deployments. This reach capability enhances the care given in theater and maximizes the utilization and employment of scarce medical resources.

1-11. The AHS supports both the protection warfighting function with FHP operations and the sustainment warfighting function with HSS operations.

FOCUS OF THE ARMY HEALTH SYSTEM

1-12. As the operational environment becomes increasingly complex and lethal, sustaining the health of the fighting forces becomes a critical factor in the success or failure of the mission. Comprehensive planning enhances the capability of medical units to provide effective AHS support, and ultimately, increases the chances for survival of the wounded Soldier.

1-13. The provision of timely and effective AHS support is a team effort which integrates the clinical and operational aspects of the mission. Coordination and synchronization are key elements to ensure that a seamless system of health care delivery exists from the point of injury through successive roles of care to the CONUS-support base, is achieved. Refer to FM 4-02 for additional information.

1-14. Consistent with military operations, AHS support also operates in a continuum across strategic, operational, and tactical levels. In addition to maintaining a healthy and fit deployable force, the effectiveness of the AHS is focused and measured on its ability to—

- Provide prompt medical treatment consisting of those measures necessary to locate, recover, resuscitate, stabilize, and prepare patients for evacuation to the next role of care and/or return to duty. These resources provide Role 1 and Role 2 medical treatment on an area support basis for those units without organic medical resources.
- Employ standardized air and ground medical evacuation units/resources and provide en route medical care to patients being evacuated. Evacuation by air ambulance is the preferred means of transporting seriously wounded or injured personnel in most situations. Its use, however, is METT-TC driven and can be affected by weather, availability of resources, CBRN conditions, and air superiority issues. Evacuation from Roles 1 and 2 is a Service responsibility; however, when designated by the GCC, the US Army may provide this support to the other Services operating in the AO. Further, the US Army doctrinally provides Army support to other Services such as US Marine Corps personnel for evacuation from shore-to-ship/ship-to-shore mission.
- Field flexible, responsive, and deployable hospitals designed and structured to support a Modular Army and its varied missions, as required. These hospitals provide essential care to all patients who are evacuated out of theater and definitive care to those Soldiers capable of returning to duty within the theater evacuation policy.
- Provide a MEDLOG system (to include blood management) that is anticipatory, responsive, and tailored to continuously support missions throughout full spectrum operations. The battle rhythm of AMEDD is similar to that of the tactical commander. Medical supplies, equipment, and medical equipment maintenance and repair support is required continually throughout all phases of the operation as peak patient loads occur during combat operations. Due to the time-sensitive nature of combat wounds and traumatic injuries, patients may not survive their injuries or may have long-term disabilities which will adversely affect their quality of life if the medications and medical equipment necessary to provide treatment are not available. Refer to FM 4-02.1 for additional information.
- Establish PVNTMED programs to prevent casualties from disease and nonbattle injury (DNBI) through medical surveillance, OEH surveillance, health assessments, PVNTMED measures, and personal protective measures. Refer to Army Regulation (AR) 40-5, Department of Army (DA) Pamphlet 40-11, FM 4-02.17, FM 4-25.12, and FM 21-10 for additional information on PVNTMED services.
- Provide veterinary services to enhance the health of the command through three broad-based functions—food inspection services, animal medical care, and veterinary PVNTMED (to include the prevention of zoonotic diseases transmissible to man). As the Department of Defense (DOD) Executive Agent, the Army provides veterinary medicine support to the US Air Force (USAF) (minus food inspection support on USAF installations), US Navy, US Marine Corps, and Army forces, as well as other federal agencies, host nation, and multinational forces, when directed. For additional information on veterinary operations and activities refer to FM 4-02.18.
- Provide dental services to maximize the quick return to duty of dental patients by providing operational dental care and maintaining the dental fitness of theater forces. For additional information on dental services operations and activities refer to FM 4-02.19.
- Provide COSC to enhance unit and Soldier effectiveness through increased stress tolerance and positive coping behaviors. For additional information, refer to FM 6-22.5 and FM 4-02.51.
- Provide medical laboratory services in support of AHS operations to—
  - Assess disease processes (diagnosis).
  - Monitor the efficacy of medical treatment.
  - Identify and confirm use of suspect biological warfare and chemical warfare agents by enemy forces.

PRINCIPLES OF THE ARMY HEALTH SYSTEM

1-15. The six principles that must be applied to AHS operations are conformity, proximity, flexibility, mobility, continuity, and control.

CONFORMITY

1-16. *Conformity* with the tactical plan is the most basic element for effectively providing AHS support. In order to develop a comprehensive concept of operations, the medical commander must have direct access to the tactical commander. Army Health System planners must be involved early in the planning process and once the plan is established it must be rehearsed with the forces it supports. In stability operations, it is essential that AHS support operations are in consonance with the GCC's theater engagement plan and have been thoroughly coordinated with the supporting assistant chief of staff, civil-affairs (G-9). Army Health System plans in stability operations must be coordinated with all participating organizations and multinational forces.

PROXIMITY

1-17. The principle of *proximity* is to provide AHS support to sick, injured, and wounded Soldiers at the right time and to keep morbidity and mortality to a minimum. Army Health System support assets are placed within supporting distance of the maneuver forces which they are supporting, but not close enough to impede ongoing combat operations. As the battle rhythm of the medical commander is similar to the tactical commander's, it is essential that AHS assets are positioned to rapidly locate, acquire, stabilize, and evacuate combat casualties. Peak workloads for AHS resources occur during combat operations.

FLEXIBILITY

1-18. *Flexibility* is being prepared to and empowered to shift AHS resources to meet changing requirements. Changes in tactical plans or operations make flexibility in AHS planning and execution essential. In addition to building flexibility into operation plans (OPLANs) to support the tactical commander's scheme of maneuver, the medical commander must also ensure that he has the flexibility to rapidly transition from one level of violence to another across the spectrum of conflict. As the current era is one characterized by persistent conflict, the medical commander may be supporting simultaneous actions along the continuum from stable peace through general war. The medical commander exercises his command authority to effectively manage his scarce medical resources so that they benefit the greatest number of Soldiers in the AO. For example, there are insufficient numbers of forward surgical teams (FSTs) to permit the habitual assignment of these organizations to each brigade combat team (BCT). Therefore, the medical commander, in conjunction with the command surgeon, closely monitors these valuable assets so that he can rapidly reallocate or recommend the reallocation of this lifesaving skill to the BCTs in contact with the enemy and where the highest rates of Soldiers will potentially receive traumatic wounds and injuries are anticipated. As the tactical situation changes within that BCT AO, the command surgeon and medical commander monitor and execute resupply and/or reconstitute operations of that FST to prepare for follow-on operations which could be in another BCT's AO. This ability to rapidly re-mission these special skills maximizes the lifesaving capacity of these units, provides the highest standard of lifesaving medical interventions to the greatest number of our combat wounded, and enhances the effectiveness of the surgical care provided and the productivity of these teams.

MOBILITY

1-19. The principle of *mobility* is to ensure that AHS assets remain in supporting distance to support the maneuvering operational Army forces. The mobility, survivability (such as armor plating and other survivability measures), and sustainability of medical units organic to maneuver elements must be equal to the forces being supported. Major AHS headquarters in EAB continually assess and forecast unit movement and redeployment. Army Health System support must be continually responsive to shifting medical requirements in the operational environment. In noncontiguous operations, the use of ground ambulances may be limited depending on the security threat in unassigned areas and as stated in

paragraph 1-4, air ambulance use may be limited by environmental conditions and enemy air defense threat. Therefore, to facilitate a continuous evacuation flow, medical evacuation must be a synchronized effort to ensure timely, responsive, and effective support is provided to the tactical commander.

CONTINUITY

1-20. *Continuity* in care and treatment is achieved by moving the patient through progressive, phased roles of care, extending from the point of injury or wounding to the CONUS-support base. Each type of AHS unit contributes a measured, logical increment in care appropriate to its location and capabilities. In current operations, lower casualty rates, availability of rotary-wing air ambulances and other situational variables often times enables a patient to be evacuated from the point of injury directly to the supporting combat support hospital (CSH). In more traditional combat operations, higher casualty rates, extended distances, and patient condition may necessitate that a patient receive care at each role of care to maintain his physiologic status and enhance his chances of survival. The medical commander, with his depth of medical knowledge, his ability to anticipate follow-on medical treatment requirements, and his assessment of the availability of his specialized medical resources can adjust the patient flow to ensure each Soldier receives the care required to optimize patient outcome.

CONTROL

1-21. *Control* is required to ensure that scarce AHS resources are efficiently employed and support the tactical and strategic plan. It also ensures that the scope and quality of medical treatment meet professional standards, policies, and US and international law. As the AMEDD is comprised of 10 medical functions which are interdependent and interrelated, control of AHS support operations requires synchronization to ensure the complex interrelationships and interoperability of all medical assets remains in balance to optimize the effective functioning of the entire system. Within the theater, the most qualified commander to orchestrate this complex support is the medical commander due to his training, professional knowledge, education, and experience. In a joint and multinational environment it is essential that coordination be accomplished across all Services and multinational forces to leverage all of the specialized skills within the theater. Due to specialization and the low density of some medical skills within the Military Health System (MHS) force structure, the providers may only exist in one Service (for example, the US Army has the only Veterinary Corps officers in the MHS).

ARMY MEDICAL DEPARTMENT BATTLEFIELD RULES

1-22. The AMEDD has developed the battlefield rules to aid in establishing priorities and in resolving conflicts between competing priorities within AHS activities. These battlefield rules are (in order of their priority) to—

- Be there (maintain a medical presence with the Soldier).
- Maintain the health of the command.
- Save lives.
- Clear battlefield of casualties.
- Provide state-of-the-art medical care.
- Ensure early return to duty.

1-23. These rules are intended to guide the medical planner to resolve system conflicts encountered in designing and coordinating AHS operations. Although medical personnel always seek to provide the full scope of AHS support and services in the best possible manner, during every combat operation there is an inherent possibility of conflicting support requirements. The planner or operator applies these rules to ensure that the conflicts are resolved appropriately.

1-24. The rationale for the battlefield rules is based on the prevention of disease and injury and the evolving clinical concept, which demonstrates that with good medical care the trauma victim will probably survive the injury.

HEALTH THREAT

1-25. The term *health threat* is defined as a collective term used to designate all potential or continuing enemy actions and environmental situations that could adversely affect the combat effectiveness of friendly forces, to include wounds, injuries, or sickness incurred while engaged in a joint operation.

1-26. In addition to wounds and injuries from conventional weapons and munitions, the health threat is comprised of the categories discussed in Table 1-1.

Table 1-1. Health threat

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

1-27. For additional information on the health threat refer to FM 4-02.17.

MEDICAL INTELLIGENCE

1-28. Medical intelligence is the product resulting from the collection, evaluation, analysis, integration, and interpretation of all available general health and bioscientific information. Medical intelligence is concerned with one or more of the medical aspects of foreign nations or the AO and which is significant to AHS or general military planning. Until medical information is processed or analyzed, it is not considered to be medical intelligence. Medical information pertaining to foreign nations is processed by the National Center for Medical Intelligence. For additional information on medical intelligence, refer to FM 4-02 and FM 4-02.17.

SECTION III — MEDICAL COMMANDER AND THE COMMAND SURGEON

MEDICAL COMMANDER

1-29. The medical commander exercises C2 (authority and direction) over his subordinate medical resources. As discussed in FM 3-0, the commander is the focus of C2 and uses two processes in decisionmaking. He uses an analytic approach to evaluate information and data systematically, proposes courses of action, and determines which course of action will provide the optimal results. The commander also makes decisions intuitively. For the medical commander, the intuitive decisionmaking process is guided by professional judgment gained from experience, knowledge, education, intelligence, and intuition. Experienced staff members use their intuitive ability to recognize the key elements and implications of a particular problem or situation, reject the impractical, and select an adequate solution.

1-30. The leader-developed medical professional has been trained in critical thinking, assessing situations, determining requirements for follow-on services, and decisive decisionmaking skills since the beginning of his professional career. These are essential and critical skills which have been taught, nurtured, and cultivated throughout his professional medical education and training. The medical commander's experience base cannot be viewed from a purely military perspective of when he entered the Army, but must be viewed holistically to encompass all of the training, education, and experience he received prior to and after his military career began. The military and leader development training, education, and experience coupled with his proven critical thinking skills and ability to take decisive action make him the most qualified commander to determine how medical assets will be employed in support of the tactical commander and to successfully accomplish his Title 10 responsibilities for the care of his Soldiers.

1-31. The construct of mission command provides for centralized planning and decentralized execution and is driven by mission orders. Successful mission command demands that subordinate leaders at all echelons exercise disciplined initiative, acting aggressively and independently to accomplish the mission within the commander's intent. Mission command gives the subordinate leaders at all echelons the greatest possible freedom of action. While mission command restrains higher-level commanders from micromanaging subordinates, it does not remove them from the fight. *Rather, mission command frees these commanders to focus on accomplishing their higher commander's intent and on critical decisions only they can make.* Within the medical C2 structure it enables the MEDCOM (DS) commander to retain a regional focus in support of the GCC's and Army service component command's (ASCC) theater engagement plan, while still providing effective and timely direct support to the supported tactical commanders and providing general support on an area basis to theater forces at EAB (such as those conducting aerial ports of debarkation, sea ports of debarkation, and tactical assembly areas operations or to other temporary or permanent troop concentrations). One consequence of the enduring regional focus of the ASCC is to drive specialization in its subordinate MEDCOM (DS) since unique health threats, local needs and capabilities, other Service capabilities, and geographic factors are distinctly related to a particular region. This characteristic is in contrast to some other staff and subordinate unit functions that are performed in much the same ways regardless of region.

COMMAND SURGEON

DUTIES AND RESPONSIBILITIES

1-32. At all levels of command, a command surgeon is designated. This AMEDD officer is a special staff officer charged with planning for and executing the AHS mission. At the lower levels of command, this officer may be dual-hatted as a medical unit commander; further, he may have a small staff section to assist him in his planning, coordinating, and synchronizing the AHS effort within his AO.

1-33. The command surgeon is responsible for ensuring that all AMEDD functions are considered and included in running estimates, OPLANs, and operation orders (OPORDs). The command surgeon retains technical supervision of all AHS operations. At the higher levels of command, the scope of duties and responsibilities expand to include all subordinate levels of command.

1-34. Through mission command, the command surgeon may be empowered to act somewhat independently, however, the nonmedical commander can retain the authority to make the decisions which he feels are critical. Mission command, to be successful, requires an environment of trust and mutual understanding which may be challenging to establish for newly assigned staff members who have not had a previous supporting relationship with the command. Sustainment unit commanders who previously commanded multifunctional battalions earlier in their careers may want to rely on that experience rather than the medical judgment and experience of a newly assigned command surgeon without realizing the complexities of managing the full array of medical specialty units and personnel. The effectiveness, responsiveness, and the efficiency of the deployed resources may be adversely impacted and Soldier survival rates may decrease and DNBI rates may rise.

1-35. The duties and responsibilities of command surgeons may include, but are not limited to—

- Advising the commander on the health of the command.
- Developing and coordinating the HSS and FHP portion of OPLANs to support the combatant/tactical commander's decisions, planning guidance, and intent.
- Determining the medical workload requirements (patient estimates) based upon the casualty estimate developed by the assistant chief of staff, personnel and/or personnel staff officer (S-1).
- Determining, in conjunction with the staff judge advocate (SJA) and the chain of command, the eligibility for medical care in a US Army medical treatment facility (MTF). Refer to Appendix A for additional information.
- Maintaining situational understanding by coordinating for current AHS information with surgeons of the next higher, adjacent, and subordinate headquarters.
- Recommending task organization of medical units/elements to satisfy all mission requirements.
- Recommending policies concerning support of civil-military operations (CMO).
- Monitoring the availability of and recommending the assignment, reassignment, and utilization of AMEDD personnel within his AO.
- Developing, coordinating, and synchronizing health consultation services.
- Evaluating and interpreting medical statistical data.
- Monitoring implementation of Army medical information programs.
- Recommending policies and determining requirements and priorities for MEDLOG (to include blood and blood products, medical supply/resupply, medical equipment maintenance and repair, production of medicinal gases, optometric support, and fabrication of single- and multivision optical lens and spectacle fabrication and repair).
- Recommending medical evacuation policies and procedures.
- Monitoring medical regulating and patient tracking operations.
- Determining AHS training requirements.
- Developing policies, protocols, and procedures pertaining to the medical and dental treatment of sick, injured, and wounded personnel. These policies, protocols, and procedures will be in consonance with applicable regulations, directives, and instructions; higher headquarters policies; standing operating procedures; applicable STANAGs and ABCA standards; memorandums of understanding or agreement; and Status of Forces Agreements.
- Ensuring field medical records and/or electronic medical records, when available, are maintained on each Soldier at the primary care MTF according to AR 40-66 and FM 4-02.4.
- Ensuring compliance with the theater blood bank service program.
- Ensuring a viable veterinary program (to include inspection of subsistence and outside the continental US food production and bottled water facilities, veterinary PVNTMED, and animal medical care) is established.
- Ensuring a medical laboratory capability or procedures for obtaining this support from out of theater resources are established for the identification and confirmation of the use of suspect biological warfare and chemical warfare agents by opposition forces. This also includes the capability for collecting specimens/samples, packaging, and handling requirements and escort/chain of custody requirements. Refer to FM 4-02.7 for additional information.

- Planning for and implementing PVNTMED operations and facilitating health risk communications (to include PVNTMED programs and initiating PVNTMED measures to counter the health threat). Refer to FM 4-02.17 for additional information on the health threat.
- Planning for and ensuring pre- and postdeployment health assessments are accomplished.
- Establishing and executing a medical surveillance program (refer to DOD Directive [DODD] 6490.2, DOD Instruction [DODI] 6490.03, Joint Chiefs of Staff Memorandum MCM 0028-07, AR 40-66, and FM 4-02.17 for an in-depth discussion).
- Establishing and executing an OEH surveillance program (FM 3-100.4).
- Recommending COSC, behavioral health (BH), and substance abuse control programs.
- Coordinating for medical intelligence with the supporting intelligence officer/section/unit. Pursuing other avenues to obtain medical intelligence and/or medical information such as the—
  - National Center for Medical Intelligence.
  - United States Army Center for Health Promotion and Preventive Medicine.
  - Centers for Disease Control and Prevention.
  - United States Public Health Services.
  - International organizations (such as the United Nations, the World Health Organization, or the Pan American Health Organization, and other nongovernmental organizations [NGOs]).
  - Information gathered from site visits to host nation medical facilities.
- Identifying commander's critical information requirements, priority intelligence requirement, essential elements of friendly information, and friendly forces information requirements as they pertain to the health threat; ensuring they are incorporated into the command's intelligence requirements.
- Coordinating for foreign humanitarian assistance, disaster relief, and medical response to weapons of mass destruction or terrorist incidents, and civil support operations, when authorized.
- Advising commanders on AHS CBRN defensive actions (such as immunizations, use of chemoprophylaxis, pretreatments, and barrier creams).
- Ensuring individual informed consent is established before the administration of investigational new drugs as described in Executive Order 13139 and AR 40-7.
- Assessing special equipment and procedures required to accomplish the AHS mission in specific environments such as urban operations, mountainous terrain, extreme cold weather operations, jungles, and deserts. Requirements are varied, depending upon the scenario, and could include—
  - Obtaining pieces of equipment or clothing not usually carried (piton hammers, extreme cold weather parka, jungle boots, or the like).
  - Adapting medical equipment sets for a specific scenario to include adding items based on the forecasted types of injuries to be encountered (such as more crush injuries and fractures in urban operations or mountain operations). In certain scenarios (such as urban operations), some medical supplies and equipment may not be carried into the fight initially (such as sick call materials), but rather brought forward by follow-on forces. In mountain operations, bulky or heavy items (such as extra tentage) may not accompany the force because of the difficulty in traversing the terrain.
  - Having individual Soldiers carry additional medical items, such as bandages and intravenous fluids.
- Recommending disposition instructions for captured enemy medical supplies and equipment. Under the provisions of the Geneva Conventions, medical supplies and equipment are protected from intentional destruction and should be used to initially treat sick, injured, or wounded enemy prisoners of war (EPWs) and detainees. Refer to FM 4-02 for additional information on the Geneva Conventions.
- Submitting to higher headquarters those recommendations on medical problems/conditions that require research and development.

- Recommending theater policy for medically evacuating contaminated patients.
- Coordinating and monitoring patient decontamination operations to include—
  - Theater policies on patient decontamination operations.
  - Layout and establishment of patient decontamination site.
  - Use of collective protection.
  - Use of nonmedical Soldiers to perform patient decontamination procedures under medical supervision.

This paragraph implements STANAGs 2132 and 2350

STANDARD OF CARE

1-36. The command surgeon is responsible for the standard of care which is provided to sick, wounded, and injured Soldiers by subordinate medical personnel.

PAIN MANAGEMENT

1-37. The command surgeon must ensure that standardized protocols for the alleviation of pain (to include the administration of pain relief medications by nonphysician health care providers) are established and disseminated. Further, he must ensure and certify that each combat medic (or other military occupational specialty [MOS] 68W provider), working under the supervision of a physician, has received sufficient training to—

- Recognize when pain management measures and medications are required.
- Provide pain management measures (elevation, immobilization, and ice [when available]).
- Select the appropriate medication (such as acetaminophen, ibuprofen, or morphine sulfate); determine the mode of administration (oral or parenteral); and be knowledgeable of the possible side effects and how to treat them; and administer the appropriate medication.
- Document the treatment provided (DA Form 7656, Tactical Combat Casualty Care Card, or Department of Defense Form 1380, U.S. Field Medical Card) to include the marking of individuals who have received morphine sulfate.

CONTROLLED SUBSTANCES

1-38. The command surgeon is also responsible for ensuring that all controlled substances are stored, safeguarded, issued, and accounted for according to the provisions of AR 40-3. The medical equipment sets for the combat medic includes morphine sulfate. When the mission supported involves a high risk of trauma, the command surgeon may authorize the combat medic to carry morphine sulfate to alleviate severe pain caused by trauma or wounding. This medication must be accounted for when issued to the combat medic and upon mission completion.

ARMY SERVICE COMPONENT COMMAND SURGEON

1-39. Each combatant command and subordinate commands have an ASCC assigned. The ASCC supports the GCC by conducting Army operations in support of the GCC's established objective. The Army contributes forces to perform combat, sustainment, and support activities in the theater. Under Army Modularity principles, at echelons below the ASCC, there are no fixed relationships among units or headquarters and few assets dedicated to any particular region. However, in the case of the ASCC, the enduring link between the command and a particular region of the world requires the ASCC surgeon to develop specialized capabilities and a particular understanding of its region. In the case of HSS and FHP, unique medical and environmental threats, local capabilities and needs, other Service capabilities, and geographic factors require a degree of regional specialization and expertise that is not shared by many other commanders or special staff officers. This specialized regional expertise is necessary in order to

support the GCC and ASCC commanders' theater engagement plans, as well as ensure state-of-the-art medical support for operations.

1-40. Army Health System support for the Army component in a theater is the responsibility of the ASCC commander. The command surgeon is on the commander's special staff.

1-41. The ASCC command surgeon is the senior medical staff officer on the ASCC commander's staff. The ASCC command surgeon is a separate position from the MEDCOM (DS) commander. The ASCC command surgeon—

- Has staff responsibility for health care provided to the theater.
- Has staff responsibility for planning, coordinating, and developing policies for the AHS support of Army forces.
- Provides advice concerning the health of the command and the occupied or friendly territory within the ASCC AO.
- Determines the health threat and provides advice concerning the medical effects of the environment and of CBRN weapons on personnel, military working dogs (MWDs), rations, and water.
- Recommends changes to the theater evacuation policy and provides input and personnel to the theater patient movement requirements center (TPMRC), as required.
- Determines the policy for the requisition, procurement, storage, maintenance, distribution, management, and documentation of Class VIII materiel, blood and blood products, and special medical-peculiar items of subsistence. This includes recommendations for establishment or designation of a theater lead agent for medical materiel and the assignment of missions for the single integrated MEDLOG manager (SIMLM).
- Develops and monitors mass casualty plans.
- Recommends priority of fills for all AMEDD officer and warrant officer (WO) vacancies and makes recommendations concerning the assignment of enlisted personnel with AMEDD specialties within the command.

CORPS SURGEON

1-42. Corps is the largest tactical units in the US Army. They are the instruments by which higher echelons of command conduct operations at the operational level. Higher headquarters tailor corps for the theater and the mission for which they are deployed. They contain organic maneuver and sustainment capabilities to sustain operations for a considerable period (when deployed as part of a larger ground force). For a more detailed discussion of corps operations, see FM 100-15.

1-43. The corps surgeon is a special staff officer in the corps headquarters. This officer has a 13-man staff section to assist him in planning and executing staff requirements. The corps surgeon has direct access to the corps commander on all AHS support matters. With input from the MEDCOM (DS) commander, he keeps the corps commander and his staff informed on all matters concerning the health of the command, medical readiness, and the AHS aspects of combat operations and effectiveness. As command surgeon, he advises the corps commander and staff on all AHS support matters related to personnel, health threat, operations, and MEDLOG. The surgeon's cell is normally functionally organized under the sustainment warfighting function, but may be directly under the corps chief of staff depending on the desires of the corps commander. He establishes coordination with surgeons and medical commanders of higher, subordinate, and adjacent headquarters through command channels, except for technical matters, which are coordinated through technical channels.

1-44. The duties of a command surgeon are discussed in paragraph 1-35. In addition to these duties, the corps surgeon and his staff—

- Provide current information on the corps AHS support situation to surgeons of the next higher, adjacent, and subordinate headquarters.
- Develop health consultation services within the corps.
- Evaluate and interpret AHS statistical data.

- Develop, in conjunction with higher headquarters, corps evacuation policies.
- Determine corps AHS training policies and programs as required.
- Ensure compliance with the theater blood bank service program.
- Initiate PVNTMED programs (to include medical surveillance and OEH surveillance) and procedures within the corps.
- Coordinate access to intelligence of medical interest with the deputy chief of staff, security/plans/operations (DCSSPO) and ensure that the health threat, medical intelligence, and intelligence of medical interest are integrated into AHS OPLANs and OPORDs.

DIVISION SURGEON

1-45. The division surgeon is a Medical Corps officer (area of concentration [AOC] 60A00). He is a division-level special staff officer and normally works under the staff supervision of the division chief of staff.

1-46. The principle duties and responsibilities of the division surgeon are advising the commanding general on the health of the command. As chief of the division surgeon section, the division surgeon is able to contribute to the division's warfighting capability by providing timely and effective AHS support planning (to include developing patient estimates) for inclusion in the division planning process and the conduct of full spectrum operations. The division surgeon operating from within the division surgeon section coordinates for EAB medical support and ensures that the information is integrated into the commander's ground tactical plan. The division surgeon is responsible for the technical supervision of all subordinate medical officers assigned to the command. He provides oversight and coordinates of all HSS and FHP activities throughout the division AO.

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Chapter 2
Medical Command (Deployment Support)

The complexities of the operational environment, the myriad of medical functions and assets, and the requirement to provide health care across full spectrum operations to diverse populations (US, joint, multinational, host nation, and civilian) necessitates a medical command authority that is regionally focused and capable of utilizing the scarce medical resources available to their full potential and capacity. The MEDCOM (DS) conserves the fighting strength of the tactical commander through synchronization of AHS operations and commanding and controlling medical brigades (MEDBDEs) (support), medical battalions (multifunctional) (MMBs), and/or other medical units assigned/attached to the headquarters providing HSS/FHP to tactical commanders and theater forces and simultaneously conduct of stability operations.

SECTION I — HEADQUARTERS AND HEADQUARTERS COMPANY, MEDICAL COMMAND (DEPLOYMENT SUPPORT)

MISSION AND ASSIGNMENT

2-1. The headquarters and headquarters company (HHC), MEDCOM (DS) (TOE 08640G000) provides C2, administrative assistance, and technical supervision of assigned and attached units. Medical units which may be assigned or attached to this organization are provided in Appendix C.

2-2. The MEDCOM (DS) serves as the medical force provider within the theater. As the medical force provider, the MEDCOM (DS) commander identifies and evaluates health care requirements throughout his AO. Within the MEDCOM (DS) AO, medical resources may be dispersed over an extended area and may include numerous areas with increased patient densities, transient troop populations, varying levels of hostilities, and significantly different health care requirements. To successfully execute AHS operations, the MEDCOM (DS) commander must have the ability to rapidly task-organize and reallocate medical assets across command and geographical boundaries. This ability is crucial to ensure the medical force package is effectively tailored to optimize the use of scarce medical resources.

2-3. The MEDCOM (DS) is composed of an operational command post (OCP) and a main command post (MCP) that can deploy autonomously into the AO. It possesses a centralized capability to effectively and efficiently task-organize medical elements based on specific AHS requirements in the AO. The MEDCOM (DS) serves as the medical force provider for the AO and focuses on AO medical OPLANs and medical contingency plans. It monitors threats within the AO, ensures required medical capabilities to mitigate these health threats, and maintains visibility and utilization of medical infrastructure, treatment, and evacuation capabilities. It accomplishes its Title 10 responsibilities and Army support to other Services for the AO. The MEDCOM (DS) partners and trains with host nation and multinational medical units. It establishes a command relationship with the ASCC commander and the GCC to influence and improve the delivery of health care and is linked to the theater sustainment command by the medical logistics management center for coordination and planning. The MEDCOM (DS) is assigned to the ASCC and is allocated on a basis of one per theater.

REGIONAL FOCUS

2-4. The MEDCOM (DS) maintains a regional focus that encompasses all of the GCC's area of responsibility. As in all regions of the world, neighboring countries often have economic, social, and religious ties and are dealing with similar health issues. The issues which may be at the heart of the social unrest in the deployment area can usually be found to exist in the other countries within the same region. Medical forces, due to their humanitarian mission, have always been more acceptable to host nations than the operational Army. The medical commander's ability to cultivate medical professional contacts within a nation or group of nations, facilitates the planning for and execution of regional strategies that will potentially mitigate the underlying social, economic, cultural, health, and political conditions which can foster civil unrest.

2-5. By establishing linkages to the civilian and governmental health care authorities in each nation, the senior medical command headquarters can actively monitor existing health threats, develop regional strategies to mitigate these threats, enhance the host nation government's legitimacy with the affected population, and reduce human suffering. The medical commander provides the GCC with an effective tool to assist in shaping the security environment by alleviating the health conditions which impact the development of strong social, economic, and political infrastructures. The GCC can deploy medical experts to provide consultation and advice to assist host nations in broadening their medical capacity in both the public and private health sectors through the development and implementation of health care programs specifically designed to address the particular health challenges faced by the host nation.

2-6. Military medical training exercises can be mutually beneficial to the host nation and US forces. These exercises provide a forum for training medical personnel in the identification and treatment of diseases and conditions that are not endemic in the US and provide the host nation military or civilian medical personnel training on emerging state-of-the-art technologies and medical protocols. The care provided which is incidental to the training mission, assists the host nation in overcoming the adverse impacts of the diseases/conditions treated and enhances its legitimacy in the eyes of it citizens.

2-7. The effects of focusing on interregional cooperation are to eradicate diseases or the environmental conditions that promote the growth of disease vectors. The interregional cooperation which results may also favorably affect the economic, social, and political fabric of the nation, remove obstacles to interregional cooperation in other sectors, and enhance the standard of living of the host nation residents.

CAPABILITIES AND LIMITATIONS

2-8. The MEDCOM (DS) provides—

- Command and control of theater medical units providing AHS support within the AO.
- Subordinate medical organizations to operate under the MEDBDE and/or MMB and to provide medical capabilities to the BCT.
- Advice to the ASCC commander and other senior-level commanders on the medical aspects of their operations.
- Staff planning, supervision of operations, and administration of assigned and attached medical units.
- Assistance with coordination and integration of strategic capabilities from the sustaining base to units in the AO.
- Advice and assistance in facility selection and preparation.
- Coordination with the USAF TPMRC for medical regulating and movement of patients from MTFs.
- Consultation services and technical advice in all aspects of medical and surgical services.
- Functional staff to coordinate medical plans and operations, hospitalization, PVNTMED, tactical and strategic medical evacuation, veterinary services, nutrition care services, COSC, medical laboratory services, and area medical support to supported units.

- Coordination and orchestration of MEDLOG operations to include Class VIII supplies/resupply, distribution, medical maintenance and repair support, optical fabrication, and blood management.
- Planning and support for SIMLM, when designated.
- Veterinary support for zoonotic disease control, investigation and inspection of subsistence, and animal medical care.
- Preventive medicine support for medical and OEH surveillance, potable water inspection, pest management, food facility inspection, and control of medical and nonmedical waste.
- Legal advice to the commander, staff, subordinate commanders, Soldiers, and other authorized persons.
- Health threats monitoring within the AO and ensuring required capabilities to mitigate threats are identified.
- Religious support to the command. This includes coordinating with the headquarters unit ministry team for required religious support throughout the AO and providing consultation capability to subordinate MEDCOM (DS) unit ministry teams.
- Minimum mission essential wartime requirements for personnel and equipment.

2-9. This unit is dependent upon appropriate elements of the theater sustainment command for sustainment, health care, finance, supplemental transportation, security during tactical moves, sustainment area security and area damage control, CBRN decontamination assistance, and laundry and bath.

2-10. This unit requires 100 percent of its TOE equipment and supplies to be transported in a single lift, while using its authorized organic vehicles.

ORGANIZATION AND FUNCTIONS

INTERNAL STAFF AND OPERATIONS

2-11. Section I of this chapter combines the MCP and OCP of the MEDCOM (DS) to provide a description of the composition and capabilities of the command's coordinating, special, and personal staff structure. For additional information on the composition, duties, and responsibilities of the various Army staffs refer to FM 5-0.

Coordinating Staff

2-12. Figure 2-1 graphically depicts the organization of the MEDCOM (DS) coordinating staff. The coordinating staff officers are the commander's principal staff assistants and are directly accountable to the chief of staff. Coordinating staff officers are responsible for one or a combination of broad fields of interest. They help the commander coordinate and supervise the execution of plans, operations, and activities. Collectively through the chief of staff, they are accountable for the commander's entire field of responsibilities. The staff is not accountable for functional areas the commander decides to personally control.

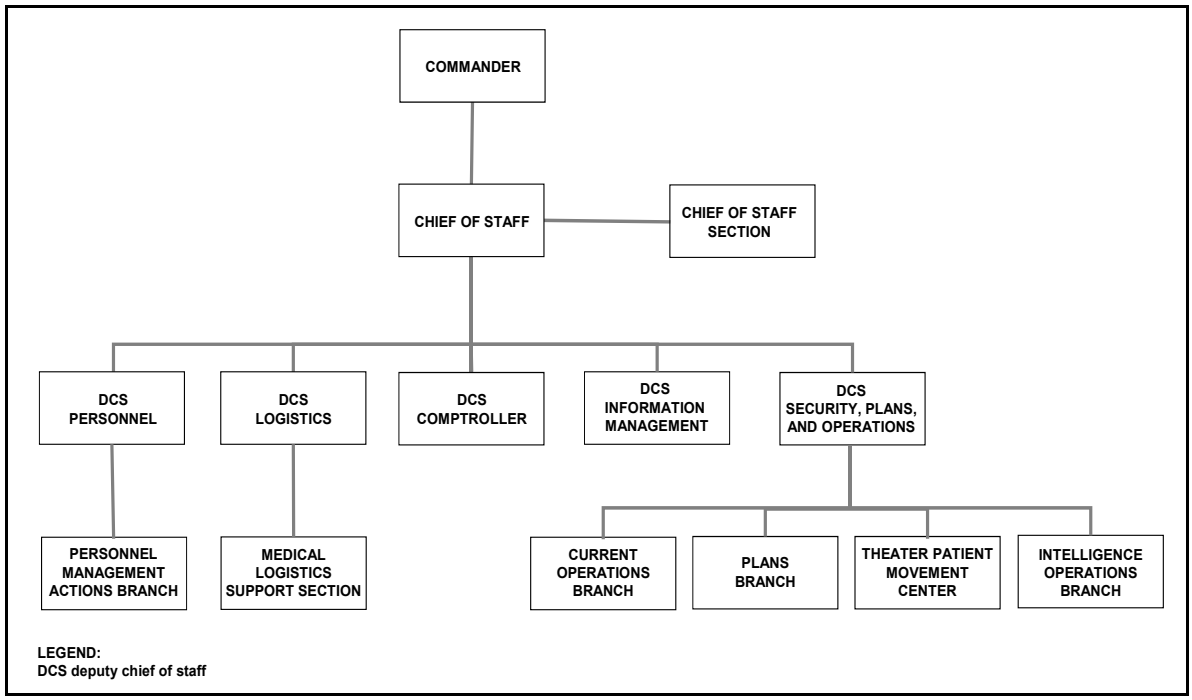

Figure 2-1. Medical command (deployment support) coordinating staff

Special and Personal Staffs

2-13. The special staff depicted in Figure 2-2 helps the commander and other members of the staff in their professional and technical functional areas. Special staffs are organized according to functional areas.

2-14. The personal staff depicted in Figure 2-2 works under the commander's immediate control. They also serve as special staff officers as they coordinate actions and issues with other staff members.

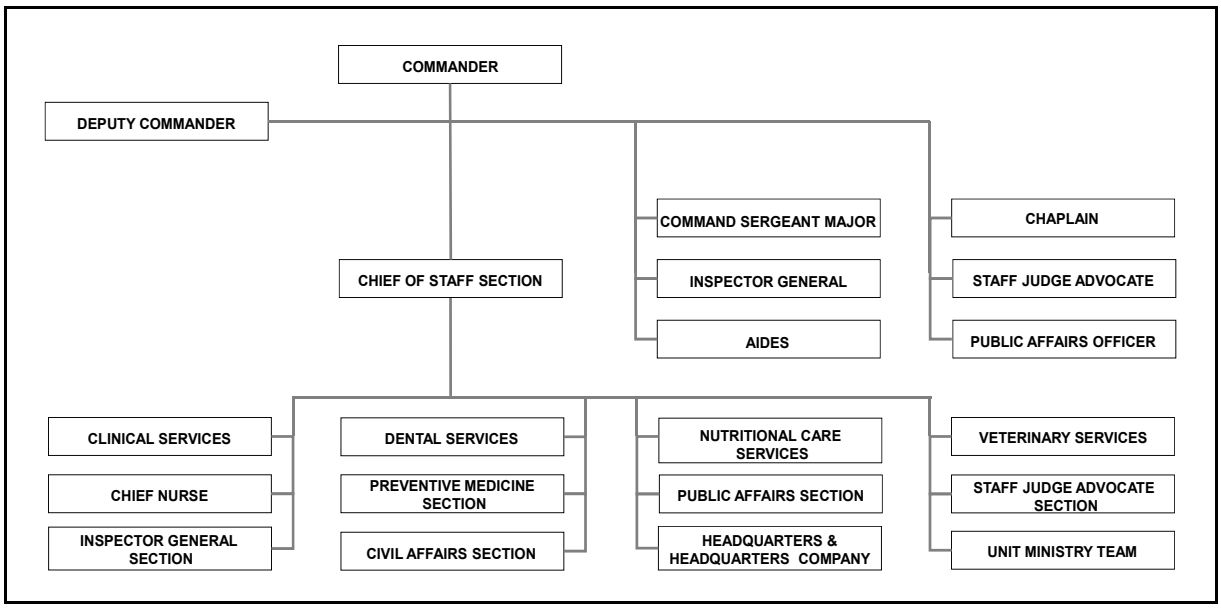

Figure 2-2. Medical command (deployment support) special and personal staffs

COMMAND SECTION

2-15. The command section (Table 2-1) provides C2 and management of all MEDCOM (DS) services. Personnel of this section supervise and coordinate the MEDCOM (DS) operations and administrative services.

Table 2-1. Command section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Command section	00B00	O8	Commander	GO
	00B00	O7	Deputy commander**	GO
	01A00	O3	Aide-de-camp	IMM
	01A00	O2	Aide-de-camp**	IMM
	00Z5O	E9	Command sergeant major	NC
	42A3O	E6	Executive administrative assistant	NC
	88M3O	E6	Senior vehicle driver	NC
	92G3O	E6	Enlisted aide**	NC

Table 2-1. Command section (continued)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Command section (continued)	92G3O	E6	Enlisted aide	NC
	88M2O	E5	Vehicle driver**	NC

LEGEND
**MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
GO general officer
IMM immaterial
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned Officer

Commander

2-16. The commander (Major General/O8, AOC 00B00) directs, coordinates, and controls assigned and attached medical units in the theater to accomplish the mission. The commander deploys with the MCP.

Deputy Commander

2-17. The deputy commander (Brigadier General/O7, AOC 00B00) also serves as the commander of the OCP. He must remain informed of the operations so he can assume command, if necessary. The deputy commander assumes command functions as directed by the commander or in his absence. The deputy commander deploys with the OCP.

Aide-de-Camps

2-18. The aide-de-camp (Captain [CPT]/O3, AOC 01A00) performs such duties as directed by the commanding general. The aide-de-camp deploys with the MCP.

2-19. The aide-de-camp (Lieutenant/O2, AOC 01A00) performs such duties as directed by the deputy commander. The aide-de-camp deploys with the OCP.

Command Sergeant Major

2-20. The command sergeant major (CSM) (CSM/E9, MOS 00Z5O) is the principal enlisted representative to the commander. He advises the commander and staff on all matters pertaining to the welfare and morale of enlisted personnel in terms of assignment, reassignment, promotion, and discipline. He provides counsel and guidance to noncommissioned officers (NCOs) and other enlisted personnel of the MEDCOM (DS). He is also responsible for the reception of newly assigned enlisted personnel into the unit. The CSM evaluates the implementation of individual Soldier's training on common Soldier tasks and supervises the MEDCOM (DS) NCO professional development program. The CSM deploys with the MCP.

Executive Administrative Assistant

2-21. The executive administrative assistant (Staff Sergeant [SSG]/E6, MOS 42A3O) provides administrative assistance, prepares and edits correspondence for signature by the commander and deputy commander, maintains and tracks correspondence and suspense's, and prepares reports, as required. The executive assistant deploys with the MCP.

Senior Vehicle Driver

2-22. The senior vehicle driver (SSG/E6, MOS 88M3O) operates the wheeled vehicles in the command section for the commander. The senior vehicle driver deploys with the MCP.

Enlisted Aides

2-23. The enlisted aides (SSG/E6, MOS 92G3O) provide administrative assistance to the commander and deputy commander. One enlisted aide deploys with the OCP and one with the MCP.

Vehicle Driver

2-24. The vehicle driver (Sergeant [SGT]/E5, MOS 88M2O) operates the wheeled vehicles in the command section for the deputy commander. The vehicle deploys with the OCP.

CHIEF OF STAFF SECTION

2-25. The chief of staff section (Table 2-2) plans, directs, and coordinates the execution of staff tasks and functions. It reviews organizational activities and recommends changes, as necessary, to the MEDCOM (DS) commander. This section ensures synchronization of staff activities and ensures that required coordination is accomplished.

Table 2-2. Chief of staff section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Chief of staff section	67A00	O6	Chief of staff	MS
	67A00	O4	Secretary general staff**	MS
	67A00	O4	Secretary general staff	MS

LEGEND
**MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
MS Medical Service Corps
MOS military occupational specialty

Chief of Staff

2-26. The chief of staff (Colonel [COL], AOC 67A00) is the MEDCOM (DS) commander's principal assistant for directing, coordinating, supervising, and training the special and coordinating staffs, except in those areas the commander reserves for himself. The MEDCOM (DS) commander delegates the necessary executive management authority to the chief of staff. The chief of staff frees the commander from routine details and passes pertinent data, information, and insights from the staff to the commander and from the commander to the staff. For an in-depth discussion of the duties and responsibilities of the chief of staff, refer to FM 5-0. The chief of staff deploys with the MCP.

Secretary General Staff

2-27. The secretaries general staff (Major (MAJ)/O4, AOC 67A00) act as the executive officers for the chief of staff. They perform such duties as the chief of staff may direct in each respective command post. There are two officers assigned to this section. One secretary general staff deploys with the MCP and one with the OCP.

DEPUTY CHIEF OF STAFF, PERSONNEL

2-28. The deputy chief of staff, personnel (DCSPER) (Lieutenant Colonel [LTC]/O5, AOC 70F67) (Table 2-3) serves as the principal staff element for all internal MEDCOM (DS) matters pertaining to human resource (HR) activities. This section is responsible for establishing, monitoring, and assessing MEDCOM (DS) HR policies. This section has primary or coordinating responsibility for MEDCOM (DS) strength management; finance support; casualty management; casualty estimates; morale, welfare, and recreation (MWR) activities; education; safety and accident prevention; alcohol and drug abuse programs;

and equal opportunity activities. Further, this section provides overall administrative services for the command, to include: personnel administration, mail distribution, awards and decorations, and leaves. This section coordinates with elements of supporting agencies for finance, HR, and administrative services as required. This section receives and processes actions including promotions, reassignments, awards, personnel security clearances, personnel accounting, and strength management. The section prepares the MEDCOM (DS) personnel estimate and recommends priorities of fill for replacement to the MEDCOM (DS) commander and the DCSSPO. Refer to FM 1-0 and FM 5-0 for additional information. This section monitors the Professional Filler System and the integration of Professional Filler System personnel into subordinate medical units.

Table 2-3. Deputy chief of staff, personnel

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Deputy chief of staff, personnel	70F67	O6	Deputy chief of staff, personnel	MS
	70F67	O5	Health services personnel officer**	MS
	42B00	O4	Personnel management officer	AG
	42B00	O4	Personnel management officer**	AG
	42A5O	E9	Chief human resources sergeant	NC
	42A4O	E7	Senior human resources sergeant**	NC
	42A2O	E5	Human resources sergeant**	NC
	42A1O	E4	Human resources specialist	
	42A1O	E4	Human resources specialist**	
	42A1O	E3	Human resources specialist**	

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AG Adjutant General Corps
AOC area of concentration
MS Medical Service Corps
MOS military occupational specialty
NC noncommissioned officer

Deputy Chief of Staff, Personnel

2-29. The DCSPER (COL/O6, AOC 70F67) advises the commander and staff on matters pertaining to all aspects of health services HR management. He is responsible to the chief of staff for the personnel functions within the command. The DCSPER deploys with the MCP.

Health Services Personnel Officer

2-30. The health services personnel officer (LTC/O5, AOC 70F67) advises the deputy commander and staff on all aspects of health services HR management in the OCP. This includes matters/policy pertaining to active duty AMEDD personnel, deployed Reserve Component personnel, civilian staff, contractors accompanying US forces, and patients. He plans, develops, and directs administrative management activities and services in medical organizations, to include: distribution, publications, correspondence, document reproduction, records and files management, and application of sophisticated administrative

techniques such as desktop publishing and micrographics. He plans, develops, and directs personnel systems that support and implement programs concerning the eight personnel management life cycle functions. Included are strength accounting, maintenance of personnel records, personnel requisitioning, reassignments, reenlistments, promotions, casualty reporting, eliminations, and awards and decorations. This officer manages the activities of personnel operational elements providing support to the MEDCOM (DS) and its subordinate units. He trains military and civilian personnel in HRs support, organizational administration, and develops policy/procedures for these operations for AMEDD field and combat applications. The health services personnel officer deploys with the OCP.

Personnel Management Officers

2-31. The personnel management officers (MAJ/O4, AOC 42B00) plans, develops, and directs personnel systems which support and implements programs including strength accounting, maintenance of personnel records, personnel requisitioning, reassignment, reenlistment, promotions, casualty reporting, eliminations, and awards and decorations. This officer manages the activities of personnel operational elements providing specific support to the organizations, headquarters, and individuals. They operate the personnel and administrative subsystem that supports personnel programs and activities. They integrate all aspects of personnel systems within an organization/headquarters and controls the interaction of the various subparts of each. There are two officers assigned to this section. One personnel management officer deploys with the OCP and one with the MCP.

Human Resources Personnel

2-32. The chief HR sergeant (Sergeant Major [SGM]/E9, MOS 42A5O) is responsible to the DCSPER for specific personnel functions which include personnel management, records, actions, and preparation of Electronic Military Personnel Office changes. He ensures coordination between subordinate unit HR and the MEDCOM (DS). He advises the MEDCOM (DS) commander, DCSPER, and other staff members on personnel administrative matters. He also supervises the activities of subordinate personnel. The chief HR sergeant deploys with the MCP.

2-33. The senior HR sergeant (Sergeant First Class [SFC]/E7, MOS 42A4O) performs duties of and supervises the functions of subordinates to include the quality assurance of tasks performed and products prepared. He advises the DCSPER and other staff members on personnel administration activities and supervises subordinate HR personnel. The senior HR sergeant deploys with the OCP.

2-34. The HR sergeant (SGT/E5, MOS 42A2O) provides technical guidance to subordinate Soldiers in accomplishment of his duties in the OCP. The HR sergeant deploys with the OCP.

2-35. The HR specialists (Specialist [SPC]/E4, MOS 42A1O) prepare and process awards, evaluations, promotions, officer/enlisted personnel records, classification/reclassification actions, retention, casualty documents, letters of sympathy, transfers, reassignments, discharges, retirement, qualifications for special assignment, orders, and requests for orders. They process applications for officer candidate school, warrant officer flight training/other training, identification cards/tags, leaves, passes, line of duty determinations, military personnel data, temporary duty, travel, personnel/transition processing, security clearances, training and reassignment, military and special pay programs, personnel accounting, meal cards, training file, and unit administration. They prepare personnel accounting and strength reports. These specialists requisition and maintain office supplies, blank forms, and publications and military and nonmilitary correspondence in draft/final copy. Further, they maintain files, post changes to Army regulations/publications, and initiate actions for passports and visas. They monitor the appointment of line of duty officer/investigations, survivor assistance, and summary court officers. One HR specialist deploys with the OCP and one with the MCP.

2-36. The HR specialist (Private First Class (PFC)/E3, MOS 42A1O) performs duties as described in paragraph 2-35 and is the vehicle driver for the section. The HR specialist deploys with the OCP.

PERSONNEL MANAGEMENT/ACTIONS

2-37. Personnel management/actions (Table 2-4) develop personnel policies for promotions, appointments, demotions, classifications, assignments, reassignments, decorations, awards, separations, and rotations for the MEDCOM (DS) according to theater policy. It maintains continuous personnel loss data and obtains summarized personnel information for use in preparing support plans. In coordination with the civil affairs (CA) section, this branch provides policy and guidance on procurement, administration, and utilization of civilian personnel in the command. This branch is also responsible for establishing and monitoring Family readiness groups.

Table 2-4. Personnel management/actions

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Personnel management/actions	70F67	O4	Personnel staff officer	MS
	42A5O	E8	Senior human resources sergeant**	NC
	42A2O	E5	Human resources sergeant	NC
	42A1O	E4	Human resources specialist	

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Personnel Staff Officer

2-38. The personnel staff officer (MAJ/O4, AOC 70F67) serves as the branch chief and advises the DCSPER and staff in all aspects of health services HR management. This includes matters/policies pertaining to active duty AMEDD personnel, civilian staff, and patients. The personnel staff officer deploys with the MCP.

Human Resources Personnel

2-39. The senior HR sergeant (Master Sergeant (MSG)/E8, MOS 42A5O) performs duties of and supervises subordinate HR personnel while performing specialized or all encompassing HR functions. Serves as the DCSPER noncommissioned officer in charge in the OCP. The senior HR sergeant deploys with the OCP.

2-40. The HR sergeant (SGT/E5, MOS 42A2O) performs duties at preceding skill levels and provides technical guidance to subordinate Soldiers in accomplishment of these duties. The HR sergeant deploys with the MCP.

2-41. This Soldier assists in the duties as discussed in paragraph 2-35. The HR specialist deploys with the MCP.

DEPUTY CHIEF OF STAFF, SECURITY/PLANS/OPERATIONS

2-42. Deputy chief of staff, security/plans/operations (Table 2-5) is the principal staff section in matters concerning security, plans, intelligence, operations, organization, training, and CBRN defensive activities. It prepares broad planning guidance, policies, and programs for command organizations, operations, and functions. This section is responsible for plans and operations, deployment, relocation, and redeployment of the MEDCOM (DS). It directs and coordinates medical evacuation operations, both ground and air. It provides 24-hour continuous operations capability. This section develops policies and guidance for training and training evaluation of the command. This section has four principal functional elements—the

current operations branch, the plans branch, the intelligence/operations branch, and the theater patient movement center (TPMC). For additional information on the responsibilities of this staff section, refer to FM 5-0.

Table 2-5. Deputy chief of staff, security/plans/operations

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Deputy chief of staff, security/plans/operations	70H67	O6	Deputy chief of staff, security/plans/operations	MS
	68Z5O	E9	Chief medical noncommissioned officer	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Deputy Chief of Staff, Security/Plans/Operations

2-43. The DCSSPO (COL/O6, AOC 70H67) is the principal staff officer for the commander in matters concerning operations, plans, organization, and training. His duties require a high degree of coordination with other staff members. The DCSSPO deploys with the MCP.

Chief Medical Noncommissioned Officer

2-44. The chief medical NCO (SGM/E9, MOS 68Z5O) is the principal NCO who supervises and performs related duties as the senior advisor to the DCSSPO. The chief medical NCO deploys with the MCP.

CURRENT OPERATIONS BRANCH

2-45. The current operations branch (Table 2-6) is responsible for all operational planning functions to include deployment, relocation, and redeployment of the MEDCOM (DS).

Table 2-6. Current operations branch

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Current operations branch	70H67	O5	Medical operations officer**	MS
	70H67	O4	Medical operations officer	MS
	70H67	O4	Medical operations officer (2)**	MS
	74B00	O4	Chemical officer**	CM
	74B00	O3	Assistant chemical officer**	CM
	68Z5O	E9	Chief operations sergeant**	NC
	68W5O	E8	Operations noncommissioned officer	NC
	68W5O	E8	Operations noncommissioned officer**	NC
	74D5O	E8	Chemical operations noncommissioned officer**	NC

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
CM Chemical Corps
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Medical Operations Officers

2-46. The medical operations officer (LTC/O5, AOC 70H67) serves as the DCSSPO and is the principal advisor to the DCSSPO in the areas of field medical operations and evacuation. This officer serves as the chief of the branch. The medical operations officer deploys with the OCP.

2-47. The medical operations officers (MAJ/O4, AOC 70H67) are responsible to the branch chief for the operations and training functions of the MEDCOM (DS). They supervise all AHS operations in support of tactical operations conducted by the MEDCOM (DS) to include planning and relocation of each command post. They are responsible for the formulation of the tactical standing operating procedure (TSOP) and production of OPORDs. There are three medical operations officers assigned to this section. Two medical operations officers deploy with the OCP and one with the MCP.

Chemical Officers

2-48. The chemical officer (MAJ/O4, AOC 74B00) is the technical advisor to the MEDCOM (DS) commander and DCSSPO on matters pertaining to CBRN operations. He plans CBRN defensive operations and advises subordinate units on contamination avoidance and personnel and equipment decontamination operations. The chemical officer deploys with the OCP.

2-49. The assistant chemical officer (CPT/O3, AOC 74B00) assists the chemical officer with the performance of his planning responsibilities. The assistant chemical officer deploys with the OCP.

Chief Operations Sergeant

2-50. The chief operations sergeant (SGM/E9, MOS 68Z5O) is responsible to the medical operations officer for preparation of OPORDs and map overlays. He also supervises subordinate staff and serves as the CSM's representative in the OCP. The chief operations sergeant deploys with the OCP.

Operations Noncommissioned Officers

2-51. The operations NCOs (MSG/E8, MOS 68W5O) are responsible to the chief operations sergeant and the medical operations officer for operations and training functions of the MEDCOM (DS). They supervise the establishment and operation of the tactical operations center and are involved in the planning for and relocation of each command post. They assist in the formulation of the TSOP and production of OPORDs. One operations NCO deploys with the OCP and one deploys with the MCP.

Chemical Operations Noncommissioned Officer

2-52. The chemical operations NCO (MSG/E8, MOS 74D5O) provides CBRN operations advice and support to the chemical officer. The chemical operations NCO deploys with the OCP.

PLANS BRANCH

2-53. The plans branch (Table 2-7) authenticates and publishes OPLANs and OPORDs. This branch exercises staff supervision over medical activities, assists the commander in developing and training the unit's mission essential task list, and identifies training requirements based on medical missions and the unit's training status. This branch is responsible for developing and implementing training programs, directives, and orders and maintaining the unit readiness status reports of each unit in the MEDCOM (DS).

Table 2-7. Plans branch

Paragraph title	*AOC/MOS*	*GRADE*	*Title*	*Branch*
Plans branch	70H67	O5	Medical plans officer	MS
	70H67	O4	Medical plans officer	MS
	70H67	O4	Medical plans officer**	MS
	68W5O	E8	Plans noncommissioned officer**	NC

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Medical Plans Officers

2-54. The medical plans officer (LTC/O5, AOC 70H67) is the principal advisor to the DCSSPO in the areas of field medical plans and contingency plans. The medical plans officer deploys with the MCP.

2-55. The medical plans officers (MAJ/O4, AOC 70H67) are responsible to the senior medical plans officer for future planning and analysis of MEDCOM (DS) planning factors. There are two officers assigned to this branch. One medical plans officer deploys with the OCP and one with the MCP.

Plans Noncommissioned Officer

2-56. The plans NCO (MSG/E8, MOS 68W5O) is responsible to the senior medical plans officer, and assists in the formulation of OPLANs and analysis of MEDCOM (DS) planning factors. The plans NCO deploys with the OCP.

INTELLIGENCE/OPERATIONS BRANCH

2-57. The intelligence/operations branch (assistant chief of staff, intelligence [G-2]/assistant chief of staff, operations [G-3]) (Table 2-8) acquires, analyzes, and evaluates intelligence, to include health threat information and medical and OEH surveillance data. In coordination with the PVNTMED officer, it identifies DNBI trends and processes data accordingly. It identifies the commander's critical information requirements and other intelligence requirements. It also presents intelligence assessments, evaluations, and recommendations to the DCSSPO. The staff provides threat analysis to support operations security planning. It develops plans and requirements for terrain studies, mapping, and charting. It collects and distributes weather data. This branch assists the DCSSPO in preparing OPLANs. Further, this section provides advice and consultation on all activities comprised by the protection warfighting function and composite risk management.

Table 2-8. Intelligence/operations branch G-2/G-3

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Intelligence/operations G-2/G-3 branch	70H67	O5	Medical operations officer	MS
	70H67	O4	Intelligence officer**	MS
	70H67	O3	Medical operations officer**	MS
	68Z5O	E9	Chief medical noncommissioned officer	NC
	68W5O	E8	Intelligence medical sergeant	NC
	68W5O	E8	Intelligence medical sergeant**	NC
	31B4O	E7	Force protection supervisor**	NC
	35F3O	E6	Technical intelligence analyst	NC

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
MS Medical Service Corps
MOS military occupational specialty
NC noncommissioned officer

Medical Operations Officers

2-58. The medical operations officer (LTC/O5, AOC 70H67) is responsible for all protection warfighting functions and medical intelligence for the MEDCOM (DS). He serves as the assistant staff officer, security/intelligence and is the principal advisor to the commander in the areas of tactical, physical, and personnel security, and medical intelligence. The medical operations officer deploys with the MCP.

2-59. The medical operations officer (CPT/O3, AOC 70H67) serves as the assistant intelligence officer and is responsible to the intelligence officer for medical intelligence products for the MEDCOM (DS). He is responsible for the intelligence products required by the planning and operations staff and assists with

operations security and communications security (COMSEC) staff assistance for subordinate organizations. The medical operations officer deploys with the OCP.

Intelligence Officer

2-60. The intelligence officer (MAJ/O4, AOC 70H67) is responsible to the medical operations officer for the acquisition and analysis of medical intelligence information. He interfaces with the ASCC G-2 for relevant tactical intelligence and ensures this information is disseminated to subordinate commands. He functions as the operations security and COMSEC officer for the MEDCOM (DS). The intelligence officer deploys with the OCP.

Chief Medical Noncommissioned Officer

2-61. The chief medical NCO (SGM/E9, MOS 68Z5O) serves as the chief security NCO. He is responsible to the DCSSPO for physical security, to include the MEDCOM (DS) defense plan, preparation of the unit plan, OPORDs, map overlays, and intelligence information and records. He supervises subordinate staff and assists in managing the MCP. The chief medical NCO deploys with the MCP.

Intelligence Medical Sergeants

2-62. The intelligence medical sergeants (MSG/E8, 68W5O) assist the intelligence officer and supervise and provide technical guidance within the AMEDD and Army special staff activities in each command post. One intelligence medical sergeant deploys with the OCP and one with the MCP.

Force Protection Supervisor

2-63. The force protection supervisor (SFC/E7, MOS 31B4O) coordinates with military police platoons, detachments and sections. He supervises and performs duties as provost sergeant and coordinates with the chief operations sergeant for defense of the MEDCOM (DS) in the OCP. He prepares plans and OPORDs in support of security of resources and facilities occupied by the MEDCOM (DS). He deploys with the OCP.

Technical Intelligence Analyst

2-64. The technical intelligence analyst (SSG/E6, MOS 35F3O) assists the intelligence officer and provides tactical intelligence products relevant to the MEDCOM (DS) AO. He provides interface between the ASCC operational intelligence cell and the MEDCOM (DS) for health threat information and tactical intelligence requirements. The technical intelligence analyst deploys with the MCP.

THEATER PATIENT MOVEMENT CENTER

2-65. The TPMC (Table 2-9) is responsible to the DCSSPO for maintaining 24-hour continuous operations and conducting split-based operations. The TPMC is responsible for medical regulating of all patients in the theater and preparation of patient statistical reports. This center coordinates with the TPMRC for intertheater evacuation of all patients leaving the theater and for specific patient movement item requirements and medical attendant requirements. The TPMC interfaces with the TPMRC for intratheater air evacuation when evacuation distances exceed the capabilities of Army rotary-wing aircraft. This section synchronizes intratheater evacuation plans with the intertheater evacuation plan to ensure a seamless transition between tactical and strategic evacuation systems. This section performs patient tracking procedures and monitors in-transit visibility of MEDCOM (DS) patients. Refer to Joint Publication (JP) 4-02 and FM 4-02.2 for additional information on medical evacuation and medical regulating. Additionally this section provides advice and consultation on the maintenance and disposition of medical records. Refer to AR 40-66, AR 40-400, and FM 4-02.4 for information on the maintenance and disposition of medical records for deployed forces. This staff section was previously referred to as the medical regulating office.

Table 2-9. Theater patient movement center

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Theater patient movement center	70E67	O5	Patient administration officer	MS
	67J00	O4	Aeromedical evacuation officer (2)**	MS
	70E67	O3	Patient administration officer (2)**	MS
	68G5O	E8	Patient administration noncommissioned officer	NC
	68G2O	E5	Patient administration noncommissioned officer (2)**	NC
	68G1O	E4	Patient administration specialist (2)**	
THEATER PATIENT MOVEMENT CENTER (CONTINUED)	68G1O	E3	Patient administration specialist (2)**	

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Patient Administration Officers

2-66. The patient administration officer (LTC/O5, AOC 70E67) serves as the MEDCOM (DS) medical regulating officer and is responsible to the DCSSPO for planning, organizing, directing, and controlling the patient movement and the administrative aspects of the MEDCOM (DS). He advises the commander on patient administration matters. The patient administration officer deploys with the MCP.

2-67. The patient administration officers (CPT/O3, AOC 70E67) assist the patient administration officer in developing plans and procedures for patient administration support to include patient statistical reports and medical regulating in the OCP. There are two patient administration officers that deploy with the OCP.

Aeromedical Evacuation Officers

2-68. The aeromedical evacuation officers (MAJ/O4, AOC 67J00) ensure tactical and strategic evacuation requirements are synchronized. They assist the MEDBDEs with planning the intratheater aeromedical evacuation across multinational operations. They coordinate direct and general support aeromedical evacuation missions with the general support aviation battalion. Further, they advise the DCSSPO on all matters related to aeromedical evacuation. There are two aeromedical evacuation officers that deploy with the OCP.

Patient Administration Noncommissioned Officers

2-69. The patient administration NCO (MSG/E8, MOS 68G5O) performs duties as the senior patient administrative NCO for the command. The patient administration NCO deploys with the MCP.

2-70. The patient administration NCOs (SGT/E5, MOS 68G2O) are responsible to the patient administration NCO for implementing the US Transportation Command Regulating and Command and Control Evacuation System for the MEDCOM (DS) in the OCP. They process correspondence received for medical information. They also assist in supervising subordinate personnel. The patient administration NCOs deploy with the OCP.

Patient Administration Specialists

2-71. The patient administration specialists (SPC/E4, MOS 68G1O) are responsible to the patient administration NCO for preparing, consolidating, and maintaining medical records and statistics pertaining to patient data. There are two patient administration specialists that deploy with the OCP.

2-72. The patient administration specialist (PFC/E3, MOS 68G1O) is responsible to the patient administration NCO for preparing, consolidating, and maintaining medical records and statistics pertaining to patient data. There are two patient administration specialists that deploy with the OCP.

DEPUTY CHIEF OF STAFF, LOGISTICS

2-73. The deputy chief of staff, logistics (Table 2-10) has primary responsibility for monitoring all logistics support to MEDCOM (DS) units, including Class VIII supply/resupply, medical equipment, medical equipment maintenance and repair, optical fabrication, medical gases, medical contractors, general supply, maintenance, transportation, field services, and construction support. The deputy chief of staff, logistics, integrates those functions that sustain the MEDCOM (DS) assigned and attached units in the AO. This section provides staff supervision and overall coordination for internal logistics support of MEDCOM (DS) units.

Table 2-10. Deputy chief of staff, logistics

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Deputy chief of staff, logistics	70K67	O6	Deputy chief of staff, logistics	MS
	70K67	O4	Health services materiel officer**	MS
	670A0	W4	Command maintenance officer	WO
	920A0	W3	Property book officer	WO
	915E0	W3	Senior automotive maintenance warrant officer**	WO
	92Z5O	E9	Senior supply supervisor	NC
	92Y4O	E7	Supply sergeant**	NC
	92Y1O	E4	Supply specialist**	
	92Y1O	E4	Supply specialist	

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
WO warrant officer

Deputy Chief of Staff, Logistics

2-74. The deputy chief of staff, logistics (COL/O6, AOC 70K67) serves as the principal advisor to the commander and provides supervision and coordination of logistics, food service, supply, transportation, and maintenance support for the subordinate units. The deputy chief of staff, logistics, deploys with the MCP.

Health Services Materiel Officer

2-75. The health services materiel officer (MAJ/O4, AOC 70K67) serves as the principal advisor to the deputy commander for unit logistics and maintenance planning and operations in the OCP. The health services materiel officer deploys with the OCP.

Command Maintenance Officer

2-76. The command maintenance officer (Chief Warrant Officer [CWO]/W4, MOS 670A0) performs duties as the senior medical maintenance officer in the MEDCOM (DS). He manages maintenance requirements for vehicles, power generation equipment, as well as medical equipment. He supervises the technical and tactical performance of all medical equipment maintainer MOSs. He manages maintenance operations of various types and size. Further, he advises on equipment systems compatibility, replacement, and economical retention. The command maintenance officer deploys with the MCP.

Property Book Officer

2-77. The property book officer (CWO/W3, MOS 920A0) is the primary property accountability officer in the MEDCOM (DS). He directs the command property accountability operations and monitors asset visibility of major end items within the command. The property book officer deploys with the MCP.

Senior Automotive Maintenance Warrant Officer

2-78. The support automotive maintenance warrant officer (CWO/W3, MOS 915E0) performs duties as the specialty trained motor maintenance officer in the OCP. He manages maintenance requirements by applying technical knowledge and technical management skills. He supervises the technical and tactical performance of many different maintainer MOSs. This CWO manages maintenance operations of various types and size. Further, he advises on equipment systems compatibility, replacement, and economical retention. He also evaluates performance and quality of equipment through an analysis of maintenance indicators. The senior automotive maintenance warrant officer deploys with the OCP.

Senior Supply Supervisor

2-79. The senior supply supervisor (SGM/E9, MOS 92Z5O) performs supervisory and management duties related to large-sized logistics operations, stock control, property management, and storage activities. The senior supply supervisor deploys with the MCP.

Supply Sergeant

2-80. The supply sergeant (SFC/E7, MOS 92Y4O) performs supervisory and management duties shown at preceding level of skill. He analyzes statistical data and reports to ascertain trends, conformance to standard and directives, and efficiency of operations in the OCP. He coordinates logistical activities with other staff elements and subordinate units. Further, he conducts assistance visits to subordinate elements and develops and executes training programs. The supply sergeant deploys with the OCP.

Supply Specialists

2-81. The supply specialists (SPC/E4, MOS 92Y1O) perform the duties of receiving, inspecting, inventorying, loading, unloading, segregating, storing, issuing, and turning-in of all organizational supplies and equipment. They operate automation equipment and prepare all organizational supply documents. They maintain and use the automated supply system for accounting of organizational and installation supplies and equipment. There are two supply specialists assigned to this section. One supply specialist deploys with the OCP and one with the MCP.

MEDICAL LOGISTICS SUPPORT SECTION

2-82. The MEDLOG support section (Table 2-11) monitors, coordinates, and facilitates MEDLOG operations within the command. This includes Class VIII supply and resupply, blood management and

distribution, medical equipment maintenance and repair, medical gases, and optical lens fabrication and repair. This section plans for the SIMLM mission, when designated. As the SIMLM, it coordinates with and provides MEDLOG support to all Services deployed in the AO. This section coordinates with and establishes a liaison with the medical logistics management center forward team. The medical logistics management center forward team provides a centralized, theater-level management of critical Class VIII materiel, patient movement items, and medical maintenance. Refer to FM 4-02.1 for additional information on the medical logistics management center. Further, this section coordinates and facilitates contracting operations in support of the medical mission. (The availability of contracting support for medical services and supplies may be limited by the stringent requirements of the Food and Drug Administration for medical supplies and US standards for professional services.)

Table 2-11. Medical logistics support section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Medical logistics support section	70K67	O5	Chief, logistics**	MS
	71E67	O4	Clinical laboratory officer**	MS
	71E67	O4	Clinical laboratory officer	MS
	70K67	O4	Supply management officer	MS
	70K67	O4	Health service materiel officer	MS
	88D00	O3	Transportation officer	TC
	88D00	O3	Transportation officer**	TC
	670A0	W3	Unit maintenance officer**	WO
	68A5O	E9	Chief biomedical equipment noncommissioned officer	NC
	68K5O	E9	Chief medical laboratory noncommissioned officer	NC
	68Z5O	E9	Chief medical logistics noncommissioned officer**	NC
	68J5O	E8	Medical logistics sergeant**	NC
	68H4O	E7	Senior optical laboratory noncommissioned officer	NC
	68J4O	E7	Medical logistics sergeant (2)**	NC

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
WO warrant officer

Chief Logistics

2-83. The chief logistics (LTC/O5, AOC 70K67) is the senior health service materiel officer in the section and serves as the section chief. He plans, coordinates, controls, and manages the functional areas pertaining to the highly specialized and technical materiel and services utilized in support of the health care delivery system. He exercises staff responsibility for units engaged in Class VIII supply, optical fabrication, medical maintenance, blood support, quality control operations, and other MEDLOG support in the OCP. He plans and directs activities of personnel and units responsible for the receipt, storage, and issue of all Class VIII medical supply, optical fabrication support, blood support, and medical maintenance support. He provides command policy and monitors the collection, evacuation, and accountability for all MEDLOG items of supply classified as salvage, surplus, abandoned, or uneconomically repairable. As a chief, logistics, he advises the commander of MEDLOG matters and unit mission capabilities. He plans, directs, and implements the multifunctional areas of medical materiel management and their integration into the overall DOD logistics system, as well as the support interface between the Army in the field, wholesale logistics, and industry. Further, he directs and/or exercises staff supervision of units engaged in the production, acquisition, receipt, storage and preservation, issue, and distribution of medical equipment, medical repair parts, and medical supplies. He serves as the focal point for medical property management and accountability procedures. As a staff officer, he advises the deputy chief of staff, logistics, on matters regarding supply and services support and other MEDLOG functions. The chief logistics deploys with the OCP.

Clinical Laboratory Officers

2-84. The clinical laboratory officers (MAJ/O4, AOC 71E67) serve as the Area Blood Program Officers. They serve as blood and blood products distribution officers. They coordinate, direct, and prepare and provide reports and establish policy. They provide guidance on all issues and actions associated with blood collection, manufacturing, and storage to support Soldiers, organizations, medical units, and to others, as directed. One clinical laboratory officer deploys with the OCP and one with the MCP.

Supply Management Officer

2-85. The supply management officer (MAJ/O4, AOC 70K67) is responsible for the establishment and maintenance of contracts for supplies and services for the MEDCOM (DS). The supply management officer deploys with the MCP.

Health Services Materiel Officer

2-86. The health services materiel officer (MAJ/O4, AOC 70K67) serves as the principal advisor to the chief, logistics for health care facility planning in the theater. The health services materiel officer deploys with the MCP.

Transportation Officers

2-87. The transportation officers (CPT/O3, AOC 88D00) coordinate with subordinate and other organizations for all transportation issues for the MEDCOM (DS). They develop plans, directions, and priorities for all MEDCOM (DS) transportation issues. They monitor all transportation requirements for MEDLOG and normal unit transportation issues. One transportation officer deploys with the OCP and one with the MCP.

Unit Maintenance Officer

2-88. The unit maintenance officer (CWO/W3, MOS 670A0) performs duties as a specially trained medical maintenance officer in the MEDCOM (DS) and the OCP. He manages maintenance requirements by applying technical knowledge and technical management skills. He supervises the technical and tactical performance of medical equipment maintainer MOSs. Manages maintenance operations of various types and size. He advises on equipment systems compatibility, replacement, and economical retention.

Evaluates performance and quality of equipment through an analysis of maintenance indicators. The unit maintenance officer deploys with the OCP.

Chief Biomedical Equipment Noncommissioned Officer

2-89. The chief biomedical equipment NCO (SGM/E9, MOS 68A5O) performs technical and administrative management, coordination, control, and operational duties as the principal medical maintenance NCO. He reviews quality control procedures relevant to the performance of medical maintenance operations. He reviews technical training procedures and advises subordinates on technical training issues. This NCO writes, develops, and coordinates command-wide regulations and policies relating to AMEDD logistical material maintenance programs. He serves as advisor on medical maintenance operations to subordinate units. The chief biomedical equipment NCO deploys with the MCP.

Chief Medical Laboratory Noncommissioned Officer

2-90. The chief medical laboratory NCO (SGM/E9, MOS 68K5O) assists the clinical laboratory officers with the management of blood and blood products. He coordinates with the CONUS-sustaining base for area medical laboratory services and provides consultation services and technical advice for medical laboratory operations. The chief medical laboratory NCO deploys with the MCP.

Chief Medical Logistics Noncommissioned Officer

2-91. The chief MEDLOG NCO (SGM/E9, MOS 68Z5O) is the principal NCO who supervises and performs related duties as the senior enlisted advisor to deputy commanders on all matters pertaining to logistics operations in the OCP. The chief MEDLOG NCO deploys with the OCP.

Medical Logistics Sergeant

2-92. The MEDLOG sergeant (MSG/E8, MOS 68J5O) assists the chief MEDLOG NCO with his duties. The MEDLOG sergeant deploys in the OCP.

2-93. The MEDLOG sergeants (SFC/E7, MOS 68J4O) assist in the execution of MEDLOG support operations and the SIMLM mission. They facilitate reception, staging, onward movement, and integration operations and resolve aerial port of debarkation/sea port of debarkation transportation, shipping, cross-docking, and delivery issues. They coordinate theater distribution of medical supplies with subordinate MEDLOG units and facilitate the supply chain management flow for medical materiel from CONUS/depot/commercial sources into theater. They coordinate Army Materiel Command-related requirements for medical forces deploying into theater. The MEDLOG sergeants deploy with the OCP.

Senior Optical Laboratory Noncommissioned Officer

2-94. The senior optical laboratory NCO (SFC/E7, MOS 68H4O) directs, plans, coordinates, and implements the quality assurance program for all optical fabrication production within the MEDCOM (DS). He provides reports and optical capability assessments. He coordinates all external optical support and monitors internal production capabilities. He advises the commander on the status of optical support within the MEDCOM (DS) and theater. The senior optical laboratory NCO deploys with the MCP.

CIVIL AFFAIRS SECTION

2-95. The CA section (Table 2-12) integrates CMO planning within the MEDCOM (DS) AO and with the ASCC G-9. This section provides the regional focus (paragraph 2-4) of the GCC area of responsibility. This section conducts area assessments and estimates on the impact of the local populace on MEDCOM (DS) operations to include the assessment of the host/foreign nation medical infrastructure. The CA section facilitates and develops assessments of host nation country's medical infrastructure to assist the MEDCOM (DS) commander in planning and executing AHS support in the theater. This section develops cross-cultural communications to facilitate interpersonal relationships in a host nation environment. This

section assists the MEDCOM (DS) commander in preparing medical functional studies, assessments, and estimates of how the host nation civilian and military populations affect patient workloads in US MTFs. It provides assistance to and liaisons for NGO and the International Committee of the Red Cross that offer medical treatment/supplies to the host nation involved in the conflict/operation. Refer to for FM 8-42 for the medical aspects of stability operations.

Table 2-12. Civil affairs section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Civil affairs section	38A00	O5	Civil affairs officer**	CA
	38A00	O3	Civil affairs officer	NC
	66B00	O3	Community health nurse**	AN
	66B00	O3	Community health nurse	AN

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AN Army Nurse Corps
AOC area of concentration
CA civil affairs
MOS military occupational specialty
NC noncommissioned officer

Civil Affairs Officers

2-96. The CA officer (LTC/O5, AOC 38A00) normally locates with the OCP and is responsible for the integration of CMO activities into the MEDCOM (DS) OPLAN. He facilitates and develops assessments of the host nation medical infrastructure to assist the MEDCOM (DS) commander in planning and executing AHS support in the theater. He assists the MEDCOM (DS) commander in preparing medical functional studies, assessments, and estimates of the impact of displaced civilian operations in regard to the affect on US military MTFs. He provides liaison to the ASCC G-9 in order to facilitate the medical operations of various NGOs and international organizations operating within the theater. In conjunction with the SJA, advises the MEDCOM (DS) commander regarding his legal and moral obligations to the indigenous civilian population. The CA officer deploys with the OCP.

2-97. The CA officer (CPT/O3, AOC 38A00) performs duties as the CA staff and prepares economic, cultural, governmental and special functional studies, assessments, and estimates. Coordinates with, enhances, develops, establishes, or controls civil infrastructures in operational areas to support friendly operations. He provides CA advice and assistance to subordinate commanders and, when directed, civil paramilitary, host nation leaders, and agencies. He directs and participates in the conduct of CA conventional, foreign internal defense, unconventional warfare, civil administration and other operations. He develops cross-cultural communicative and linguistic skills that facilitate interpersonal relationships in a host nation environment. The CA officer deploys with the MCP.

Community Health Nurses

2-98. The community health nurses (CPT/O3, AOC 66B00) coordinate the appropriate medical care for indigenous personnel with the MEDCOM (DS) AO. They anticipate and prepare for the operations/situational impact on human health issues in order to facilitate as soon as possible the return to the preoperational/situational level of health or better. One community health nurse deploys with the OCP and one with the MCP.

DEPUTY CHIEF OF STAFF, INFORMATION MANAGEMENT

2-99. The deputy chief of staff, information management (Table 2-13) is responsible for all aspects of automation and communications-electronics (CE) support within the MEDCOM (DS). This section establishes a medical automation office and is responsible for medical automation policy and guidance for all subordinate commands. This section identifies CE requirements for data transmission services and

coordinates these requirements with the signal command. This section provides advice and consultation on the interface of medical automation systems with other automated systems within the theater.

Table 2-13. Deputy chief of staff, information management

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Deputy chief of staff, information management	70D67	O6	Deputy chief of staff, information management	MS
	70D67	O5	Biomedical information management officer**	MS
	25A00	O4	Communication electronics officer	SC
	25A00	O4	Communication electronics officer**	SC
	70D67	O4	Biomedical information management officer**	MS
	70D67	03	Health service system manager	MS
	251A0	W2	Information system technician**	WO
	251A0	W2	Information system technician	WO
	25B5O	E8	Information system chief	NC
	25U5O	E8	Signal support system chief**	NC
	25B3O	E6	Information system team chief**	NC
	25B2O	E5	Senior information systems specialist	NC
	25B1O	E4	Information system specialist**	
	25U1O	E4	Signal information service specialist**	
	42AOO	E4	Human resources specialist	
	25U1O	E3	Signal support information specialist**	
	25B1O	E3	Information system specialist**	

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
SC Signal Corps
WO warrant officer

Deputy Chief of Staff, Information Management

2-100. The deputy chief of staff, information management (COL/O6, AOC 70D67) is responsible for advising the commander and staff on all automatic data processing and information management matters affecting the command. The deputy chief of staff, information management deploys with the MCP.

Biomedical Information Management Officers

2-101. The biomedical information management officer (LTC/O5, AOC 70D67) serves as the assistant chief of staff, information management and is responsible for advising the deputy commander and staff on all automatic data processing and information management matters affecting the command in the OCP. The biomedical information management officer deploys with the OCP

2-102. The biomedical information management officer (MAJ/O4, AOC 70D67) advises and assists the assistant chief of staff, information management and the deputy commander in this area of health care information management and/or biomedical systems engineering in the OCP. He formulates policies and plans for the development, implementation, operation and evaluation of patient-oriented information systems and medical administration information support systems. He integrates telecommunications, automation, visual information, and records management with subordinate units. He provides managerial expertise and technical guidance in planning, developing, implementing, operating, maintaining, and disposing of information systems. He conducts technical analysis to implement information systems; plans, develops, operates and maintains, disposes of automation, telecommunications, visual information, and records management needed to support health care operations. The biomedical information management officer deploys with the OCP.

2-103. The health services system manager (a biomedical information management officer) (CPT/O3, AOC 70D67) supports the biomedical information management officer in advising and assisting the deputy chief of staff, information management, in this area of health care information management and/or biomedical systems engineering. His duties are similar to those described in paragraph 2-102. The health services system manager deploys with the MCP.

Communications-Electronics Officers

2-104. The CE officers (MAJ/O4, AOC 25A00) are responsible for advising on all CE matters, including location of headquarters, location of CE facilities, and the use of signal activities. They serve as the principal signal advisors to the MEDCOM (DS) commander on all communications matters. They are responsible to the deputy chief of staff, information management for the planning, supervising, coordinating, and providing technical assistance in the installation, operation, management, and operator-level maintenance of radio, field wire, and switchboard communications systems. They supervise all subordinate communications personnel and are the primary signal operations officer in each command post. One CE officer deploys with the OCP and one with the MCP.

Information System Technicians

2-105. The information system technicians (CWO/O2, MOS 251A0) manage personnel and equipment assets associated with automated information system (AIS), internet protocol (IP) networks to include the internetworking of systems in the OCP. They perform configuration management. They develop maintenance programs for organizational AIS. They execute AIS recovery procedures and execute the system integration plan. These officers develop and implement a software installation plan. They evaluate present AIS requirements to validate the information management plan. They prepare mission need statements to acquire new AISs. They implement security training and awareness programs and information systems security training plans. They conduct AIS security inspections and prepare and evaluate the AIS accreditation plan. They develop contingency operation for tactical internet and monitor implementation. They direct AIS network operating system software installation and the installation of AIS application software on a server. They direct the setup of a personal computer for stand-alone operations. They develop standing operating procedures for the AIS network. Further, they diagnose AIS malfunctioning components and direct necessary corrective action. They evaluate new software for AIS. They direct AIS network hardware installation and integration of AIS into a tactical network. They implement a tactical intranet/web. They implement a tactical video teleconferencing system. They perform systems administration of tactical AIS and network administration of tactical AIS. Additionally, they direct training of personnel in the installation, operation, administration, and maintenance of tactical AIS internet. One information system technician deploys with the OCP and one with the MCP.

Signal Support System Personnel

2-106. The signal support system chief (MSG/E8, MOS 25U5O) is responsible for integrating signal systems and networks; installing operating, and maintaining designated radio and data systems; performing signal support functions; and training and providing technical assistance to the users of signal equipment. The signal support system chief deploys with the OCP.

2-107. The signal information service specialist (SPC/E4, MOS 25U1O) assists in those duties as discussed in paragraph 2-106. The signal information service specialist deploys with the OCP.

2-108. The signal support information specialist (PFC/E3, MOS 25U1O) assists in those duties as discussed in paragraph 2-106. The signal support information specialist deploys with the OCP.

Information Systems Personnel

2-109. The information system chief (MSG/E8, MOS 25B5O) is responsible for equipment assets associated with AIS and IP networks to include the internetworking of systems in the OCP. The information system chief deploys with the OCP.

2-110. The senior information systems specialist (SGT/E5, MOS 25B2O) supports the information system chief in the management of equipment assets associated with AIS and IP networks to include the internetworking of systems. The senior information systems specialist deploys with the MCP.

2-111. The information system specialist (SPC/E4, MOS 25B1O) supports the information system chief by accomplishing the duties discussed in paragraph 2-110. The information system specialist deploys with the OCP.

2-112. The information system specialist (PFC/E3, MOS 25B1O) performs duties as discussed in paragraph 2-110. The information system specialist deploys with the OCP.

Human Resources Specialist

2-113. The HR specialist (SPC/E4, MOS 42A1O) requisitions and maintains office supplies, blank forms, and publications and military/nonmilitary correspondence in draft/final copy. Further, he maintains files and posts changes to Army regulations/publications. The HR specialist deploys with the MCP.

DEPUTY CHIEF OF STAFF, COMPTROLLER

2-114. The deputy chief of staff, comptroller (Table 2-14) is responsible for budget preparation and resource management analysis and implementation for the command. It provides staff assistance on budget matters; establishes funding ceilings for subordinate units; and monitors budget program execution. This section coordinates funding of foreign humanitarian assistance and other operations which may require special and/or additional funding. This section funds approved contractual services and materiel. Further, it monitors and provides advice and assistance on reimbursement for medical services rendered from third parties, other Services, and multinational forces, as specified by regulations, memorandum of agreements or understandings.

Table 2-14. Deputy chief of staff, comptroller

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Deputy chief of staff, comptroller	70C67	O6	Deputy chief of staff, comptroller	MS
	70C67	O4	Health services comptroller**	MS
	44C5O	E8	Financial management advisor	NC
	44C3O	E6	Senior financial management analyst**	NC
	44C2O	E5	Accounting analyst	NC
	44C2O	E5	Internal control analyst	NC
	44C1O	E4	Accounting technician	

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
MS Medical Service Corps
MOS medical occupational specialty
NC noncommissioned officer

Deputy Chief of Staff, Comptroller

2-115. The deputy chief of staff, comptroller (COL/O6, AOC 70C67) directs and coordinates finance and accounting functions and serves as the adviser to the commander on all financial matters. The deputy chief of staff, comptroller deploys with the MCP.

Health Services Comptroller

2-116. The health services comptroller (MAJ/O4, AOC 70C67) performs and coordinates finance and accounting functions and serves as the advisor to the deputy commander on all financial matters in the OCP. The health services comptroller deploys with the OCP.

Financial Management Personnel

2-117. The financial management advisor (MSG/E8, MOS 44C5O) performs duties in the preceding level of skill, provides technical guidance to personnel in accomplishment of those duties and supervises financial management operations. He is the senior enlisted financial management advisor and provides technical and operational advice to the deputy chief of staff, comptroller on all matters relating to financial management. As the senior enlisted financial management inspector of the command, he inspects all functions and activities of financial management. The financial management advisor deploys with the MCP.

2-118. The senior financial management analyst (SSG/E6, MOS 44C3O) performs and coordinates finance and accounting functions and serves as the advisor to the deputy commander on all financial matters in the OCP. The senior financial management analyst deploys with the OCP.

2-119. The accounting analyst (SGT/E5, MOS 44C2O) performs duties of the preceding level of skill. He verifies accuracy of commitment registers, accounting documents and databases, disbursing reports, and documents, travel vouchers, vendor payments, and pay documents. He establishes and maintains pay accounts on foreign nationals. The accounting analyst deploys with the MCP.

Internal Control Analyst

2-120. The internal control analyst (SGT/E5, MOS 44C2O) performs duties of the preceding level of skill. He verifies accuracy of commitment registers, accounting documents and databases, disbursing reports and documents, travel vouchers, vendor payment, and pay documents. He establishes and maintains pay accounts on foreign nationals. The internal control analyst deploys with the MCP.

Accounting Technician

2-121. The accounting technician (SPC/E4, MOS 44C1O) receives and posts funding, commitment, and obligations documents to accounting and budget systems. He receives and processes treasury checks for payment. He maintains disbursing files and prepares periodic financial reports. He receives reviews, prepares, and computes travel vouchers. Further, he receives, reviews, and processes pay documents. The accounting technician receives and reviews contracts, invoices and receiving reports. He prepares payment vouchers in accordance with various government regulations. He performs duties as cashier. The accounting technician deploys with the MCP.

CLINICAL SERVICES

2-122. The clinical services (Table 2-15) personnel serve as the commander's principal consultants and technical advisors for the command in general medicine, neuropsychiatry (NP), COSC, BH, pharmacy services, clinical practices, procedures, and protocols, and optometry. This section is responsible for developing and implementing clinical policies and procedures for the commander. Further, this section monitors and coordinates with subordinate medical functional staff sections.

2-123. This staff section is responsible for—

- Neuropsychiatry, BH, and COSC to include establishing and monitoring policies, programs, and consultations services; advising on the medical evacuation priorities, procedures, medications, and types of platforms to use for stress-related or mentally ill patients; and coordinating for reconstitution, reinforcement, or augmentation of forward-deployed BH assets.
- Medical and surgical services to include providing consultation support, monitoring patient statistical data on types of wounds, injuries, and illnesses to identify trends, ensuring required professional skills are available and requesting augmentation when required, monitoring care of EPW or personnel in US custody (retained/detained), recommending the designation of MTFs for specific situations or medical conditions (such as for EPW patients only or all cases of head trauma). This section also develops and implements medical and surgical clinical policies and guidelines which are in consonance with the Defense Medical Standardization Board Deployable Medical Systems Clinical Policy and Guidelines and Patient Treatment Briefs and STANAG 2068. This section identifies medical issues requiring research and clinical investigation.
- Pharmacy to include developing and establishing a theater formulary, monitoring pharmacy operations within the command to ensure compliance with regulatory requirements, providing consultation on prescription and investigational new drug, establishing policy and procedures for dispensing over-the-counter drugs, monitoring proficiency of enlisted pharmacy personnel, and establishing training programs as required.
- Optometry to include monitoring the occupational vision program, providing consultation on all matters pertaining to vision evaluation and correction, and developing protocols for the diagnosis and treatment of ocular injuries and diseases in concert with supporting ophthalmologist.
- Medical laboratory to include monitoring medical laboratory operations within the command to ensure adequate capability is available to meet medical laboratory requirements, coordinating for reconstitution, reinforcement, or augmentation of medical laboratory resources, as required, and providing consultation to subordinate medical laboratory personnel.

2-124. This section ensures that health care providers are properly credentialed and their scope of practice is defined. They also establish quality assurance measures and peer review of technical matters. This

section is also responsible for establishing and monitoring professional medical education and training programs and policies.

2-125. This section, in conjunction with the patient administration officers in the TPMC, monitors the maintenance and disposition of patient medical records.

Table 2-15. Clinical services

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Clinical services	00B00	O7	Deputy commander, professional services	GO
	60W00	O6	Psychiatrist	MC
	61F00	O6	Medical consultant**	MC
	61J00	O6	Surgical consultant**	MC
	67E00	O6	Pharmacy officer**	MS
	67F00	O5	Optometry officer	MS
	73A67	O5	Social worker	MS
	72A67	O5	Nuclear medical science officer	MS
	01A00	O2	Aide-de-camp	IMM
	68Q5O	E8	Senior pharmacy noncommissioned officer	NC
	68W5O	E8	Senior health care noncommissioned officer	NC
	92G3O	E6	Enlisted aide	NC
	88M2O	E5	Vehicle driver	NC

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
GO general officer
IMM immaterial
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Deputy Commander for Professional Services

2-126. The deputy commander for professional services (Brigadier General/O7, AOC 00B00) is the director of all clinical services within the command and monitors the standard of care provided in command MTFs. He develops, implements, and monitors clinical policy, consultation services, and medical programs of the command. He provides guidance and consultation on medical ethics issues. When designated, he serves as the detainee operations medical director for all internment facilities within the theater. The deputy commander for professional services deploys with the MCP.

Psychiatrist

2-127. The psychiatrist (COL/O6, AOC 60W00) provides consultative services, monitors COSC activities, and may examine, diagnose, and treat or prescribe course of treatment for personnel suffering from emotional or behavioral illness, or situational maladjustment. The psychiatrist deploys with the MCP.

Medical Consultant

2-128. The medical consultant (COL/O6, AOC 61F00) provides consultative services and may examine, diagnose, and treat or recommend course of management for adults with medical illnesses. This physician maintains visibility of medical treatment issues and mitigation of evolving health threats to ensure subordinate MEDBDEs and MTFs are informed, equipped, and supplied to provide appropriate treatment. He works closely with the PVNTMED section to identify and mitigate disease processes, vectors, and biological threats. The medical consultant deploys with the OCP.

Surgical Consultant

2-129. The surgical consultant (COL/O6, AOC 61J00) provides consultative services and may examine, diagnose, and treat or prescribe courses of treatment and surgery for patients having injuries, or disorders with surgical conditions, and performs required surgery. He maintains visibility of the joint trauma system patient treatment issues, wounding patterns, and weapons effects in order to ensure subordinate MEDBDEs and MTFs are informed, equipped, and supplied to provide appropriate treatment. He works closely with the TPMC to ensure surgical patients are evacuated to the appropriate MTF. He is the primary advisor to the MEDCOM (DS) commander regarding the utilization and assignment of FSTs in the theater. The surgical consultant deploys with the OCP.

Pharmacy Officer

2-130. The pharmacy officer (COL/O6, AOC 67E00) plans, implements, directs, executes, and evaluates pharmaceutical care activities within the MEDCOM (DS). His duties include clinical and consultative pharmacy and pharmacy management administration. He works closely with the deputy chief of staff, logistics and MEDLOG support section to synchronize formularies within the theater with the logistics support available to ensure efficiencies are met and pharmacological supply requests are processed accurately. He provides reachback to the US Army Medical Materiel Agency and the Defense Medical Standardization Board on formulary and pharmaceutical issues. He assists and advises subordinate medical units during stability operations on dosing for pediatric and geriatric patients. The pharmacy officer deploys with the OCP.

Optometry Officer

2-131. The optometry officer (LTC/O5, AOC 67F00) provides consultative services and may serve as a primary health care provider. The optometry officer is the clinical advisor to the deputy commander, professional services on all aspects of optometry support. As a provider, he may independently conduct examinations to prevent, diagnose, treat, and manage diseases and disorders of the visual system, the eye and associated structures, as well as diagnose related systemic conditions. He prescribes spectacles, contact lenses, low vision aids, medicines and other therapy to treat eye injuries and disease. He may use medical/surgical instruments in providing treatment. His duties include direct patient care, consultation, research, training, vision conservation and readiness, staff assignments, and laboratory management. The optometry officer deploys with the MCP.

Social Worker

2-132. The social worker (LTC/O5, AOC 73A67) provides support services concerning group interventions on the institutional level. He coordinates with public and private social service agencies to include NGOs providing services required with host nation support and CMO. The social worker deploys with the MCP.

Nuclear Medical Science Officer

2-133. The nuclear medical science officer (LTC/O5, AOC 72A67) executes medical planning, issues guidance, and executes health risk assessments for CBRN threats. He identifies nonmilitary radiological threat sources and provides guidance on rendering safe and safeguarding these sources, as well as health risk assessment of such operations. He mitigates the health impact of civil and military radiation facilities to the force especially if they are damaged. Further, he provides guidance and expert analysis to ensure injury prevention, situational monitoring, and recommends use of potassium iodide per the Food and Drug Administration/Nuclear Regulatory Commission guidelines for units that must operate near nuclear power reactors. He works closely with the chemical officers and NCO to develop countermeasures and procedures dealing with patient decontamination and evacuation, as well as the use of collective protection and improvised shelter protection against CBRN agents. He coordinates with the theater radiation safety officer on radiation issues. In the absence of a theater radiation safety officer, serves as the theater subject matter expert for radiological and nuclear issues. The nuclear medical science officer deploys with the MCP.

Aide-de-Camp

2-134. The aide-de-camp (Lieutenant /O2, AOC 01A00) performs such duties as directed by the deputy commander, professional services. The aide-de-camp deploys with the MCP.

Senior Pharmacy Noncommissioned Officer

2-135. The senior pharmacy NCO (MSG/E8, MOS 68Q5O) provides support to the pharmacy officer in directing, planning, coordinating, and implementing the quality assurance program for the entire spectrum of medical materiel and pharmaceuticals for the MEDCOM (DS). The senior pharmacy NCO deploys with the MCP.

Senior Health Care Noncommissioned Officer

2-136. The senior health care NCO (MSG/E8, MOS 68W5O) provides advice to the deputy commander professional services on all matters relating to those enlisted personnel working in clinical staff positions. He provides support to the section in directing, planning, and coordinating AHS support for the theater. The senior health care NCO deploys with the MCP.

Enlisted Aide

2-137. The enlisted aide (SSG/E6, MOS 92G3O) performs such duties as directed by the deputy commander, professional services. The enlisted aide deploys with the MCP.

Vehicle Driver

2-138. The vehicle driver (SGT/E5, MOS 88M2O) operates a wheeled vehicle for the deputy commander, professional services and is the radio operator for the section. The vehicle driver deploys with the MCP.

DENTAL SERVICES

2-139. Dental services (Table 2-16) personnel serve as the commander's principal consultants and the command's technical advisor in dentistry. This section directs the establishment and implementation of policy and programs for all dental activities, this includes preventive dentistry and educational programs, operational dental care (emergency and essential), and oral and maxillofacial surgical procedures. This section ensures oral health surveillance policies, programs, and procedures are developed and implemented within the theater. It also advises the commander on the dental aspects of foreign humanitarian assistance operations, plans, and programs, as required. For additional information on operational dental care refer to FM 4-02.19.

Table 2-16. Dental services

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Dental services	63R00	O6	Dental surgeon	DC
	63H00	O5	Public health dentist	DC
	68Z5O	E9	Chief dental noncommissioned officer	NC

LEGEND
AOC area of concentration
DC Dental Corps
MOS military occupational specialty
NC noncommissioned officer

Dental Surgeon

2-140. The dental surgeon (COL/O6, AOC 63R00) is the senior dental advisor to the deputy commander, professional services and the MEDCOM (DS) commander. He serves as the dental surgeon for the command. He provides consultative services, establishes dental policies and procedures and may examine, diagnose, and treat or prescribe course of treatment and surgery for patients having injuries or disorders with dental conditions and performs required surgery. The dental surgeon deploys with the MCP.

Public Health Dentist

2-141. The public health dentist (LTC/O5, AOC 63H00) conducts research, studies and analyses of epidemiologic and dental health issues. He makes recommendations on policies and programs for dental health and provides consultation and advice to the CA officer on CMO dental operations or activities. The public health dentist deploys with the MCP.

Chief Dental Noncommissioned Officer

2-142. The chief dental NCO (SGM/E9, MOS 68Z5O) is the principal NCO who supervises and performs related duties as the senior enlisted dental advisor to the dental surgeon and deputy commander, professional services. He monitors dental activities in subordinate commands and compiles appropriate statistical data and reports. The chief dental NCO deploys with the MCP.

VETERINARY SERVICES

2-143. Veterinary services (Table 2-17) personnel serve as the commander's principal consultant and the command's technical advisor for veterinary activities and employment of veterinary assets. It provides technical supervision of food inspection, animal medical care, and veterinary PVNTMED support. The US Army is the Executive Agent for veterinary services for all Services (DODD 6400.4) (with the exception of food inspection operations on USAF installations). Refer to FM 4-02.18 for additional information.

Table 2-17. Veterinary services

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Veterinary services	64Z00	O6	Senior veterinarian**	VC
	68R5O	E9	Senior veterinary noncommissioned officer**	NC

LEGEND
**MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
MOS military occupational specialty
NC noncommissioned officer
VC Veterinary Corps

Senior Veterinarian

2-144. The senior veterinarian (COL/O6, AOC 64Z00) plans, directs and supervises veterinary activities within the theater. He coordinates veterinary support issues with the ASCC surgeon and/or combatant command surgeon. Further, he coordinates veterinary support of CMO activities and programs with the CA officer and the ASCC G-9. The senior veterinarian deploys with the OCP.

Senior Veterinary Noncommissioned Officer

2-145. The senior veterinary NCO (SGM/E9, MOS 68R5O) serves on the veterinary staff and provides staff advice and coordination of veterinary activities with other staff sections, subordinate veterinary units, DOD organizations, and as required with host nation counterparts. He participates in command review of subordinate unit activities, evaluates training programs and provides recommendations for improvement. He develops budgets, training schedules, and authorization documents. He assists the senior veterinarian in strategic planning, composite risk management procedures, tactical communication plans, and advises the senior veterinarian and CSM on all issues involving enlisted veterinary MOS Soldiers. The senior veterinary NCO deploys with the OCP.

NUTRITION CARE SERVICES

2-146. Nutrition care services (Table 2-18) personnel serve as the commander's principal consultant and the command's technical advisor in nutrition care. This section ensures the coordination required to obtain medical supplemental rations is accomplished and that assigned and attached hospitals have required items to prepare medical diets. This section also coordinates with the unit ministry team to ensure the availability of rations for hospitalized patients with religion-based dietary restrictions. This section coordinates with CA officers when nutrition issues arise in CMO.

Table 2-18. Nutrition care services

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Nutrition care services	65C00	O6	Dietetic consultant	SP
	68Z5O	E9	Chief nutrition noncommissioned officer	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
NC noncommissioned officer
SP Army Medical Specialist Corps

Dietetic Consultant

2-147. The dietetic consultant (COL/O6, AOC 65C00) formulates policies, develops procedures, and directs and supervises the operation of nutrition care services and the provision of comprehensive nutrition care programs. He provides advice and oversight of medical food preparation and service systems in MTFs and field medical units. He ensures modified diets and foods are available and prepared for patients in the CSH. He coordinates and ensures the procurement and receipt of safe, wholesome food items/rations for patients and staff during wartime and peacetime. He develops and implements nutrition health promotion programs for the military community and develops and directs nutrition education or dietary intervention programs for deployed forces. He assists the physician with nutritional assessment and therapeutic dietary intervention of patients and participates and conducts applied research. He serves as a consultant at all levels of nutrition-related health and performance issues and medical food service operation in Role 3 MTFs. He develops, implements, and directs nutrition and medical food service education programs for hospital food service specialists and other medical personnel. The dietetic consultant provides advice and consultation in developing diets for EPWs, retained personnel, and detainees. He also provides advice and consultation in the development of nutrition programs for refeeding operations for famine victims and other malnourished civil populations during stability operations. The dietetic consultant deploys with the MCP.

Chief Nutrition Noncommissioned Officer

2-148. The chief nutrition NCO (SGM/E9, MOS 68Z5O) is the principal NCO who supervises and performs related duties as the senior advisor to the dietetic consultant and subordinate units performing nutrition care operations. He provides advice in establishing nutrition care plans for host nation personnel, EPW, and detainees that incorporate cultural and religious considerations in menu planning and food preparation. The chief nutrition NCO deploys with the MCP.

CHIEF NURSE

2-149. The chief nurse (Table 2-19) serves as the commander's principal advisor on all issues affecting nursing practices and personnel. This section develops, plans, and implements policies for nosocomial infection control and quality assurance nursing programs. The chief nurse (nursing consultant) is responsible for nursing policy, resourcing, and technical supervision of subordinate nursing personnel. This section analyzes and evaluates nursing care and procedures in subordinate units. The nursing consultant evaluates host nation health care delivery systems and hospitalization capabilities and integrates clinical policy with joint and multinational forces.

Table 2-19. Chief nurse

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Chief nurse	66N00	O6	Nursing consultant	AN
	68Z5O	E9	Chief clinical noncommissioned officer	NC

LEGEND
AN Army Nurse Corps
AOC area of concentration
MOS military occupational specialty
NC noncommissioned officer

Nursing Consultant

2-150. The nursing consultant (COL/O6, AOC 66N00) serves as the principal advisor to the commander on all nursing issues and other duties as stated in paragraph 2-149. The nursing consultant deploys with the MCP.

Chief Clinical Noncommissioned Officer

2-151. The chief clinical NCO (SGM/E9, MOS 68Z5O) is the principal NCO who supervises and performs related duties as the senior advisor to the nursing consultant. He advises the nursing consultant on any issues arising with enlisted nursing personnel. He provides advice and consultation services to subordinate units on policies and procedures relating to nursing care and practices. The chief clinical NCO deploys with the MCP.

PREVENTIVE MEDICINE SECTION

2-152. The PVNTMED section (Table 2-20) serves as the commander's principal consultant and the command's PVNTMED and environmental sciences advisors. This section develops, plans, and implements PVNTMED policies and programs for the theater. These programs include medical surveillance, OEH surveillance, pest management activities, epidemiological investigations, food service facility sanitation and hygiene, and inspection of potable water supplies. This section monitors and analyzes DNBI reports submitted by subordinate medical units. It performs trend analysis which is used to identify shifts from the baseline of diseases within the AO (as a shift may indicate the use of biological warfare agents against the deployed force). It also evaluates host nation capabilities and integrates PVNTMED policy with joint and/or multinational forces. This section coordinates with the CA section for operations to restore essential services in the host nation during stability operations. Refer to AR 40-5 and DA Pamphlet 40-11 for additional information on PVNTMED programs. This section provides advice and consultation on PVNTMED measures and issues arising in theater internment facilities.

2-153. This section, in conjunction with the chemical officer advises the DCSSPO and the MEDCOM (DS) commander on the medical aspects of CBRN defensive measures. This includes, but is not limited to, policies, programs, and procedures pertaining to immunizations, chemoprophylaxis, barrier creams, pretreatments, and the use of investigational new drugs. For additional information on PVNTMED refer to FM 4-02.17 and for additional information on CBRN defensive measures refer to FM 4-02.7.

Table 2-20. Preventive medicine section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Preventive medicine section	60C00	O6	Preventive medicine officer	MC
	72B67	O5	Entomologist**	MS
	72D67	O5	Environmental science officer	MS
	72D67	O5	Environmental science officer**	MS
	72E67	O5	Environmental engineer**	MS
	68S5O	E9	Chief preventive medicine noncommissioned officer	NC

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
MC Medical Corps
MS Medical Service Corps
MOS military occupational specialty
NC noncommissioned officer

Preventive Medicine Officer

2-154. The PVNTMED officer (COL/O6, AOC 60C00) is the principal advisor to the commander on PVNTMED issues and operations. He develops and implements policies and procedures for PVNTMED programs and operations. He determines the status of and conditions influencing the health of military and

appropriate civilian personnel; formulates and recommends measures for health improvements; and plans, coordinates, and directs a program designed to maintain the health of the command, improve physical fitness, and prevent disease and injury. He provides advice and the status of PVNTMED activities in internment facilities within the theater and recommends policies, procedures, and training required to enhance sanitation practices and mitigate problems. This physician maintains a regional focus of the ASCC and combatant command area of responsibility. He establishes and maintains contacts with the medical community in the region to promote regional cooperation in resolving and mitigating the effects of underlying health issues in the region. The PVNTMED officer deploys with the MCP.

Entomolgist

2-155. The entomologist (LTC/O5, AOC 72B67) plans, leads, manages, advises, directs, and participates in research, operational and consultative medical entomology, and pest management activities. He provides the effective control of pests and vectors of disease affecting the health, morale, and environment in the theater. He ensures that the medical surveillance programs and activities are being implemented, data is being maintained and analyzed, and trends are being identified in a timely manner. He advises the MEDCOM (DS) commander and deputy commander, professional services on measures and methods for eliminating pests in MEDCOM (DS) facilities and AOs. The entomologist deploys with the OCP.

Environmental Science Officers

2-156. The environmental science officers (LTC/O5, AOC 72D67) advise on or perform professional and scientific work in environmental health and industrial hygiene. Their functions include identification, evaluation, and formulation of recommendations for the control of potential health hazards. They develop environmental health and industrial hygiene criteria and standards, policies, programs, practices, and operations directed toward the prevention of disease, illness, and injury. They ensure that the OEH surveillance programs and activities are being implemented, evaluate data, and identify trends. There are two environmental science officers assigned to this section. One environmental science officer deploys with the OCP and one with the MCP.

Environmental Engineer

2-157. The environmental engineer (LTC/O5, AOC 72E67) advises on or performs professional and scientific work utilizing environmental engineering principles and practices to protect health and the environment. His duties include the assessment of existing and proposed weapons, equipment, clothing, training devices, and materiel systems. His activities relate to the design and formulation of recommendations to preserve and enhance health and environmental conditions including: air, water, noise, liquid and solid waste disposal, and institutional hygiene. The environmental engineer deploys with the OCP.

Chief Preventive Medicine Noncommissioned Officer

2-158. The chief PVNTMED NCO (SGM/E9, AOC 68S5O) assists the PVNTMED officer with his duties to include writing, developing, and coordinating command wide regulations and policies relating to PVNTMED services. He participates in command review and approval of subordinate unit activities. He assists in planning and placement of PVNTMED units. Further, he evaluates training programs and provides recommendations for improvement. He participates in studies and reviews and maintains records of strength, location, and employment of PVNTMED assets. The chief PVNTMED NCO deploys with the MCP.

INSPECTOR GENERAL SECTION

2-159. This inspector general section (Table 2-21) is responsible to the commander for inquiring into and reporting on matters that impact the overall efficiency of the command to include the performance of the mission, state of discipline, operating efficiency, and economy. The inspector general section conducts inspections, investigations, surveys, and studies as the commander directs and as laws and regulations prescribe.

Table 2-21. Inspector general section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Inspector general section	05A00	O5	Inspector general	IMM
	05A00	O4	Inspector general**	IMM
	68W5B	E8	Inspector general noncommissioned officer	NC
	68W4B	E7	Inspector general noncommissioned officer**	NC

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
IMM immaterial
MOS military occupational specialty
NC noncommissioned officer

Inspector Generals

2-160. The inspector general (LTC/O5, AOC 05A00) serves as the principal advisor to the MEDCOM (DS) commander for command inspections and other investigations. The inspector general deploys with the MCP.

2-161. The inspector general (MAJ/O4, AOC 05A00) serves as the principal advisor to the deputy commander for command inspections and other investigations. The inspector general deploys with the OCP.

Inspector General Noncommissioned Officers

2-162. The inspector general NCO (MSG/E8, MOS 68W5B) is the principal NCO who supervises and performs related duties as the senior advisor to the inspector general on all matters pertaining to enlisted personnel. The inspector general NCO deploys with the MCP.

2-163. The inspector general NCO (SFC/E7), MOS 68W4B) is responsible for completing reports as required. He assists the inspector general with the performance of his duties in the OCP. The inspector general NCO deploys with the OCP.

PUBLIC AFFAIRS SECTION

2-164. The public affairs section (Table 2-22) serves as the commander's focal point for command information, public information, and community relations matters. The MEDCOM (DS) public affairs officer (PAO) has the overall responsibility for building an understanding of Army health care services/programs within the AO. Additionally, as the official spokesperson for the command, releases information, as appropriate, on the medical aspects of—

- Incidents, engagements, or accidents involving other commands, Services, and/or multinational forces.
- Stability operations in conjunction with the CA officer.
- Controversial issues that are likely to attract national media attention.
- Detainee medical operations.

Table 2-22. Public affairs section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Public affairs section	46A00	O5	Public affairs officer	IMM
	46A00	O4	Public affairs officer**	IMM
	46Z4O	E7	Public affairs operations noncommissioned officer**	NC

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
IMM immaterial
MOS military occupational specialty
NC noncommissioned officer

Public Affairs Officers

2-165. The PAO (LTC/O5, AOC 46A00) serves as the principal advisor to the commander on all command (internal) information and public information (including media and community relations). The PAO deploys with the MCP.

2-166. The PAO (MAJ/O4, AOC 46A00) advises the deputy commander on all public affairs matters. He develops, coordinates, and supervises these activities within the command. The PAO deploys with the OCP.

Public Affairs Operations Noncommissioned Officer

2-167. The public affairs operations NCO (SFC/E7, MOS 46Z4O) plans and organizes work schedules and assigns specific tasks in support of command information and public affairs programs. He supervises the preparation of information for release on Army matters through news releases, articles, web-based media, and photographs. He facilitates public information through media relations. Further, this NCO supervises or prepares evaluations, reports, correspondence, records, and plans pertaining to Army public affairs programs. This NCO coordinates with Armed Forces Radio and Television Service affiliates/personnel or comparable broadcast activity. The PAO NCO deploys with the OCP.

STAFF JUDGE ADVOCATE

2-168. The functions of the SJA (Table 2-23) are to provide legal advice and services to the commander, staff, subordinate commanders, Soldiers, and other authorized personnel. The SJA section develops and executes plans and programs in the fields of criminal law and related military justice, administrative law, litigation, environmental law, regulatory law, intelligence activities law, labor and civilian personnel law, and medical jurisprudence. This section advises the commander on the legal aspects of determining eligibility for care in US military MTFs. This section also advises the commander on any issues arising with the provisions of the Geneva Conventions and other international treaties or agreements.

Table 2-23. Staff judge advocate

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Staff judge advocate	27A00	O5	Staff judge advocate	JA
	27A00	O3	Judge advocate	JA
	27A00	O3	Judge advocate**	JA
	270A0	W2	Legal administrator	WO
	27D4O	E7	Senior paralegal noncommissioned officer	NC
	27D3O	E6	Court reporter	NC
	27D2O	E5	Paralegal noncommissioned officer**	NC
	27D1O	E4	Paralegal specialist**	
	27D1O	E3	Paralegal specialist	

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
JA Judge Advocate General Corps
MOS military occupational specialty
NC noncommissioned officer
WO warrant officer

Staff Judge Advocate

2-169. The SJA (LTC/O5, AOC 27A00) furnishes legal advice and services to the active Army and deployed Reserve Component Soldiers in civil and criminal legal practice, including the fields of business, property, administration, and financial operations under the jurisdiction of the DA. He provides defense counsel services for Army personnel whenever required by law or regulation and authorized by the Judge Advocate General or his designee. These services include representation at trials by courts-martial, administrative boards, and other criminal and adverse administrative actions. He performs other defense-related duties as prescribed by the US Army Trial Defense Service. The SJA deploys with the MCP.

Judge Advocates

2-170. The judge advocates (CPT/O3, AOC 27A00) assist the SJA in the accomplishment of his duties. These officers perform duties as specified in paragraph 2-169. There are two officers assigned to this section. One judge advocate deploys with the OCP and one with the MCP.

Legal Administrator

2-171. The legal administrator (CWO/W2, MOS 270A0) manages overall military and civilian administrative functions of the SJA section. He directs the accomplishment of the SJA section legal office information management functions, such as correspondence, telecommunications, records management, automation, reprographics, micrographics, forms, printing and publications, and visual aids. He directs training of personnel in the operation of computers, peripherals, and all off-line equipment. Further, this WO analyzes legal operations to determine where automated systems will enhance legal services. He reviews internal automated legal research utilization reports. This warrant office serves as the chief paralegal administrator for administrative law, claims, criminal law, legal assistance, international law (where applicable), and administrative support services. He evaluates management data to determine how

to maximize existing legal support, resources, and improve effectiveness and efficiency of operations, management, and training. He develops and prepares reports pertaining to manpower staffing and utilization programs, manpower survey documents, and organization studies for legal services systems. He develops fiscal requirements, executes program budget guidance, authenticates funding obligations, and monitors all such requirements. He implements Army Law Library service policies, procedures, and systems. Additionally, he authenticates legal and administrative documents. He reviews and develops technical correspondence and reports and provides procedural instruction and guidance to or advises legal officers, commanders and staff, and senior legal NCOs in comprehensive legal technical areas. He ensures technical procedures are complied with in preparation of legal and administrative documents. He performs legal research, drafts documents, memoranda, and administrative opinions. The legal administrator deploys with the MCP.

Paralegal Personnel

2-172. The senior paralegal NCO (SFC/E7, MOS 27D4O) supervises the operation of the paralegal personnel assigned to the SJA and provides consultation and assistance to subordinate command paralegal personnel and activities. He plans, task-organizes, and provides logistical support to the SJA section. This NCO coordinates the requisition and assignment of paralegal specialists/NCOs with the DCSPER and develops and implements training of paralegal specialists/NCOs. The senior paralegal NCO deploys with the MCP.

2-173. The court reporter (SSG/E6, MOS 27D3O) (a paralegal NCO) supervises the operation of the command paralegal personnel. He trains and provides guidance to subordinates on complex paralegal administrative issues. He coordinates with units concerning tasking and training of paralegal specialist and NCOs. He conducts extensive paralegal research and adjudicates personal property claims. The court reporter deploys with the MCP.

2-174. The paralegal NCO (SGT/E5, MOS 27D2O) supervises the OCP paralegal staff. He assists the Judge Advocate as required. He maintains law/administrative library and section files and records. Further, he monitors and reviews actions to ensure accuracy and timely dispatch or disposition. The paralegal NCO deploys with the OCP.

2-175. The paralegal specialist (SPC/E4, MOS 27D1O) operates performs his paralegal responsibilities for the OCP. He assists the SJA as required and maintains law/administrative library and section files and records. He monitors and reviews actions to ensure accuracy and timely dispatch or disposition. The paralegal specialist deploys with the OCP.

2-176. The paralegal specialist (PFC/E3, MOS 27D1O) is responsible to the court reporter and senior paralegal NCO for general typing and administrative functions for the section. The paralegal specialist deploys with the MCP.

COMPANY HEADQUARTERS

2-177. The company headquarters (Table 2-24) commander is responsible for Soldiers assigned to the MEDCOM (DS) headquarters that are not assigned or attached to subordinate commands. Besides the common staff responsibilities, the headquarters commander is responsible for: developing the MEDCOM (DS) headquarters occupation plan; ensuring local headquarters security (to include constructing defensive positions); arranging for and moving the headquarters; training; conducting MWR activities for headquarters personnel; obtaining or providing food service, quarters, health care, field sanitation, and supply for headquarters personnel; receiving, accommodating, and orienting visitors and Professional Filler System personnel; providing and prioritizing motor transportation support (organic to or allocated for use by the headquarters); and maintaining equipment organic to or allocated for use by the headquarters.

Table 2-24. Company headquarters

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Company headquarters	05A00	O3	Commander	MS
	70B67	O2	Executive officer**	MS
	915E0	W3	Senior automotive maintenance warrant officer**	WO
	68W5M	E8	First sergeant	NC
	63X4O	E7	Motor sergeant**	NC
	92Y4O	E7	Senior supply noncommissioned officer**	NC
	92G3O	E6	Senior first cook	NC
	92G3O	E6	Senior first cook**	NC
	92Y3O	E6	Supply sergeant	NC
	92Y3O	E6	Supply sergeant**	NC
	42A2O	E5	Human resources sergeant	NC
	42A2O	E5	Human resources sergeant**	NC
	92G2O	E5	First cook	NC
	92G2O	E5	First cook**	NC
	42A1O	E4	Human resources specialist	
	74D1O	E4	Decontamination specialist	
	74D1O	E4	Decontamination specialist**	
	63B1O	E4	Wheeled vehicle mechanic	
	63B1O	E4	Wheeled vehicle mechanic**	
	52D1O	E4	Power generation equipment repairman	
	52D1O	E4	Power generation equipment repairman**	

Table 2-24. Company headquarters (continued)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Company headquarters (continued)	92A1O	E4	Equipment records/parts specialist	
	92A1O	E4	Equipment records/parts specialist**	
	92G1O	E4	Cook**	
	92Y1O	E4	Armorer	
	92Y1O	E4	Armorer**	
	92A1O	E3	Equip records/parts specialist	
	92G1O	E3	Cook**	
	92G1O	E3	Cook	

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
WO warrant officer

Commander

2-178. The commander (CPT/O3, AOC 05A00) is responsible to the chief of staff for all activities in the company headquarters. He administers Uniform Code of Military Justice actions for enlisted personnel and plans and conducts common task training. The commander deploys with the MCP.

Executive Officer

2-179. The executive officer (First Lieutenant/O2, AOC 70B67) is the company commander's representative in the OCP. He assists in the establishment of the OCPs operational and life support areas. He coordinates and executes local area security with the force protection NCO and DCSSPO. The executive officer deploys with the OCP.

Senior Automotive Maintenance Warrant Officer

2-180. The support automotive maintenance officer (CWO/W3, MOS 915E0) performs duties as the specially trained motor maintenance officer. He manages maintenance requirements by applying technical knowledge and technical management skills and supervises the technical and tactical performance of many different maintainer MOSs. He manages maintenance operations of various types and size and provides advice on equipment systems compatibility, replacement, and economical retention. This WO evaluates performance and quality of equipment through an analysis of maintenance indicators. The senior automotive maintenance WO deploys with the OCP.

First Sergeant

2-181. The first sergeant (1SG/E8, MOS 68W5M) is responsible to the company commander for all enlisted matters. He also assists in supervising company administration and training activities. He

provides guidance to the enlisted members of the company and represents them to the company commander. He also functions as the reenlistment NCO. The 1SG deploys with the MCP.

Motor Sergeant

2-182. The motor sergeant (SFC/E7, MOS 63X4O) performs technical and administrative management, coordination, control, and operational duties as the principal motor maintenance NCO. He reviews quality control procedures relevant to the performance of maintenance, operator training, and dispatching operations. He reviews technical training procedures and advises subordinates on technical training issues. The motor sergeant supervises the activities of the unit motor pool. The motor sergeant deploys with the OCP.

Supply Personnel

2-183. The senior supply NCO (SFC/E7, MOS 92Y4O) is responsible to the 1SG for the requisitioning, accountability, and issuing of general supplies and equipment for the MEDCOM (DS). In addition, he serves as the 1SG's representative in the OCP and assists the executive officer in supervising company personnel. He maintains the property book for the MEDCOM (DS) on the Tactical Army Combat Service Support Computer System, using the standard Property Book Unit Supply – Enhanced system. The senior supply NCO supervises the activities of the subordinate supply personnel. The senior supply NCO deploys with the OCP.

2-184. The supply sergeants (SSG/E6, MOS 92Y3O) manage the receiving, inspecting, inventorying, loading, unloading, segregating, storing, issuing, and turn-in of all organizational and installation supplies and equipment in the MCP and the OCP. They operate automation equipment and prepare all organizational supply documents. They manage automated supply systems for accounting of organizational and installation supplies and equipment. One supply sergeant deploys with the MCP and one with the OCP.

2-185. The armorers (SPC/E4, MOS 92Y1O) assist the supply sergeants in the accomplishment of their duties in the MCP and OCP. They issue and receive small arms to include pistols, rifles, and squad automatic weapons. They secure and control weapons and ammunition in security areas. They schedule and perform preventive and organizational maintenance on weapons. One of the armorers deploys with the OCP and one with the MCP.

Cooks

2-186. The senior first cooks (SSG/E6, MOS 92G3O) coordinate with the food service officer, food advisor, and senior food operations sergeant. They coordinate with the troop issue subsistence activity, facility engineers, and veterinary activity. They plans and implement menus to ensure nutritionally balanced meals in each command post. They ensure the accuracy of accounting and equipment records. They develop and initiate standing operating procedures and safety, energy, security, and fire prevention programs. They evaluate contract food service operations and ensure contractor compliance in food service contract operations. One senior first cook deploys with the MCP and one deploys with the OCP.

2-187. The first cooks (SGT/E5, MOS 92G2O) provide technical guidance to lower grade personnel in field kitchen operations. They ensure that proper procedures, temperatures, and time periods are adhered to during food preparation. They direct safety, security, and fire prevention procedures. Further, they perform limited supervisory and inspection functions including shift supervision. One first cook deploys with the MCP and one with the OCP.

2-188. The cooks (SPC/E4, MOS 92G1O) perform preliminary food preparation procedures in the MCP and OCP. They prepare and/or cook menu items listed on the production schedule. They bake, fry, braise, boil, simmer, steam, and sauté foods as prescribed by Army recipes. They set up serving lines, garnishes food items, and apply food protection and sanitation measures in field environments. They receive and store subsistence items and perform general housekeeping duties. They operate, maintain, and clean field kitchen equipment. They also erect, strike, and store all types of field kitchens. They perform preventive maintenance on field kitchen equipment. One cook deploys with the MCP and one with the OCP.

2-189. The cooks (PFC/E3, MOS 92G1O) perform duties as described in paragraph 2-188. One cook deploys with the MCP and one with the OCP.

Human Resources Personnel

2-190. The HR sergeants (SGT/E5, MOS 42A2O) provide technical guidance to subordinate Soldiers in the accomplishment of duties in each command post. They are the light-vehicle drivers for the section. One HR sergeant deploys with the MCP and one with the OCP.

2-191. The HR specialist (SPC/E4, MOS 42A1O) performs duties as discussed in paragraph 2-35. The HR specialist deploys with the MCP.

Decontamination Specialists

2-192. The decontamination specialists (SPC/E4, MOS 74D1O) are responsible for training personnel on the proper individual and equipment decontamination procedures. They are the light-vehicle drivers for their section. One decontamination specialist deploys with the OCP and one deploys with the MCP.

Wheeled Vehicle Mechanics

2-193. The wheeled vehicle mechanics (SPC/E4, MOS 63B1O) are responsible to the motor sergeant for those mechanical duties within their scope of responsibility. They also perform driver operator duties. One wheeled vehicle mechanic deploys with the OCP and one with the MCP.

Power Generation Equipment Repairmen

2-194. The power generation repairmen (SPC/E4, MOS 52D1O) are responsible to the motor sergeant for those mechanical duties within their scope of responsibility. They also perform driver operator duties. There are two power general repairmen assigned to this section. One power generation equipment repairman deploys with the OCP and one with the MCP.

Equipment Records/Parts Specialists

2-195. The equipment records/parts specialists (SPC/E4, MOS 92A1O) are responsible to the motor sergeant for maintaining equipment records and repair parts lists and performing maintenance control duties in the MCP and the OCP. There are two specialists assigned to this section. One equipment records/parts specialist deploys with the MCP and one with the OCP.

2-196. The equipment records/parts specialist (PFC/E3, MOS 92A1O) is responsible to the motor sergeant for maintaining equipment records and repair parts lists and performing maintenance control duties. The equipment parts specialist deploys with the MCP.

UNIT MINISTRY TEAM

2-197. The unit ministry team (Table 2-25) provides religious support and pastoral care for assigned staff and subordinate organizations. This team develops, exercises staff supervision over, and implements the commander's religious support program; provides moral and spiritual leadership to the command and community; advises the commander and staff, in coordination with the CA officer, of the impact of the faith and practice of indigenous religious groups in the AO; and provides liaison to indigenous religious leaders. This team coordinates with subordinate MEDCOM (DS) chaplains to ensure availability of rations within the theater for hospitalized patients with religion-based dietary restrictions.

Table 2-25. Unit ministry team

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Unit ministry team	56A00	O6	Chaplain	CH
	56A00	O5	Assistant chaplain**	CH
	56M5O	E8	Chaplain assistant noncommissioned officer	NC
	56M2O	E5	Chaplain assistant noncommissioned officer**	NC

LEGEND
** MEDCOM (DS) (Operational Command Post) Staff
AOC area of concentration
CH Chaplain Corps
MOS military occupational specialty
NC noncommissioned officer

Chaplains

2-198. The chaplain (COL/O6, AOC 56A00) functions as the principal advisor to the commander for all matters in which religion impacts on command programs, personnel, policy, and procedures. He provides for the spiritual well-being and morale of MEDCOM (DS) personnel. He also provides religious services and pastoral counseling to Soldiers in the AO. He provides advice and consultation for subordinate chaplains assigned to hospitals or other MTFs on hospital ministry. The chaplain deploys with the MCP.

2-199. The assistant chaplain (LTC/O5, AOC 56A00) is supervised by the MEDCOM (DS) chaplain, coordinates the program of religious ministries, including workshops, pastoral counseling, and religious education. He supervises the activities of the other ministry team staff. The assistant chaplain deploys with the OCP.

Chaplain Assistant Noncommissioned Officers

2-200. The chaplain assistant NCO (MSG/E8, MOS 56M5O) is responsible to the MEDCOM (DS) Chaplain and assists him in his duties. He also supervises the activities of subordinate personnel. The chaplain assistant NCO deploys with the MCP.

2-201. The chaplain assistant NCO (SGT/E5, MOS 56M2O) is responsible to the chaplain assistant for the support of religious operations. He prepares the chapel for worship and prepares sacraments for Protestant, Catholic, Orthodox, and Jewish faiths. He is the light-vehicle driver for the section. The chaplain assistant NCO deploys with the OCP.

JOINT AUGMENTATION

2-202. The MEDCOM (DS) headquarters may be augmented by functional specialists from other Services based on METT-TC and availability of joint augmentation resources. Augmentation support to coordinate and facilitate interoperability in AHS support operations may include USAF aeromedical evacuation liaison teams or other medical regulating personnel to enhance medical regulating and medical evacuation of MEDCOM (DS) patients by the USAF strategic aeromedical evacuation system; US Navy personnel to expedite and deconflict shore-to-ship/ship-to-shore aeromedical evacuation operations conducted by US Army rotary-wing aeromedical evacuation aircraft and hospitalization of US Army personnel in US Navy afloat facilities; USAF/US Navy MEDLOG personnel when the US Army is designated as the SIMLM to ensure responsive MEDLOG support, to include blood management, for Service-unique MEDLOG requirements; and USAF/US Navy communications personnel to assure communications connectivity and interoperability of communications equipment and AIS.

SECTION II — MEDICAL COMMAND (DEPLOYMENT SUPPORT) (OPERATIONAL COMMAND POST)

MISSION AND ASSIGNMENT

2-203. The positions which comprise the MEDCOM (DS) OCP are designated on the TOE from positions within the HHC, MEDCOM (DS) (TOE 08641GA00). The OCP provides C2, administrative assistance, and technical supervision of assigned or attached medical units. The OCP can deploy autonomously into the AO during early entry and theater opening operations. Further, the OCP can be deployed to other AOs outside its habitually supported theater to provide medical C2 in support of that operation.

2-204. The OCP is a deployable, versatile module. It provides interface and liaison with supported forces in the AO and with BCTs. The OCP has an assigned standard requirements code to facilitate the placement of personnel in the command post and to integrate the command post into the Time Phased Force Deployment List.

2-205. As the force builds within the AO, the OCP can be incrementally expanded or be augmented with additional planning and professional expertise with the deployment of personnel from the MCP to build the structure required providing campaign-quality health care to the deployed force.

CAPABILITIES AND LIMITATIONS

2-206. The OCP can conduct early entry operations and serves as the forward medical element of the MEDCOM (DS). The OCP provides connectivity between the HHC, MEDCOM (DS) in CONUS and/or deployed home station and the medical units in the AO.

CAPABILITIES

2-207. The OCP provides appropriate staff elements for C2 and support to assigned or attached units in the AO.

2-208. The OCP is allocated on the basis of one element per HHC, MEDCOM (DS).

2-209. The OCP provides a robust planning, controlling, and coordinating capability to facilitate the provision of health care to an expanding force. The MEDCOM (DS) OCP provides—

- Command and control of theater medical units providing AHS support within the AO.
- Subordinate medical organizations to operate under the MEDBDE and/or MMB and provide medical capabilities to the BCT medical company (brigade support battalion).
- Advice to the ASCC commander and other senior-level commanders on the medical aspects of their operations.
- Staff planning, supervision of operations, and administration of assigned and attached medical units.
- Assistance with coordination and integration of strategic capabilities from the sustaining base to units in the AO.
- Advice and assistance in facility selection and preparation.
- Coordination with the USAF TPMRC for medical regulating and movement of patients from MEDCOM (DS) MTFs.
- Consultation services and technical advice in all aspects of medical and surgical services.
- Functional staff to coordinate medical plans and operations, medical and surgical consultation, PVNTMED, tactical and strategic medical evacuation, and veterinary services.
- Coordination and orchestration of MEDLOG operations to include Class VIII, distribution, medical maintenance and repair support, optical fabrication, and blood management.
- Planning and support for the SIMLM, when designated.

- Veterinary support for zoonotic disease control, investigation and inspection of subsistence, and animal medical care.
- Preventive medicine support for medical and OEH surveillance, potable water inspection, pest management, food facility inspection, and control of medical and nonmedical waste.
- Legal advice to the commander, staff, subordinate commanders, Soldiers, and other authorized persons.
- Health threat monitoring within the AO and ensuring required capabilities to mitigate threats are identified.
- Religious support to the command. This includes coordinating with the headquarters unit ministry team for required religious support throughout the AO and providing consultation capability to subordinate MEDCOM (DS) unit ministry teams.
- Provides advice and recommendations for the conduct of CMO.
- Facilitates the reception, staging, onward movement, and integration of medical units.
- Provides reach to the MCP and US Army Medical Command in CONUS.
- Performs field maintenance on all organic equipment except COMSEC equipment.

LIMITATIONS

2-210. This element is dependent upon—

- Appropriate supporting elements in the AO for finance; personnel and administrative services; field services; physical security; and supplemental transportation.
- The supporting base operations or collocated medical unit for food service; water distribution; Role 1 medical care; general supply; power generation; and unit maintenance for vehicles and communications equipment.
- The MCP for reachback capability and to support personnel rotations.

MOBILITY

2-211. The OCP is required to be fully mobile. When deployed, it has sufficient organic vehicles to provide single lift capability for 100 percent of its personnel and equipment.

ORGANIZATION AND FUNCTIONS

2-212. This section provides a brief description of the operational elements in the OCP. A full (detailed) depiction of section functions and specific job descriptions is provided in Section I.

COMMAND SECTION ELEMENT

2-213. The command section element of the OCP (Table 2-26) provides C2 and management of all MEDCOM (DS) services within the OCP. Personnel of this element supervise and coordinate the operations and administrative services of the command element.

Table 2-26. Command section element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Command section element (OCP)	00B00	O7	Deputy commander	GO
	01A00	O2	Aide-de-camp	IMM
	92G3O	E6	Enlisted aide	NC

Table 2-26. Command section element (operational command post) (continued)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Command section element (OCP) (continued)	88M2O	E5	Vehicle driver	NC

LEGEND
AOC area of concentration
IMM immaterial
GO general officer
MOS military occupational specialty
NC noncommissioned officer
OCP operational command post

CHIEF OF STAFF SECTION ELEMENT

2-214. The chief of staff section element of the OCP (Table 2-27) plans, directs, and coordinates the execution of staff functions. It reviews organizational activities and recommends changes, as necessary, to the deputy commander.

Table 2-27. Chief of staff section element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Chief of staff section element (OCP)	67A00	O4	Secretary to the general staff	MS

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
OCP operational command post

DEPUTY CHIEF OF STAFF, PERSONNEL ELEMENT

2-215. The DCSPER element (Table 2-28) serves as the advisor to the commander on personnel issues and provides administration services for the command. He monitors the casualty feeder reports pertaining to MEDCOM (DS) personnel/medical units and takes appropriate action when necessary. He provides information to the deputy commander on the HR aspects of unit readiness status and issues.

Table 2-28. Deputy chief of staff, personnel section element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Deputy chief of staff, personnel element (OCP)	70F67	O5	Health service personnel officer	MS
	42A4O	E7	Senior human resources sergeant	NC
	42A2O	E5	Human resources sergeant	NC
	42A1O	E4	Human resources specialist	
	42A1O	E3	Human resources specialist	

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
OCP operational command post

PERSONNEL MANAGEMENT/ACTIONS ELEMENT

2-216. Personnel management/actions element (Table 2-29) provides overall administrative services for the command to include personnel management and personnel actions, awards, decorations, and leaves. This element provides reachback to home station on Family readiness group issues of its Soldiers.

Table 2-29. Personnel management/actions element (operational command post)

Paragraph title	*AOC/MOS*	*GRADE*	*TITLE*	*BRANCH*
Personnel management/actions element (OCP)	42A5O	E8	Senior human resources sergeant	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
NC noncommissioned officer
OCP operational command post

CURRENT OPERATIONS BRANCH ELEMENT

2-217. The current operations branch element (Table 2-30) provides security, plans and operations support, and deployment, relocation, and redeployment of the MEDCOM (DS) headquarters.

Table 2-30. Current operations branch element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Current operations branch element (OCP)	70H67	O5	Medical operations officer	MS
	70H67	O4	Medical operations officer	MS
	74B00	O4	Chemical officer	CM
	74B00	O3	Assistant chemical officer	CM
	68Z5O	E9	Chief operations sergeant	NC
	68W5O	E8	Operations noncommissioned officer	NC
	74D5O	E8	Chemical operations noncommissioned officer	NC

LEGEND
AOC area of concentration
CM Chemical Corps
MS Medical Service Corps
MOS military occupational specialty
NC noncommissioned officer
OCP operational command post

PLANS BRANCH ELEMENT

2-218. The plans branch element (Table 2-31) provides all functions of the protection warfighting function and medical intelligence of the MEDCOM (DS). This element assists the deputy commander in the coordination of FHP responsibilities under the protection warfighting function.

Table 2-31. Plans branch element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Plans branch element (OCP)	70H67	O4	Medical plans officer	MS
	68W5O	E8	Plans noncommissioned officer	NC

LEGEND
AOC area of concentration
MOS medical occupational specialty
MS Medical Service Corps
NC noncommissioned officer
OCP operational command post

INTELLIGENCE/OPERATIONS G-2/G-3 ELEMENT

2-219. The intelligence/operations G-2/G-3 element (Table 2-32) provides all functions of the protection warfighting function and medical intelligence of the MEDCOM (DS). This element coordinates with supporting G-2, the National Center for Medical Intelligence, and US Army Center for Health Promotion and Preventive Medicine for up-to-date information on health hazards in the AO to include sources of civilian toxic industrial materials hazards.

Table 2-32. Intelligence/operations G-2/G-3 element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Intelligence/operations G-2/G-3 element (OCP)	70H67	O4	Intelligence officer	MS
	70H67	O3	Medical operations officer	MS
	68W5O	E8	Intelligence medical sergeant	NC
	31B4O	E7	Force protection supervisor (2)	NC

LEGEND
AOC area of concentration
MOS medical occupational specialty
MS Medical Service Corps
NC noncommissioned officer
OCP operational command post

THEATER PATIENT MOVEMENT CENTER ELEMENT

2-220. The TPMC element (Table 2-33) provides for the medical regulating of all patients in the AO and preparation of patient statistical reports. It coordinates with the TPMRC and/or joint patient movement requirements center, if established, for all patients leaving the theater. It coordinates with the USAF for all strategic patient movement. It maintains 24-hour continuous operations. This was previously referred to as the medical regulating office.

Table 2-33. Theater patient movement center element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Theater patient movement center element (OCP)	67J00	O4	Aeromedical evacuation officer (2)	MS
	70E67	O3	Patient administration officer (2)	MS
	68G2O	E5	Patient administration noncommissioned officer(2)	NC
	68G1O	E4	Patient administration specialist (2)	
	68G1O	E3	Patient administration specialist (2)	

LEGEND
AOC area of concentration
MOS medical occupational specialty
MS Medical Service Corps
NC noncommissioned officer
OCP operational command post

DEPUTY CHIEF OF STAFF, LOGISTICS SECTION ELEMENT

2-221. This deputy chief of staff, logistics section element (Table 2-34) serves as advisor to the deputy commander and provides supervision and coordination of logistics, food service, supply, transportation, and maintenance support for the subordinate units. This element monitors the status of Class VIII supplies and, when designated, the SIMLM mission.

Table 2-34. Deputy chief of staff, logistics section element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Deputy chief of staff, logistics section element (OCP)	70K67	O4	Health service materiel officer	MS
	915E0	W3	Senior automotive maintenance warrant officer	WO
	92Y4O	E7	Supply sergeant	NC
	92Y1O	E4	Supply specialist	

LEGEND
AOC area of concentration
MOS medical occupational specialty
MS Medical Service Corps
NC noncommissioned officer
OCP operational command post
WO warrant officer

MEDICAL LOGISTICS SUPPORT SECTION ELEMENT

2-222. The MEDLOG support section element (Table 2-35) provides planning, policies, and programs for MEDLOG operations. It coordinates and synchronizes the execution of the MEDLOG mission in the AO (including) Class VIII supply operations, medical maintenance support, optical fabrication, and blood management.

Table 2-35. Medical logistics support section element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Medical logistics support section element (OCP)	70K67	O5	Chief logistics	MS
	71E67	O4	Clinical laboratory officer	MS
	88D00	O3	Transportation officer	TC
	67AA0	W3	Unit maintenance officer	WO
	68Z5O	E9	Chief medical logistics noncommissioned officer	NC
	68J5O	E8	Medical logistics sergeant	NC
	68J4O	E7	Medical logistics sergeant	NC

LEGEND
AOC area of concentration
MOS medical occupational specialty
MS Medical Service Corps
NC noncommissioned officer
OCP operational command post
TC Transportation Corps
WO warrant officer

CIVIL AFFAIRS SECTION ELEMENT

2-223. The CA section element (Table 2-36) facilitates and develops assessments of host nation medical infrastructure to assist the medical operations officer in planning and executing health care in the AO. It assists the commander in preparing medical functional studies, assessments, and estimates of how displaced persons affect the workload of MEDCOM (DS) MTFs. This element coordinates with the ASCC G-9 on the medical aspects stability operations. This element also assists the ASCC G-9 and other participating Army organizations, multinational forces, and host nation military with the development of plans and programs aimed at eliminating or mitigating the impact of health hazards with the AO and the region.

Table 2-36. Civil affairs section element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Civil affairs section element (OCP)	38A00	O5	Civil affairs officer	CA
	66B00	O3	Community health nurse	AN

LEGEND
AN Army Nurse Corps
AOC area of concentration
CA civil affairs
MOS military occupational specialty
OCP operational command post

DEPUTY CHIEF OF STAFF, INFORMATION MANAGEMENT ELEMENT

2-224. The deputy chief of staff, information management element (Table 2-37) provides for all aspects of automation and CE support for the command. It assists the commander and staff on C2 signal requirements, capabilities, and operations. This section coordinates with the signal command element bandwidth requirements and connectivity issues arising in the MEDCOM (DS) or subordinate medical units.

Table 2-37. Deputy chief of staff, information management element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Deputy chief of staff, information management (OCP)	70D67	O5	Biomedical information management officer	MS
	25A00	O4	Communications-electronics officer	SC
	70D67	O4	Biomedical information management officer	MS
	251A0	W2	Information system technician	WO
	25U5O	E8	Signal support system chief	NC
	25B3O	E6	Information system team chief	NC
	25B1O	E4	Information system specialist	
	25U1O	E4	Signal information services specialist	
	25B1O	E3	Information system specialist	
	25U1O	E3	Signal support system specialist	

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
OCP operational command post
SC Signal Corps
WO warrant officer

DEPUTY CHIEF OF STAFF, COMPTROLLER ELEMENT

2-225. The deputy chief of staff, comptroller element (Table 2-38) directs and monitors all finance and accounting functions for the command, to include budget planning, contract payments, and internal review. It provides advice and recommends courses of action for funding operations conducted during stability operations and medical contracting issues.

Table 2-38. Deputy chief of staff, comptroller element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Deputy chief of staff, comptroller section element (OCP)	70C67	O4	Health services comptroller	MS
	44C3O	E5	Senior finance management analyst	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
OCP operational command post

CLINICAL SERVICES ELEMENT

2-226. Clinical services element (Table 2-39) serves as the deputy commander's principal consultants and the command's technical advisor in medical and surgical operations, procedures, and protocols, and pharmacy. It provides advice and coordinates medical support to detainee operations and during stability operations. The element provides advice and a reachback capability for medical specialty care and for the treatment of pediatric and geriatric patients when necessary. This element also recommends the employment of FSTs in the AO. This element also coordinates the medical response to mass casualty situations arising within the theater.

Table 2-39. Clinical services element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Clinical services element (OCP)	61F00	O6	Medical consultant	MC
	61J00	O6	Surgical consultant	MC
	67E00	O6	Pharmacy officer	MS

LEGEND
AOC area of concentration
MC Medical Corps
MOS military occupational specialty
MS Medical Service Corps
OCP operational command post

VETERINARY SERVICES ELEMENT

2-227. Veterinary services element (Table 2-40) serves as the commander's principal consultant and the command's technical advisor for veterinary activities and employment of veterinary assets. It provides technical supervision of food inspection, animal medical care, and veterinary PVNTMED support.

Table 2-40. Veterinary services element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Veterinary services element (OCP)	64Z00	O6	Senior veterinarian	VC
	68R5O	E9	Senior veterinary noncommissioned officer	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
NC noncommissioned officer
OCP operational command post
VC Veterinary Corps

PREVENTIVE MEDICINE ELEMENT

2-228. The PVNTMED element (Table 2-41) serves as the commander's principal consultant and the command's PVNTMED and environmental science advisor. This element must ensure that medical and OEH surveillance activities are established and implemented immediately and that surveillance data is documented and reported in a timely manner. This section coordinates with the CA section on the PVNTMED aspects of stability operations.

Table 2-41. Preventive medicine element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Preventive medicine element (OCP)	72B67	O5	Entomologist	MS
	72D67	O5	Environmental science officer	MS
	72E67	O5	Environmental engineer	MS

LEGEND
AOC area of concentration
MS Medical Service Corps
MOS military occupational specialty
OCP operational command post

INSPECTOR GENERAL SECTION ELEMENT

2-229. The inspector general section element (Table 2-42) conducts command inspections and investigations and provides inspector general assistance as required.

Table 2-42. Inspector general section element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Inspector general section element (OCP)	05A00	O4	Inspector general	MS
	68W4B	E7	Inspector general noncommissioned officer	NC

LEGEND
AOC area of concentration
OCP operational command post
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

PUBLIC AFFAIRS SECTION ELEMENT

2-230. The public affairs section element (Table 2-43) serves as the command's focal point for command information, public information, and community relations matters. It is essential for this element to establish contacts with the host nation civilian journalist community, US media elements operating within the AO, and the PAO staffs of supporting and supported units.

Table 2-43. Public affairs section element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Public affairs section element (OCP)	46A00	O4	Public affairs officer	IMM
	46Z4O	E7	Public affairs operations noncommissioned officer	NC

LEGEND
AOC area of concentration
IMM immaterial
MOS military occupational specialty
NC noncommissioned officer
OCP occupational command post

STAFF JUDGE ADVOCATE

2-231. The SJA element (Table 2-44) supervises the administration of military justice and other legal matters for Soldiers. It advises the commander, staff, and subordinate commanders on legal matters. It provides legal services on military law, administrative and contract law, claims, criminal law, legal assistance, operational law, and other related legal matters.

Table 2-44. Staff judge advocate element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Staff judge advocate element (OCP)	27A00	O3	Judge advocate	JA
	27D2O	E5	Paralegal noncommissioned officer	NC
	27D1O	E4	Paralegal specialist	

LEGEND
AOC area of concentration
JA Judge Advocate General Corps
MOS military occupational specialty
NC noncommissioned officer
OCP occupational command post

COMPANY HEADQUARTERS ELEMENT

2-232. This element (Table 2-45) provides company level command, supply management, local security, unit level maintenance, food services, and other life support requirements. This element prepares casualty feeder reports, as required. It coordinates decontamination operations in the event the OCP is contaminated by CBRN warfare agents. This element develops the headquarters occupation plan and coordinates the relocation of the MEDCOM (DS) headquarters, if required.

Table 2-45. Company headquarters element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Company headquarters element (OCP)	70B67	O2	Executive officer	MS
	915E0	W3	Senior automotive maintenance warrant officer	WO
	63X4O	E7	Motor sergeant	NC
	92G3O	E6	Senior first cook	NC
	92Y3O	E6	Supply sergeant	NC
	42A2O	E5	Human resources sergeant	NC
	92G2O	E5	First cook	NC
	74D1O	E4	Decontamination specialist	
	63B1O	E4	Wheeled vehicle mechanic	

Table 2-45. Company headquarters element (operational command post) (continued)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Company headquarters element (OCP) (continued)	52D1O	E4	Power generation equipment repairman	
	92A1O	E4	Equipment records/parts specialist	
	92G1O	E4	Cook	
	92Y1O	E4	Armorer	
	92G1O	E3	Cook	

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
OCP operational command post
WO warrant officer

UNIT MINISTRY TEAM ELEMENT

2-233. The unit ministry team element (Table 2-46) serves as the advisor to the commander and provides religious support and pastoral care ministry for assigned staff and subordinate organizations.

Table 2-46. Unit ministry team element (operational command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Unit ministry team element (OCP)	56A00	O5	Assistant chaplain	CH
	56M2O	E5	Chaplain assistant noncommissioned officer	NC

LEGEND
AOC area of concentration
CH Chaplain Corps
OCP occupational command post
MOS military occupational specialty
NC noncommissioned officer

SECTION III — MEDICAL COMMAND (DEPLOYMENT SUPPORT) (MAIN COMMAND POST)

MISSION AND ASSIGNMENT

2-234. The positions which comprise the MEDCOM (DS) MCP are designated on the TOE from positions within the headquarters (TOE 08641GB00). The MCP provides C2, administrative assistance, and technical supervision of assigned and attached medical units.

CAPABILITIES AND LIMITATIONS

CAPABILITIES

2-235. The MCP is a deployable augmentation module, which completes the staffing of the MEDCOM (DS) headquarters to enhance the delivery of campaign-quality health care to deployed forces in the AO. It facilitates policy development and technical guidance to subordinate units and provides interface and

liaison with supported forces in the AO. If the OCP is deployed and needs additional personnel or clinical skills, the MCP can deploy personnel to the OCP to provide a more robust medical element and additional operational and planning capabilities, increased MEDLOG staff, AISs, a more diverse clinical staff, and more depth in the SJA, inspector general, CA, and public affairs sections. The MCP has an assigned standard requirement code to facilitate the placement on and the integration into the Time Phased Force Deployment List.

2-236. The MCP is allocated on the basis of one element per HHC, MEDCOM (DS).

2-237. The MCP provides a robust planning, controlling, and coordinating capability to facilitate the provision of health care to expanding forces. The MEDCOM (DS) MCP provides—

- Medical staff planning, operational and technical supervision, and administrative assistance for subordinate units operating in the AO.
- Increased capability for medical and surgical consultation services, technical advice, and policy development in the areas of hospitalization, nursing services, pharmacy, optometry, medical laboratory, dental services, COSC, BH, and NP services, veterinary services (zoonotic disease control, investigation and inspection of subsistence, and animal medicine), nutrition care, and PVNTMED services (entomology, epidemiology, OEH surveillance, potable water inspection, pest management, food facility inspection, and control of medical and nonmedical waste).

LIMITATIONS

2-238. This element is dependent upon the—

- Appropriate supporting elements in the AO for finance; personnel and administrative services; field services; physical security; and supplemental transportation.
- Supporting base operations or collocated medical unit for food service; water distribution; Role 1 medical care; general supply; power generation; and unit maintenance for vehicles and communications equipment.

MOBILITY

2-239. The MCP is required to be fully mobile. When deployed, it has sufficient organic vehicles to provide single lift capability for 100 percent of its personnel and equipment.

ORGANIZATION AND FUNCTIONS

2-240. This section provides a brief description of the operational elements in the MCP. A more detailed description of section functions and specific job descriptions is provided in Section I.

COMMAND SECTION ELEMENT

2-241. The command section element (Table 2-47) provides C2 and management of all MEDCOM (DS) services. Personnel of this element supervise and coordinate the operations and administrative services of the command element.

Table 2-47. Command section element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Command section element (MCP)	00B00	O8	Commander	GO
	01A00	O3	Aide-de-camp	MS
	00Z5O	E9	Command sergeant major	NC

Table 2-47. Command section element (main command post) (continued)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Command section element (MCP) (continued)	42A30	E6	Executive administrative assistant	NC
	88M3O	E6	Senior vehicle driver	NC
	92G30	E6	Enlisted aide	NC

LEGEND
AOC area of concentration
GO general officer
MCP main command post
MS Medical Service Corps
MOS military occupational specialty
NC noncommissioned officer

CHIEF OF STAFF SECTION ELEMENT

2-242. The chief of staff section element (Table 2-48) plans, directs, and coordinates the execution of the staff functions. It reviews organization activities and recommends changes, as necessary to the commander.

Table 2-48. Chief of staff section element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Chief of staff section (MCP)	67A00	O6	Chief of staff	MS
	67A00	O4	Secretary general staff	MS

LEGEND
AOC area of concentration
MCP main command post
MOS military occupational specialty
MS Medical Service Corps

DEPUTY CHIEF OF STAFF, PERSONNEL ELEMENT

2-243. The DCSPER element (Table 2-49) serves as advisor to the commander on personnel issues and provides administrative services for the command.

Table 2-49. Deputy chief of staff, personnel element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Deputy chief of staff, personnel element (MCP)	70F67	O6	Deputy chief of staff, personnel	MS
	42H00	O4	Personnel management officer	AG
	42A5O	E9	Chief human resources sergeant	NC
	42A1O	E4	Human resources specialist	

LEGEND
AG Adjutant General Corps
AOC area of concentration
MCP main command post
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

PERSONNEL MANAGEMENT/ACTIONS ELEMENT

2-244. The personnel management/actions element (Table 2-50) provides overall administrative services for the command to include personnel management and personnel actions, awards, decorations, and leaves.

Table 2-50. Personnel management/actions element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Personnel management/actions element (MCP)	70F67	O4	Personnel staff officer	MS
	42A2O	E5	Human resources sergeant	NC
	42A1O	E4	Human resources specialist	

LEGEND
AOC area of concentration
MCP main command post
MS Medical Service Corps
MOS military occupational specialty
NC noncommissioned officer

CHIEF OF STAFF, SECURITY/PLANS/OPERATIONS G-2/G-3 ELEMENT

2-245. The DCSSPO G-2/G-3 element (Table 2-51) is the principal staff section in matters concerning security, plans, intelligence, operations, organization, training, and CBRN defensive activities. It prepares broad planning guidance, policies, and programs for command organizations, operations, and functions. This section develops policies and guidance for training and training evaluation of the command. This section has four principal functional elements—the current operations branch, the plans branch, the intelligence/operations branch, and the TPMC. For additional information on the responsibilities of this staff section, refer to FM 5-0.

Table 2-51. Deputy chief of staff, security/plans/operations G-2/G-3 element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Deputy chief of staff, security/plans/operations G-2/G-3 element (MCP)	70H67	O6	Deputy chief of staff, security/plans/operations	MS
	68Z5O	E9	Chief medical noncommissioned officer	NC

LEGEND
AOC area of concentration
MCP main command post
MS Medical Service Corps
MOS military occupational specialty
NC noncommissioned officer

CURRENT OPERATIONS BRANCH ELEMENT

2-246. The current operations branch element (Table 2-52) provides security, plans, and operations support, deployment, and redeployment of the command.

Table 2-52. Current operations branch element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Current operations branch element (MCP)	70H67	O4	Medical operations officer	MS
	68W5O	E8	Operations noncommissioned officer	NC

LEGEND
AOC area of concentration
MCP main command post
MS Medical Service Corps
MOS military occupational specialty
NC noncommissioned officer

PLANS BRANCH ELEMENT

2-247. The plans branch element (Table 2-53) provides security, plans and operations, deployment, and relocation and redeployment of the command.

Table 2-53. Plans branch element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Plans branch element (MCP)	70H67	O5	Medical plans officer	MS
	70H67	O4	Medical plans officer	MS

LEGEND
AOC area of concentration
MCP main command post
MS Medical Service Corps
MOS military occupational specialty
NC noncommissioned officer

INTELLIGENCE/OPERATIONS G-2/G-3 ELEMENT

2-248. The intelligence/operations G-2/G-3 element (Table 2-54) provide security, plans and operations, deployment, and relocation and redeployment of the MEDCOM (DS) and its subordinate elements.

Table 2-54. Intelligence/operations G-2/G-3 element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Intelligence/operations G-2/G-3 element (MCP)	70H67	O5	Medical operations officer	MS
	68Z5O	E9	Chief medical noncommissioned officer	NC
	68W5O	E8	Intelligence medical sergeant	NC
	35F3O	E6	Technical intelligence analyst	NC

LEGEND
AOC area of concentration
MCP main command post
MS Medical Service Corps
MOS military occupational specialty
NC noncommissioned officer

THEATER PATIENT MOVEMENT CENTER ELEMENT

2-249. The theater patient movement center element (Table 2-55) provides medical regulating support of all patients in the AO and prepares the patient statistical reports. It coordinates with TPRMC/joint patient movement requirements center for all patients leaving the AO. It works with the USAF for all strategic patient movement. It maintains 24-hour continuous operations. This element was formerly referred to as the medical regulating office element.

Table 2-55. Theater patient movement center element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Theater patient movement center element (MCP)	70E67	O5	Patient administration officer	MS
	68G5O	E8	Patient administration noncommissioned officer	NC

LEGEND
AOC area of concentration
MCP main command post
MS Medical Service Corps
MOS military occupational specialty
NC noncommissioned officer

DEPUTY CHIEF OF STAFF, LOGISTICS ELEMENT

2-250. The deputy chief of staff, logistics element (Table 2-56) serves as the principal advisor to the commander and provides supervision and coordination of logistics, food service, supply, transportation, and maintenance support for the subordinate units.

Table 2-56. Chief of staff, logistics element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Deputy chief of staff, logistics element (MCP)	70K67	O6	Deputy chief of staff, logistics	MS
	670A0	W4	Command maintenance officer	WO

Table 2-56. Chief of staff, logistics element (main command post) (continued)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Deputy chief of staff, logistics element (MCP) (continued)	920A0	W3	Property book officer	WO
	92Z5O	E9	Senior supply supervisor	NC
	92Y1O	E4	Supply specialist	

LEGEND
AOC area of concentration
MCP main command post
MS Medical Service Corps
MOS military occupational specialty
NC noncommissioned officer
WO warrant officer

MEDICAL LOGISTICS SUPPORT SECTION ELEMENT

2-251. The MEDLOG support section element (Table 2-57) provides planning, policies, and programs for MEDLOG operations. It coordinates and synchronizes the execution of the MEDLOG mission in the AO (to include Class VIII supply operations, medical maintenance support, optical fabrication, and blood management).

Table 2-57. Medical logistics support section element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Medical logistics support section element (MCP)	70K67	O4	Health service materiel officer	MS
	70K67	O4	Supply management officer	MS
	71E67	O4	Clinical laboratory officer	MS
	88D00	O3	Transportation officer	TC
	68A5O	E9	Chief biomedical logistics noncommissioned officer	NC
	68K5O	E8	Chief medical laboratory sergeant	NC
	68J4O	E7	Senior optical laboratory noncommissioned officer	NC

LEGEND
AOC area of concentration
MCP main command post
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
TC Transportation Officer

CIVIL AFFAIRS SECTION ELEMENT

2-252. The CA section element (Table 2-58) facilitates and develops assessments of the host nation medical infrastructure to assist the commander in planning, coordinating, and executing health care in the AO. It assists the commander in preparing medical functional studies, assessments and estimates of how foreign humanitarian assistance operations will affect US military MTFs. This element maintains a regional focus to support the GCC's theater engagement plan.

Table 2-58. Civil affairs section element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Civil affairs section Element (MCP)	38A00	O3	Civil affairs officer	CA
	66B00	O3	Community health nurse	AN

LEGEND
AOC area of concentration
AN Army Nurse Corps
CA civil affairs
MCP main command post
MOS military occupational specialty

DEPUTY CHIEF OF STAFF, INFORMATION MANAGEMENT ELEMENT

2-253. The deputy chief of staff, information management element (Table 2-59) provides for all aspects of automation and CE support for the command. It assists the commander and staff on C2 signals requirements, capabilities, and operations. This section also ensures connectivity with Medical Communications for Combat Casualty Care and the Theater Medical Information Program-Joint for electronic medical records and medical statistical reports.

Table 2-59. Deputy chief of staff, information management element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Deputy chief of staff, information management element (MCP)	70D67	O6	Deputy chief of staff, information management	MS
	25A00	O4	Communication-electronics officer	SC
	70D67	O3	Health services system manager	MS
	251A0	W2	Information system technician	WO
	25B5O	E8	Information system chief	NC
	25B2O	E5	Senior information system specialist	NC
	42A1O	E4	Human resources specialist	

LEGEND
AOC area of concentration
MCP main command post
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
SC Signal Corps
WO warrant officer

DEPUTY CHIEF OF STAFF, COMPTROLLER

2-254. The deputy chief of staff, comptroller element (Table 2-60) direct and monitor all finance and accounting functions for the command to include budget planning, contract payments, and internal review.

Table 2-60. Deputy chief of staff, comptroller element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Deputy chief of staff, comptroller element (MCP)	70C67	O6	Deputy chief of staff, comptroller	MS
	44C5O	E8	Finance management advisor	NC
	44C2O	E5	Accounting analyst	NC
	44C2O	E5	Internal control analyst	NC
	44C2O	E5	Accounting analyst	NC

LEGEND
AOC area of concentration
MCP main command post
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

CLINICAL SERVICES ELEMENT

2-255. The clinical services element (Table 2-61) serve as the commander's principal consultants and the command's technical advisor in pharmacy, optometry, and COSC, BH, and NP care, and nuclear medicine.

Table 2-61. Clinical services element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Clinical services element (MCP)	00B00	O7	Deputy commander, professional services	GO
	60W00	O6	Psychiatrist	MC
	67F00	O5	Optometry officer	MS
	72A67	O5	Nuclear medical science officer	MS
	73A67	O5	Social worker	MS
	01A00	O2	Aide-de-camp	IMM
	68Q5O	E8	Senior pharmacy noncommissioned officer	NC
	68W5O	E8	Senior health care noncommissioned officer	NC

Table 2-61. Clinical services element (main command post) (continued)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Clinical services element (MCP) (continued)	92G3O	E6	Enlisted aide	NC
	88M2O	E5	Vehicle driver	NC

LEGEND
AOC area of concentration
GO general officer
IMM immaterial
MC Medical Corps
MCP main command post
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

DENTAL SERVICES ELEMENT

2-256. The dental services element (Table 2-62) serves as the commander's principal consultant and the command's technical advisor in dentistry.

Table 2-62. Dental services element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Dental services element (MCP)	63R00	O6	Dental surgeon	DC
	63H00	O5	Public health dentist	DC
	68Z5O	E9	Chief dental noncommissioned officer	NC

LEGEND
AOC area of concentration
DC Dental Corps
MCP main command post
MOS military occupational specialty
NC noncommissioned officer

NUTRITION CARE SERVICES ELEMENT

2-257. The nutrition care services element (Table 2-63) serve as the commander's principal advisor on all issues effecting nutrition care in both US MTFs and during foreign humanitarian assistance operations.

Table 2-63. Nutrition care element (main command post)

PARAGRAPH TITLE	*AOC/MOS*	*Grade*	*Title*	*Branch*
Nutrition care element (MCP)	65C00	O6	Dietetic consultant	SP
	68Z5O	E9	Chief nutritional care noncommissioned officer	NC

LEGEND
AOC area of concentration
MCP main command post
MOS military occupational specialty
NC noncommissioned officer
SP Army Medical Specialist Corps

CHIEF NURSE ELEMENT

2-258. The chief nurse element (Table 2-64) serves as the commander's principal consultant on nursing practices and personnel.

Table 2-64. Chief nurse element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Chief nurse element (MCP)	66N00	O6	Nursing consultant	AN
	68Z5O	E9	Chief clinical noncommissioned officer	NC

LEGEND
AOC area of concentration
AN Army Nurse Corps
MCP main command post
MOS military occupational specialty
NC noncommissioned officer

PREVENTIVE MEDICINE SECTION ELEMENT

2-259. The PVNTMED section element (Table 2-65) serves as the commander's consultant and the command's PVNTMED and environmental science advisors.

Table 2-65. Preventive medicine section element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Preventive medicine section element (MCP)	60C00	O6	Preventive medicine officer	MC
	72D67	O5	Environmental science officer	MS
	68S5O	E9	Chief preventive medicine noncommissioned officer	NC

LEGEND
AOC area of concentration
MC Medical Officer
MCP main command post
MOS military occupational specialty
NC noncommissioned officer

INSPECTOR GENERAL SECTION ELEMENT

2-260. The inspector general section element (Table 2-66) conducts command inspections and investigates and provides inspector general assistance when required.

Table 2-66. Inspector general section element (main command post)

PARAGRAPH TITLE	*AOC/MOS*	*Grade*	*Title*	*Branch*
Inspector general section element (MCP)	05A00	O5	Inspector general	IMM
	68W5B	E8	Inspector general noncommissioned officer	NC

LEGEND
AOC area of concentration
IMM immaterial
MCP main command post
MOS military occupational specialty
NC noncommissioned officer

PUBLIC AFFAIRS SECTION ELEMENT

2-261. The public affairs section element (Table 2-67) serves as the commands focal point for command information, public information, and community relations matters.

Table 2-67. Public affairs section element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Public affairs section element (MCP)	46A00	O5	Public affairs officer	IMM

LEGEND
AOC area of concentration
IMM immaterial
MCP main command post
MOS military occupational specialty

STAFF JUDGE ADVOCATE ELEMENT

2-262. The staff judge advocate element (Table 2-68) supervises the administration of military justice and other legal matters for MEDCOM (DS) Soldiers. It advises the commander, staff, and subordinate commanders on legal matters. It provides legal services on military law, administration and contract law, claims, criminal law, legal assistance, operational law, and other related legal matters.

Table 2-68. Staff judge advocate element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Staff judge advocate element (MCP)	27A00	O5	Staff judge advocate	JA
	27A00	O3	Judge advocate	JA
	270A0	W2	Legal administrator	WO
	27D4O	E7	Senior paralegal noncommissioned officer	NC
	27D3O	E6	Court reporter	NC
	27D1O	E4	Paralegal specialist	

LEGEND
AOC area of concentration
JA Judge Advocate Corps
MCP main command post
MOS military occupational specialty
NC noncommissioned officer
WO warrant officer

COMPANY HEADQUARTERS ELEMENT

2-263. The company headquarters element (Table 2-69) provides company-level command, supply management, local security, unit-level maintenance, food services, and other life support requirements.

Table 2-69. Company headquarters element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Company headquarters element (MCP)	05A00	O3	Commander	MS
	68W5M	E8	First sergeant	NC
	92Y3O	E6	Supply sergeant	NC
	92G3O	E6	Senior first cook	NC
	42A2O	E5	Human resources sergeant	NC
	92G2O	E5	First cook	NC
	42A1O	E4	Human resources specialist	
	74D1O	E4	Decontamination specialist	
	63B1O	E4	Wheeled vehicle mechanic	
	52D1O	E4	Power generation equipment repairman	
	92A1O	E4	Equipment records/parts specialist	
	92G1O	E4	Cook	
	92Y1O	E4	Armorer	
	92A1O	E3	Equipment records/parts specialist	
	92G1O	E3	Cook	

LEGEND
AOC area of concentration
MCP main command post
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

UNIT MINISTRY TEAM ELEMENT

2-264. The unit ministry team element (Table 2-70) serves as advisor to the commander and provides religious support and pastoral care ministry for assigned staff and subordinate organizations.

Table 2-70. Unit ministry team element (main command post)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Unit ministry team element (MCP)	56A00	O6	Chaplain	CH
	56M5O	E8	Chaplain assistant noncommissioned officer	NC

LEGEND
AOC area of concentration
CH Chaplain Corps
MCP main command post
MOS military occupational specialty
NC noncommissioned officer

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Chapter 3

Medical Brigade (Support)

The MEDBDE is a subordinate C2 organization of the MEDCOM (DS). It provides C2 of all assigned and attached medical units. The focus of the MEDBDE is METT-TC-driven. One MEDBDE may be providing direct support to a tactical commander, while another may be providing AHS support to a division or corps headquarters, or theater sustainment forces. These organizations may be providing simultaneous support to stability operations occurring within their AO.

SECTION I — HEADQUARTERS AND HEADQUARTERS COMPANY, MEDICAL BRIGADE (SUPPORT)

MISSION AND ASSIGNMENT

3-1. The HHC, MEDBDE (TOE 08420G000), organizes, resources, trains, sustains, deploys, commands and controls, and supports assigned and attached medical units to provide flexible, responsive, and effective HSS and FHP to supported forces conducting joint and simultaneous full spectrum operations.

CAPABILITIES AND LIMITATIONS

3-2. The MEDBDE is composed of three standard requirement codes-identified modules (the early entry, expansion, and campaign).

3-3. The MEDBDE provides—

- Command and control of subordinate and attached units.
- Operational medical plugs augmentation to Role 2 medical companies.
- Advice to the commanders on the medical aspects of their operations.
- Medical staff planning, operational and technical supervision and administrative assistance for subordinate or attached units.
- Coordination with the supporting patient movement requirements center for medical regulating and medical evacuation support.
- Medical consultation services in—
  - Preventive medicine.
  - Behavioral health to include COSC and NP care.
  - Nutrition services.
- Advice and recommendations for the conduct of CMO.
- Control and supervision of Class VIII supply and resupply to include blood management. When designated by the GCC, serves as the SIMLM.
- Joint-capable C2 capability when augmented with appropriate joint assets.
- Support as the executive agent for veterinary services.
- Assistance in the coordinated defense of the unit's area.
- Field maintenance on all organic equipment, except CE and COMSEC.
- Religious support and pastoral care ministry.

3-4. The MEDBDE is dependent upon the sustainment brigade to arrange religious, legal, administration, finance, HR, transportation services, CBRN and decontamination assistance, and laundry and bath services support; Class I ration support; waste disposal and construction; and supplemental transportation requirements.

3-5. Maneuver enhancement brigade provides area damage control for the MEDBDE.

ORGANIZATION AND FUNCTIONS

3-6. Section I of this chapter combines the early entry, campaign, and expansion modules of the MEDBDE to provide a complete description of the composition and capabilities of the organization. This TOE will be assigned to the MEDCOM (DS). This unit is designed a Category II unit. (For unit categories, see AR 71-32.)

INTERNAL STAFF AND OPERATIONS

3-7. The MEDBDE's coordinating staff (S-staff) manages the command's internal operations through coordination with staffs of higher, lower, and adjacent units. The staff's efforts support the commander and subordinate units by providing accurate and timely information. It produces estimates, recommendations, plans and orders, and monitors execution. The staff streamlines cumbersome or time-consuming procedures by ensuring that all activities contribute to mission accomplishment. Within the MEDBDE headquarters, staff sections coordinate their functional responsibilities with other headquarters staff sections as required.

EXTERNAL COORDINATION

3-8. The MEDBDE must coordinate with the MEDCOM (DS) and other headquarters within their AO. External coordination with the combat aviation brigade and general support aviation battalion for medical evacuation support by rotary-wing aircraft is critical.

COMMAND SECTION

3-9. The command section (Table 3-1) provides C2 and management for all MEDBDE operations, activities, and services.

Table 3-1. Command section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Command section	05A00	O6	Commander**	IMM
	67A00	O5	Executive officer***	MS
	70C67	O3	Health services comptroller***	MS
	00Z5O	E9	Command sergeant major**	NC
	68W2O	E5	Health care sergeant**	NC
	68W1O	E4	Health care specialist**	

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)

AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Commander

3-10. The MEDBDE commander (COL/O6, AOC 05A00) provides C2 of assigned and attached medical companies and detachments. When the MEDBDE is providing direct support to the division, he maintains direct access to the tactical commander to ensure AHS support plans effectively support the division commander's concept of operations. He also develops close ties with the sustainment brigade to facilitate and deconflict issues arising with the theater distribution system that will impact on AHS support operations. The MEDBDE commander advises the MEDCOM (DS) CA section on medical issues related to stability operations being conducted in his AO and further provides recommendations on potential future stability operations missions. The MEDBDE coordinates medical issues related to detainee operations being conducted by subordinate units with the MEDCOM (DS) detainee operations medical director. The commander deploys with the expansion module.

Executive Officer

3-11. The executive officer (LTC/O5, AOC 67A00) also serves as the commander of the campaign module. He must remain informed of the operations so he can assume command, if necessary. The executive officer assumes command functions as directed by the commander or in his absence. The executive officer deploys with the campaign module.

Health Services Comptroller

3-12. The health services comptroller (CPT/O3, AOC 70C67) performs and coordinates finance and accounting functions and serves as the advisor to the deputy commander on all financial matters in the campaign module. The health services comptroller deploys with the campaign module.

Command Sergeant Major

3-13. The CSM (CSM/E9, MOS 00Z5O) is the principal enlisted representative to the commander. He advises the commander and staff on all matters pertaining to the welfare and morale of enlisted personnel in terms of assignment, reassignment, promotion, and discipline. He provides counsel and guidance to NCOs and other enlisted personnel of the MEDBDE. He is also responsible for the reception of newly assigned enlisted personnel into the unit. The CSM evaluates the implementation of individual Soldier's training on Warrior tasks and supervises the MEDBDE NCO professional development activities. The CSM deploys with the expansion module.

Health Care Sergeant

3-14. The health care sergeant (SGT/E5, MOS 68W2O) is the principal assistant to the commander and deploys with him to provide required administrative support. The health care sergeant deploys with the expansion module.

Health Care Specialist

3-15. The health care specialist (SPC/E4, MOS 68W1O) is the principal assistant to the CSM and deploys with him to provide required administrative support. The health care specialist deploys with the expansion module.

S-1 SECTION

3-16. The S-1 section (Table 3-2) provides overall administrative services for the command, to include personnel administration, and coordinates with elements of supporting agencies for finance, personnel, legal, and administrative services.

Table 3-2. S-1 section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-1 section	70F67	O4	S-1***	MS
	70F67	O3	Health services personnel manager	MS
	420A0	W2	Military personnel technician	WO
	42A5O	E8	Senior human resources sergeant	NC
	42A3O	E6	Human resources sergeant	NC
	42A3O	E6	Human resources sergeant***	NC
	42A2O	E5	Human resources sergeant	NC
	42A2O	E5	Human resources sergeant***	NC
	42F2O	E5	Human resources information system management sergeant***	NC
	42A1O	E4	Human resources specialist	
	42A1O	E4	Human resources specialist***	
	42F1O	E4	Human resources information system management specialist	

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)

AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-1

3-17. The S-1 (MAJ/O4, AOC 70F67) coordinates with other staff sections, subordinate companies, and the MEDCOM (DS) for all personnel core competencies of personnel readiness management; personnel accounting and strength reporting; personnel information management; reception, replacement, return to duty, rest and recuperation, and redeployment; casualty operations; legal issues; essential HR services; postal operations; and MWR operations. The S-1 also prepares and participates in the personnel estimate process, and coordinates with other staff sections. The S-1 deploys with the campaign module.

Health Services Personnel Manager

3-18. The health services personnel manager (CPT/O3, AOC 70F67) is the principal assistant to the S-1. He is responsible to the S-1 to receive and process personnel actions received from subordinate units within the MEDBDE. The health services personnel manager deploys with the early entry module.

Military Personnel Technician

3-19. The military personnel technician (CWO/W2, MOS 420A0) plans, develops, and directs personnel systems which support and implement programs including strength accounting, maintenance of personnel

records, personnel requisitioning, reassignment, reenlistment, promotions, casualty reporting, eliminations, and awards and decorations. The military personnel technician deploys with the early entry module.

Human Resources Personnel

3-20. The senior HR sergeant (MSG/E8, MOS 42A5O) performs duties of and supervises the functions of subordinates to include the quality assurance of tasks performed and products prepared. He advises the S-1 and other staff members on personnel administration activities and supervises subordinate HR personnel. The senior HR sergeant deploys with the early entry module.

3-21. The HR sergeants (SSG/E6, MOS 42A3O) perform duties at preceding skill levels and provide technical guidance to subordinate Soldiers in accomplishment of these duties. One HR sergeant deploys with the early entry module and one deploys with the campaign module.

3-22. The HR sergeants (SGT/E5, MOS 42A2O) perform duties as discussed in paragraph 3-20. The HRs sergeants deploy with the campaign module.

3-23. The HR specialists (SPC/E4, MOS 42A1O) perform duties as discussed in paragraph 3-20. One HR specialist deploys with the early entry module and one with the campaign module.

Human Resources Information System Management Sergeant

3-24. The HR information management specialist (SGT/E5, MOS 42F2O) operates and manages the S-1 information systems. He is also responsible for analyzing, processing, and maintaining information files and supporting documentation. The HR information system management sergeant deploys with the campaign module.

Human Resources Information System Management Specialist

3-25. The HR information management specialist (SPC/E4, MOS 42F1O) operates and manages the S-1 information systems. He is also responsible for analyzing, processing, and maintaining information files and supporting documentation. The HR information system management specialist deploys with the early entry module.

S-2 SECTION

3-26. The S-2 section (Table 3-3) performs all source intelligence assessments and estimates for the command. It advises the commander and staff on nuclear/chemical surety and CBRN operations.

Table 3-3. S-2 section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-2 section	70H67	O4	S-2	MS
	68W5O	E8	Intelligence medical sergeant**	NC
	68W4O	E7	Intelligence sergeant***	NC

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)

AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-2

3-27. The intelligence staff officer (S-2) (MAJ/O4, AOC 70H67) performs intelligence assessments and estimates for the command. Further, he advises the commander and staff on nuclear/chemical, issues, postures, and CBRN operations. He acquires, analyzes, and evaluates intelligence to include health threat information and medical and OEH surveillance data. The S-2 deploys with the early entry module.

Intelligence Medical Sergeant

3-28. The intelligence medical sergeant (MSG/E8, MOS 68W5O) is responsible for the acquisition and analysis of medical intelligence information. He provides tactical intelligence products relevant to the MEDBDE AO. He functions as the operations security and COMSEC NCO for the MEDBDE. The intelligence sergeant deploys with the expansion module.

Intelligence Sergeant

3-29. The intelligence sergeant (MSG/E8, MOS 68W4O) performs duties as discussed in paragraph 3-27. The intelligence sergeant deploys with the campaign module.

S-3 SECTION

3-30. The operations staff officer (S-3) section (Table 3-4) is responsible for plans and operations, deployment, relocation and redeployment of the MEDBDE, and supervising medical evacuation operations for both air and ground.

Table 3-4. S-3 section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-3 section	70H67	O5	S-3	MS
	68Z5O	E9	Chief operations sergeant**	NC
	68W1O	E3	Health care specialist	

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)

AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-3

3-31. The S-3 (LTC/O5, AOC 70H67) is responsible for planning future operations, plans and operations, deployment, relocation, and deployment of the MEDBDE and its assigned units. He prepares broad planning guidance, policies, and programs for command organizations, operations, and functions. He assists the commander in developing and training the unit mission essential task list. He identifies training requirements, based on medical missions and the unit's training programs, directives, and orders. He maintains the unit status reports for each subordinate unit. The S-3 deploys with the early entry module.

Chief Operations Sergeant

3-32. The chief operations sergeant (SGM/E9, MOS 68Z5O) is responsible to the S-3 for preparation of OPORDs and map overlays. He is responsible for operations and training functions of the MEDBDE. He supervises the establishment and operation of the tactical operations center and is involved in the planning for and relocation of each element. He assists in the formulation of the TSOP and production of OPORDs. The chief operations sergeant deploys with the expansion module.

Health Care Specialist

3-33. The health care specialist (PFC/E3, MOS 68W1O) assists the S-3 in those duties as discussed in paragraph 3-30. The health care specialist deploys with the early entry module.

S-3 OPERATIONS BRANCH

3-34. The S-3 operations branch (Table 3-5) is responsible for authenticating and publishing plans and orders. It exercises staff supervision over HSS/FHP activities and advises the commander and staff on nuclear/chemical surety and CBRN operations.

Table 3-5. S-3 operations branch

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-3 operations branch	70H67	O4	Chief medical operations branch	MS
	70H67	O3	Medical operations officer	MS
	70H67	O3	Medical operations officer***	MS
	74B00	O3	Chemical officer**	CM
	68W4O	E7	Operations sergeant	NC
	68W4O	E7	Operations sergeant***	NC
	74D3O	E6	Nuclear, biological, and chemical noncommissioned officer	NC
	68W2O	E5	Health care sergeant	NC

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)
AOC area of concentration
CM Chemical Corps
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Medical Operations Officers

3-35. The chief, medical operations branch (MAJ/O4, AOC 70H67) is responsible to the S-3 for the operations of the MEDBDE. He supervises all AHS support operations in support of tactical operations conducted by the MEDBDE to include planning and relocation of each module. He is responsible for the formulation of the TSOP and production of OPORDs. The chief, medical operations branch deploys with the campaign module.

3-36. The medical operations officers (CPT/O3, AOC 70H67) are responsible to the chief medical operations branch. They perform duties as discussed in paragraph 3-34. One medical operations officer deploys with the early entry module and one with the campaign module.

Chemical Officer

3-37. The chemical officer (CPT/O3, AOC 74B00) is the technical advisor to the MEDBDE commander and S-3 on matters pertaining to CBRN operations. He plans CBRN defensive operations and advises subordinate units on contamination avoidance and personnel and equipment decontamination operations. The chemical officer deploys with the expansion module.

Operations Sergeants

3-38. The operations sergeants (SFC/E7, AOC 68W4O) supervise the establishment and operation of the tactical operations center and are involved in the planning for and relocation of each command post. They assist in the formulation of the TSOP and production of OPORDs. One operations sergeant deploys with the early entry module and one with the campaign module.

Nulcear, Biological, and Chemical Noncommissioned Officer

3-39. The nuclear, biological, and chemical NCO (SSG/E6, MOS 74D3O) provides CBRN operations advisory and support to the chemical officer. The nuclear, biological, and chemical NCO deploys with the early entry module.

Health Care Sergeant

3-40. The health care sergeant (SGT/E5, MOS 68W2O) is responsible to the medical operations officer. He performs support of those duties discussed in paragraph 3-35. The health care sergeant deploys with the early entry module.

S-3 PLANS BRANCH

3-41. The S-3 plans branch (Table 3-6) is responsible for the current planning in the MEDBDE AO, to include deliberate and crisis planning. Additionally, it plans for future operations in the excess of 72 hours and prepares major regional contingency plans for the MEDBDE. Further, this branch prepares, authenticates, and publishes medical plans and OPLANs to include the integration of annexes and appendixes prepared by other staff sections.

Table 3-6. S-3 plans branch

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-3 plans branch	70H67	O4	Chief medical plans branch***	MS
	70H67	O3	Plans officer	MS
	68W5O	E8	Plans noncommissioned officer**	NC
	68W4O	E7	Plans sergeant***	NC
	68W4O	E7	Health care noncommissioned officer***	NC

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)

AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Plans Officers

3-42. The chief, medical plans branch (MAJ/O4, AOC 70H67) is the principal advisor to the S-3 in the areas of field medical plans and contingency plans. The chief, medical plans branch deploys with the campaign module.

3-43. The plans officer (CPT/O3, AOC 70H67) is responsible to the chief, medical plans branch for future planning and analysis of the MEDBDE planning factors. The plans officer deploys with the early entry module.

Health Care Noncommissioned Officers

3-44. The plans NCO (MSG/E8, MOS 68W5O) is responsible to the chief, medical plans branch, and assists in the formulation of the operations plans and analysis of the MEDBDE planning factors. The plans NCO deploys with the expansion module.

3-45. The plans sergeant (SFC, E7, MOS 68W4O) is responsible to the plans NCO. He performs support of those duties discussed in paragraph 3-43. The plans sergeant deploys with the campaign module.

3-46. The health care NCO (SFC/E7, MOS 68W4O) is responsible to the plans officer and assists in the formulation of the operations plans and analysis of the MEDBDE planning factors. The health care NCO deploys with the campaign module.

INTRATHEATER PATIENT MOVEMENT CENTER

3-47. The intratheater patient movement center (Table 3-7) is responsible for maintaining 24-hour coordination and oversight for patient regulating and administration within the MEDBDE AO.

Table 3-7. Intratheater patient movement center

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Intratheater patient movement center	67J00	O4	Aeromedical evacuation officer	MS
	70E67	O4	Medical regulating officer	MS
	70E67	O3	Patient administration officer***	MS
	68G4O	E7	Patient administration noncommissioned officer**	NC
	68G3O	E6	Patient administration noncommissioned officer	NC
	68G2O	E5	Patient administration noncommissioned officer	NC
	68G2O	E5	Patient administration noncommissioned officer***	NC
	68G1O	E4	Patient administration specialist**	
	68G1O	E4	Patient administration specialist***	
	68G1O	E3	Patient administration specialist**	

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)

AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Aeromedical Evacuation Officer

3-48. The aeromedical evacuation officer (MAJ/O4, AOC 67J00) ensures tactical and strategic aeromedical evacuation requirements are synchronized. He assists the MEDBDE with planning intratheater aeromedical evacuations across multinational operations. He coordinates direct and general support aeromedical evacuation missions with the general support aviation battalion. The aeromedical evacuation officer deploy with the early entry module.

Medical Regulating Officer

3-49. The medical regulating officer (CPT/O3, AOC 70E67) serves as the MEDBDE medical regulating officer and is responsible to the S-3 for planning, organizing, directing, and controlling patient movement and the administrative aspects of the MEDBDE. He advises the S-3 on patient administration matters. The medical regulating officer deploys with the early entry module.

Patient Administration Officer

3-50. The patient administration officer (CPT/O3, AOC 70E67) serves as the campaign module medical regulating officer and is responsible to the S-3 for planning, organizing, directing, and controlling the patient movement and the administrative aspects of the MEDBDE. He advises the commander on patient administration matters. The patient administration officer deploys with the campaign module.

Patient Administration Personnel

3-51. The patient administration NCO (SFC/E7, MOS 68G4O) is responsible to the medical regulating officer for implementing the US Transportation Command Regulating and Command and Control Evacuation System for the MEDBDE in the expansion module. He processes correspondence received for medical information. The patient administration NCO deploys with the expansion module.

3-52. The patient administration NCO (SSG/E6, MOS 68G3O) performs duties as discussed in paragraph 3-50. The patient administration NCO deploys with the early entry module.

3-53. The patient administration NCOs (SSG/E5, MOS 68G2O) performs those duties discussed in paragraph 3-50. One patient administration NCO deploys with the early entry module and one with the campaign module.

3-54. The patient administration specialists (SPC/E4, MOS 68G1O) are responsible to the patient administration NCO for preparing, consolidating, and maintaining medical records and statistics pertaining to patient data. One patient administration specialist deploys with the expansion module and one specialist deploys with the campaign module.

3-55. The patient administration specialist (PFC/E3, MOS 68G1O) performs those duties as discussed in paragraph 3-54. The patient administration specialist deploys with the expansion module.

S-4 SECTION

3-56. The S-4 section (Table 3-8) monitors, coordinates, and facilitates MEDLOG operations within the command. This includes Class VIII supply and resupply, blood management and distribution, medical equipment maintenance and repair, medical gases, optical lens fabrication, and spectacle fabrication and repair.

Table 3-8. S-4 section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-4 section	70K67	O5	S-4**	MS
	92Z5O	E9	Senior supply supervisor***	NC
	63Z5O	E8	Senior maintenance supervisor**	NC
	92Y2O	E5	Property book noncommissioned officer***	NC

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)

AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-4

3-57. The logistics staff officer (S-4) (LTC/O5, AOC 70K67) plans, coordinates, controls, and manages the MEDBDE logistics functions. He exercises staff responsibility for units engaged in medical supply and service operations and other logistical support. He is responsible for ensuring service support functions and directs and supervises the collection, evacuation, and accountability for all classes of supply classified as salvage, surplus, abandoned, or uneconomically repairable. He advises the commander of logistical matters and unit mission capabilities. He serves as the focal point for property management and accountability procedures of all assigned or attached units. As a staff officer, he advises the commander on matters regarding supply and services support and other logistical functions. As a materiel manager, he develops, coordinates, and supervises the supply support portion of an integrated logistics support plan. The S-4 deploys with the expansion module.

Senior Supply Supervisor

3-58. The senior supply supervisor (SGM/E9, MOS 92Z5O) performs supervisory and management duties of large-sized logistics, division supply, stock control, property management, and storage activities. The senior supply supervisor deploys with the campaign module.

Senior Maintenance Supervisor

3-59. The senior maintenance officer (MSG/E8, MOS 63Z5O) manages maintenance requirements by applying technical knowledge and technical management skills. He supervises the technical and tactical performance of many different maintainer MOSs. He manages maintenance operations of various types and size. Further, he advises on equipment systems compatibility, replacement, and economical retention. He also evaluates performance and quality of equipment through an analysis of maintenance indicators. The senior maintenance supervisor deploys with the expansion module.

Property Book Noncommissioned Officer

3-60. The property book NCO (SGT/E5, MOS 92Y2O) is responsible for the maintenance of a consolidated property book for assigned units. The property book NCO is deployed with the campaign module.

S-4 LOGISTICS OPERATIONS BRANCH

3-61. The S-4 logistics operations branch (Table 3-9) monitors, coordinates, and facilitates MEDLOG operations within the command. This includes Class VIII supply and resupply, blood management and distribution, medical equipment maintenance and repair, medical gases, and optical lens fabrication and repair.

Table 3-9. S-4 logistics operations branch

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-4 logistics operations branch	70K67	O4	Chief, logistics operations branch	MS
	67E00	O3	Pharmacy officer**	MS
	670A0	W4	Brigade maintenance officer	WO
	68J4O	E7	Medical logistics sergeant	NC
	68J1O	E4	Medical logistics specialist`	

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)

AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
WO warrant officer

Chief, Logistics Operations Branch

3-62. The chief, logistics operations branch (MAJ/O4, AOC 70K67) plans, coordinates, controls, and manages the functions pertaining to the highly specialized and technical materiel and services utilized in support of the health care delivery system. He exercises staff responsibility for units engaged in medical supply, optical fabrication, medical maintenance, blood support, quality control operations and other medical logistical support. He plans and directs activities of personnel and units responsible for the receipt, storage, and issue of all Class VIII medical supply, optical fabrication support, blood support, and medical maintenance support. He provides command policy and monitors the collection, evacuation, and accountability for all MEDLOG items of supply classified as salvage, surplus, abandoned, or uneconomically repairable. He plans, directs, and implements the multifunctional areas of medical materiel management and their integration into the overall DOD logistics system, as well as the support interface between the deployed MEDLOG resources and reach to the wholesale logistics system and industry in the CONUS-support base. Further, he directs and/or exercises staff supervision of units engaged in the production, acquisition, receipt, storage and preservation, issue, and distribution of medical equipment, medical repair parts, and medical supplies. He serves as the focal point for medical property management and accountability procedures. As a materiel manager, he develops, coordinates, and supervises the supply support portion of an integrated logistics support plan. The chief logistics deploys with the early entry module.

Pharmacy Officer

3-63. The pharmacy officer (CPT/O3, AOC 67E00) plans, implements, directs, executes, and evaluates pharmaceutical care activities within the MEDBDE. His duties include clinical and consultative pharmacy and pharmacy management administration. He works closely with the S-4 to synchronize formularies within the theater with the logistics support available to ensure efficiencies are met and pharmacological supply requests are processed accurately. The pharmacy officer deploys with the expansion module.

Brigade Maintenance Officer

3-64. The MEDBDE maintenance officer (CWO/W4, MOS 670A0) provides planning, direction, and guidance for medical equipment maintenance and unit maintenance programs for the MEDBDE. The automotive maintenance WO deploys with the early entry module.

Medical Logistics Personnel

3-65. The MEDLOG sergeant (SFC/E7, MOS 68J4O) assists the health services materiel officer in the performance of his duties. He provides the status of all Class VIII items, critical item shortages, and the status of the automated supply systems. The MEDLOG sergeant deploys with the early entry module.

3-66. The medical logistic sergeant (SPC/E4, MOS 68J1O) assists the MEDLOG sergeant with his duties. The MEDLOG specialist deploys with the early entry module.

S-4 LOGISTICS PLANS BRANCH

3-67. The S-4 logistics plans branch (Table 3-10) completes the logistics staffing to monitor, coordinate, and facilitate MEDLOG operations within the MEDBDE. This includes Class VIII supply and resupply, blood management and distribution, medical equipment maintenance and repair, medical gases, and optical lens fabrication and repair.

Table 3-10. S-4 logistics plans branch

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-4 logistics plans branch	70K67	O3	Chief, logistics plans branch***	MS
	68J5O	E8	Medical logistics sergeant**	NC

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)

AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Chief, Logistics Plans Branch

3-68. The chief, logistics plans branch (CPT/O3, AOC 70K67) plans general logistics for the MEDBDE and its assigned or attached units. He monitors internal MEDLOG support and readiness in conjunction with the S-4 Section. The chief, logistics branch deploys with the campaign module.

Medical Logistics Sergeant

3-69. The MEDLOG sergeant (MSG/E8, MOS 68J5O) coordinates MEDBDE distribution of medical supplies with subordinate units. The MEDLOG sergeant deploys with the expansion module.

S-6 SECTION

3-70. The S-6 section (Table 3-11) provides for all aspects of automation and CE for the command. It determines C2 signal requirements, capabilities, and operations. It also provides advice and consultation on medical automation systems in use within the MEDBDE.

Table 3-11. S-6 section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-6 section	70D67	O4	S-6	MS
	25A00	O3	Signal officer	SC
	254A0	W2	Signal systems technician	WO
	25U5O	E8	Signal support system chief	NC
	25B2O	E5	Senior information system specialist	NC
	25B1O	E4	Information system specialist	
	25U1O	E4	Radio retransmission operator	
	25U1O	E4	Signal support specialist**	
	25U1O	E4	Signal information services specialist***	
	25U1O	E3	Radio retransmission operator	

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
SC Signal Corps
WO warrant officer

S-6

3-71. The signal staff officer (S-6) (MAJ/O4, AOC 70D67) is responsible for automation and communications. He ensures automated systems for MEDLOG management are established and maintained and ensures connectivity to other medical-centric programs such as the US Transportation Command Regulating and Command and Control Evacuation System and the Defense Health Information Management System. The S-6 deploys with the early entry module.

Signal Officer

3-72. The signal officer (CPT/O3, AOC 25A00) is responsible for advising the S-6 staff officer and the commander on all signal systems within the MEDBDE. He provides signal consultation to subordinate units. The signal officer deploys with the early entry module.

Signal Systems Technician

3-73. The signal systems technician (CWO/W2, MOS 254A0) provides technical advice to the S-6 staff officer on the status of all signal systems within the MEDBDE. He provides consultation to subordinates on communications systems. The signal systems technician deploys with the early entry module.

Signal Support System Chief

3-74. The team chief (MSG/E8, MOS 25U5O) is responsible for planning, supervising enlisted personnel, coordinating, and providing technical assistance in the installation, operation, management, and operator-level maintenance of radio, field wire, and switchboard communications systems. The signal support system chief deploys with the early entry module.

Senior Information System Specialist

3-75. The senior information system specialist (SGT/E5, MOS 25B2O) supports the signal support system chief in the management of equipment assets associated with AIS, IP networks to include the internetworking of systems. The senior information system specialist deploys with the early entry module.

Senior Information System Specialist

3-76. The information system specialist (SPC/E4, MOS 25B1O) assists the senior information system specialist. The information system specialist deploys with the early entry module.

Radio Retransmission Operator

3-77. The radio retransmission specialist (SPC/E4, MOS 25U1O) is responsible for switchboard communications systems. The radio retransmission operator deploys with the early entry module.

Signal Support Specialist

3-78. The signal support system specialist (SPC/E4, MOS 25U1O) is responsible for operator-level maintenance of radio, field wire, and switchboard communications systems. The signal support specialist deploys with the expansion module.

Signal Information Services Specialist

3-79. The signal information system specialist (SPC/E4 MOS 25U1O) supports the signal support system in the management of equipment assets associated with AIS, IP networks to include the internetworking of systems. The signal information services specialist deploys with campaign module.

Radio Retransmission Operator

3-80. The radio retransmission specialist (SPC/E3, MOS 25U1O) performs duties as discussed in paragraph 3-78.

S-9 SECTION

3-81. The S-9 section (Table 3-12) is responsible for the integration of CMO planning within the MEDBDE. It conducts area assessments and estimates on the impact of the local populace on MTFs to include the assessment of the host/foreign national medical infrastructure in planning for and executing health care delivery.

Table 3-12. S-9 section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-9 section	38A00	O4	S-9	CA

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)
AOC area of concentration
CA civil affairs
MOS military occupational specialty

S-9

3-82. The CA officer (S-9) (MAJ/O4, AOC 38A00) facilitates and develops assessments of the host nation medical infrastructure to assist the MEDBDE commander in planning and executing AHS support in the theater. He assists the MEDBDE commander in preparing medical functional studies, assessments, and estimates of the impact of displaced civilian operations in regard to the affect on US military MTFs. In conjunction with the command judge advocate, advises the MEDBDE commander regarding his legal and moral obligations to the indigenous civilian population. The S-9 deploys with the early entry module.

CLINICAL OPERATIONS SECTION

3-83. The clinical operations section (Table 3-13) serves as the commander's principal consultants and technical advisors for the command in general medicine, PVNTMED, to include NP care, COSC, and BH. Refer to paragraph 3-116 for an in-depth discussion of this section's coordination requirements and activities.

Table 3-13. Clinical operations section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Clinical operations section	60A00	O6	Chief professional services	MC
	66N00	O6	Chief nurse**	AN
	60C00	O5	Preventive medicine officer	MC
	60W00	O5	Psychiatrist**	MC
	63R00	O5	Chief dental services**	DC
	64B00	O5	Veterinary preventive medicine officer**	VC
	65C00	O4	Dietician***	SP
	72D67	O4	Environmental science officer***	MS
	640A0	W2	Veterinary services technician***	WO
	68Z5O	E9	Chief clinical noncommissioned officer**	NC
	68S4O	E7	Preventive medicine noncommissioned officer***	NC
	68X4O	E7	Mental health noncommissioned officer	NC
	68K4O	E7	Medical laboratory noncommissioned officer**	NC
	68W1O	E4	Health care specialist**	

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)
AN Army Nurse Corps
AOC area of concentration
DC Dental Corps
MC Medical Corps
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
SP Army Medical Specialist Corps
VC Veterinary Corps
WO warrant officer

Chief, Professional Services

3-84. The chief, professional services (COL/O6, AOC 60A00) serves as the senior physician in the MEDBDE. He develops policies, procedures, and protocols for clinical activities within the MEDBDE and subordinate MTFs. He coordinates policy issues which cannot be resolved at his level with the MEDCOM (DS) deputy chief of staff, professional services and provides reachback to the Office of The Surgeon General. The chief professional services deploys with the early entry module.

Chief Nurse

3-85. The chief nurse (COL/O6, AOC 66N00) serves as the principal advisor to the commander on all matters pertaining to nursing activities. He provides technical supervision of the MEDBDE's subordinate MTF nursing personnel. For additional information refer to paragraph 3-117. The chief nurse deploys with the expansion module.

Preventive Medicine Officer

3-86. The PVNTMED officer (LTC/O5, AOC 60C00) advises on or performs professional and scientific work in environmental health and industrial hygiene. His functions include identification, evaluation, and formulation of recommendations for the control of potential health hazards. He develops environmental health and industrial hygiene criteria and standards, policies, programs, practices, and operations directed toward the prevention of disease, illness, and injury. He ensures that the OEH surveillance programs and activities are being implemented and he evaluates data and identifies trends. This physician coordinates all PVNTMED/sanitation issues relating to detainee operations being conducted in the MEDBDE AO with the detainee operations medical director. For additional information refer to paragraph 3-117. The environmental science officer deploys with the early entry module.

Psychiatrist

3-87. The psychiatrist (LTC/O5, AOC 60W00) is the principal advisor to the commander on all NP, BH, and COSC matters. The psychiatrist is the clinical consultant for all subordinate BH personnel and COSC units. When the MEDBDE is providing direct support to a division, the psychiatrist closely coordinates support requirements with the division psychiatrist. He monitors all NP, BH, and COSC activities within his AO and collects data, analyzes trends, and prepares reports. This physician monitors the BH status of US personnel working in internment facilities and provides consultation and advice on support to detainees, as required. The psychiatrist coordinates with the MEDCOM (DS) on any issues relating to internment facilities operating within the MEDBDE AO with the detainee operations medical director. Refer to Field Manual Interim (FMI) 4-02.46. For additional information refer to paragraph 3-117. The psychiatrist deploys with the expansion module.

Chief, Dental Services

3-88. The chief, dental services (LTC/O5, AOC 63R00) plans directs, and supervises dental activities within the MEDBDE. He recommends priority of fill and assignment of dental personnel to subordinate dental elements. He monitors all dental activities, ensures preventive dentistry programs are established and implemented collects data, analyzes reports to determine trends, and recommends resolution of dental issues that occur within the MEDBDE. The dental officer serves as the MEDBDE dental surgeon. He monitors dental activities conducted in internment facilities within the MEDBDE AO and coordinates any dental issues with the commander and the MEDCOM (DS) detainee operations medical director. For additional information refer to paragraph 3-117. The chief, dental services deploys with the expansion module.

Veterinary Preventive Medicine Officer

3-89. The veterinary PVNTMED officer (LTC/O5, AOC 64B00) plans, directs, and supervises veterinary activities within the MEDBDE. This officer monitors, coordinates, and provides consultation to subordinate veterinary units and personnel. He coordinates with other Services operating within the

MEDBDE AO for inspection of subsistence, animal medical care, and veterinary PVNTMED activities aimed at reducing and/or eliminating the health hazard from zoonotic diseases transmissible to man. When directed, this officer coordinates with interagency and multinational forces for the care of military working dogs and other government-owned animals. He collects and analyzes data to identify disease threats and to guard against the intentional contamination of subsistence by enemy forces or terrorists. The veterinary PVNTMED officer coordinates with the CA section on proposed veterinary activities conducted during stability operations. For additional information refer to paragraph 3-117. The veterinary PVNTMED officer deploys with the expansion module.

Dietician

3-90. The dietician (MAJ/O4, AOC 65C00) serves as a consultant of nutrition-related health and performance issues in subordinate units of the MEDBDE. The dietician coordinates with the MEDBDE CA officer on any dietetic issues arising during stability operations conducted by subordinate medical units or in subordinate CSH nutrition support operations. For additional information refer to paragraph 3-117. The dietician deploys with the campaign module.

Environmental Science Officer

3-91. The environmental science officer (MAJ/O4, AOC 72D67) advises on or performs professional and scientific work in environmental health and industrial hygiene. His functions include identification, evaluation, and formulation of recommendations for the control of potential health hazards. He develops environmental health and industrial hygiene criteria and standards, policies, programs, practices, and operations directed toward the prevention of disease, illness, and injury. He ensures that the OEH surveillance programs and activities are being implemented and he evaluates data and identifies trends. For additional information refer to paragraph 3-117. The environmental science officer deploys with the campaign module.

Veterinary Services Technician

3-92. The veterinary service technician (CWO/W2, MOS 640A0) assists the veterinary staff officer and the assigned/attached veterinary units with food safety and security. For additional information refer to paragraph 3-117. The veterinary services technician deploys with the campaign module.

Chief Clinical Noncommissioned Officer

3-93. The chief clinical NCO (SGM/E9, MOS 68Z5O) provides advice to the chief, professional services on all matters relating to those enlisted personnel working in clinical staff positions. He provides support to the section in directing, planning, and coordinating AHS support for the theater. The chief clinical NCO deploys with the expansion module.

Preventive Medicine Noncommissioned Officer

3-94. The PVNTMED NCO (SFC/E7, MOS 68S4O) assists the PVNTMED officer with his duties to include writing, developing and coordinating command wide regulations and policies relating to PVNTMED services. He participates in command review and approval of subordinate unit activities. He assists in planning and placement of field PVNTMED units. Further, he evaluates training programs and provides recommendations for improvement. He participates in studies and reviews and maintains records of strength, location, and employment of PVNTMED assets. For additional information refer to paragraph 3-117. The PVNTMED NCO deploys with the campaign module.

Mental Health Noncommissioned Officer

3-95. The mental health NCO (SFC/E7, MOS 68X4O) provides BH assessments and care within his scope of practice. He assists the behavioral science officer in COSC prevention activities. For additional information refer to paragraph 3-117. The mental health NCO deploys with the early entry module.

Medical Laboratory Noncommissioned Officer

3-96. The medical laboratory NCO (SFC/E7, MOS 68K4O) assists the logistics staff officer (S-4) in the performance of his duties. He advises the health services materiel officer on the status of and requirement for blood at lower echelons of command. He prepares and submits blood requests to higher Army and/or joint command, and monitors automated blood reporting systems. The medical laboratory NCO deploys with the expansion module.

Health Care Specialist

3-97. The health care specialist (SPC/E4, MOS 68W1O) is the principal assistant to the chief, professional services and provides required administrative support. The health care specialist deploys with the expansion module.

COMMAND JUDGE ADVOCATE SECTION

3-98. The command judge advocate section (Table 3-14) provides legal advice and services to the commander, staff, subordinate commanders, Soldiers, and other authorized personnel.

Table 3-14. Command judge advocate section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Command judge advocate section	27A00	O4	Command judge advocate***	JA
	27D2O	E5	Paralegal noncommissioned officer***	NC
	27D1O	E3	Paralegal specialist***	

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)
AOC area of concentration
JA Judge Advocate General Corps
MOS military occupational specialty
NC noncommissioned officer

Command Judge Advocate

3-99. The command judge advocate (MAJ/O4, AOC 27A00) furnishes legal advice and services to the MEDBDE in civil and criminal legal practice, including the fields of business, property, administration, and financial operations under the jurisdiction of the DA. He provides defense counsel services for Army personnel whenever required by law or regulation and authorized by the Judge Advocate General or his designee. These services include representation at trials by courts-martial, administrative boards, and other criminal and adverse administrative actions. He performs other defense-related duties as prescribed by the US Army Trial Defense Service. The command judge advocate advises the commander on ethical issues as they relate to health care operations. Further, he advises the commander and the MEDCOM (DS) detainee operations medical director on issues pertaining to the treatment of EPWs and detainees in subordinate MEDBDE CSHs and other MTFs. He advises the commander on any issues related to the Geneva Conventions and the protection of medical personnel, patients, facilities, supplies, and transports. The command judge advocate advises the commander and his staff on the eligibility of care determinations, policies, and procedures. The command judge advocate deploys with the campaign module.

Paralegal Noncommissioned Officer

3-100. The senior paralegal NCO (SGT/E5, MOS 27D2O) assists the command judge advocate on paralegal issues. He provides consultation and assistance to subordinate command paralegal personnel and activities. He plans, task-organizes, and provides logistical support to the section. He maintains the law/administrative library and section files and records. He performs research on medical-legal issues and

points of law arising within the MEDBDE. Further, he monitors and reviews actions to ensure accuracy and timely dispatch or disposition. The senior paralegal NCO deploys with the campaign module.

Paralegal Specialist

3-101. The paralegal specialist (PFC/E3, MOS 27D1O) is responsible to the paralegal NCO for general typing and administrative functions for the section. The paralegal specialist deploys with the campaign module.

COMPANY HEADQUARTERS

3-102. The company headquarters (Table 3-15) provides C2 of the company. It develops the occupation plan, training and MWR activities, life support activities, sanitation, and supply for headquarters personnel. It provides field feeding and unit vehicle maintenance organic to or allocated for use by the headquarters.

Table 3-15. Company headquarters

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Company headquarters	05A00	O3	Commander***	IMM
	68W5M	E8	First sergeant	NC
	92Y3O	E6	Supply sergeant	NC
	92G3O	E6	Food operations sergeant**	NC
	42A1O	E4	Human resources specialist***	
	91B1O	E4	Wheeled vehicle mechanic	
	92G1O	E4	Cook	
	92G1O	E4	Cook**	
	92Y1O	E4	Armorer***	
	68W1O	E3	Health care specialist***	
	92G1O	E3	Cook**	

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)
AOC area of concentration
IMM immaterial
MOS military occupational specialty
NC noncommissioned officer

Commander

3-103. The commander (CPT/O3, AOC 05A00) is responsible for Soldiers assigned to the MEDBDE headquarters. He is responsible for ensuring local headquarters security, to include constructing defensive positions; arranging for and moving the headquarters; training; conducting morale, MWR activities for headquarters personnel; obtaining or providing food service, quarters, health care, field sanitation, and supply for headquarters personnel; providing and prioritizing motor transportation support (organic to or

allocated for use by the headquarters); and maintaining equipment organic to or allocated for use by the headquarters. The commander deploys with the campaign module.

First Sergeant

3-104. The first sergeant (1SG/E8, MOS 68W5M) is responsible to the company commander for all enlisted matters. He also assists in supervising company administration and training activities. He provides guidance to the enlisted members of the company and represents them to the company commander. The 1SG deploys with the early entry module.

Supply Sergeant

3-105. The supply sergeant (SSG/E6, MOS 92Y3O) manages the receiving, inspecting, inventorying, loading, unloading, segregating, storing, issuing, and turns-in of all organizational and installations supplies and equipment in the company. He operates automation equipment and prepares all organizational supply documents. He manages automated supply systems for accounting of organizational and installation supplies and equipment. The supply sergeant deploys with the early entry module.

Food Operations Sergeant

3-106. The food operations sergeant (SSG/E6, MOS 92G3O) coordinates with the troop issue subsistence activity, facility engineers, and veterinary activity. He plans and implements menus to ensure nutritionally balanced meals. He ensures the accuracy of accounting and equipment records. He develops and initiates standing operating procedures and safety, energy, security, and fire prevention programs. The food operations sergeant deploys with the expansion module.

Human Resources Specialist

3-107. The HR specialist (SPC/E4, MOS 42A1O) provides technical guidance to subordinate Soldiers in accomplishment of his HR duties. The HR specialist deploys with the campaign module.

Wheeled Vehicle Mechanic

3-108. The wheeled vehicle mechanic (SPC/E4, MOS 91B1O) is responsible for those mechanical duties within his scope of responsibility. He also performs driver operator duties. The wheeled vehicle mechanic deploys with the early entry module.

Cooks

3-109. The cooks (SPC/E4, MOS 92G1O) perform preliminary food preparation procedures in the early entry and expansion modules. They prepare and/or cook menu items listed on the production schedule. They bake, fry, braise, boil, simmer, steam, and sauté foods as prescribed by Army recipes. They set up serving lines, garnish food items, and apply food protection and sanitation measures in field environments. They receive and store subsistence items and perform general housekeeping duties. They operate, maintain, and clean field kitchen equipment. They also erect, strike, and store all types of field kitchens. They perform preventive maintenance on field kitchen equipment. One cook deploys with the early entry module and one with the expansion module.

Armorer

3-110. The armorer (SPC/E4, MOS 92Y1O) assists the supply sergeant in the accomplishment of their duties. He issues and receives small arms to include pistols, rifles, and squad automatic weapons. He secures and control weapons and ammunition in security areas. He schedules and performs preventive and organizational maintenance on weapons. The armorer deploys with the campaign module.

Health Care Specialist

3-111. The health care specialist (PFC/E3, MOS 68W1O) is the principal assistant to the commander and deploys with him to provide required administrative support. The health care specialist deploys with the campaign module.

Cook

3-112. The cook (PFC/E3, MOS 92G1O) performs duties as described in paragraph 3-109. The cook deploys with the expansion module.

UNIT MINISTRY TEAM

3-113. The unit ministry team (Table 3-16) provides religious support and pastoral care ministry for assigned staff and subordinate organizations of the command.

Table 3-16. Unit ministry team

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Unit ministry team	56A00	O4	Chaplain***	CH
	56M3O	E6	Chaplain assistant noncommissioned officer***	NC

LEGEND
**Expansion Module, Headquarters and Headquarters Company, Medical Brigade (Support) Staff
*** Campaign Module, Headquarters and Headquarters Company, Medical Brigade (Support)

AOC area of concentration
CH Chaplain Corps
MOS military occupational specialty
NC noncommissioned officer

Chaplain

3-114. The chaplain (MAJ/O4, AOC 56A00) functions as the staff officer for all matters in which religion impacts on command programs, personnel, policy, and procedures. He provides for the spiritual well-being and morale of MEDBDE personnel. He also provides religious services and pastoral counseling to Soldiers in the AO. The chaplain deploys with the campaign module.

Chaplain Assistant Noncommissiond Officer

3-115. The chaplain assistant NCO (SSG/E6, MOS 56M3O) is responsible to the chaplain for the support of religious operations. He prepares the chapel for worship and prepares sacraments. The chaplain assistant NCO deploys with the campaign module.

COORDINATION OF CLINICAL OPERATIONS

RESPONSIBILITIES

3-116. The chief, professional services, has the responsibility to monitor the impact of all of the medical functions on the clinical services provided within the command. He accomplishes this mission through the activities of his staff and coordinating and synchronizing clinical requirements with other MEDBDE staff sections. He coordinates with—

- The S-1 for all personnel matters relating to clinical staff personnel. The chief, professional services, recommends priority of fill and assignment of all clinical personnel to subordinate MTFs. As required, he requests augmentation support for medical specialties not represented on the TOE.

- The S-2 for medical intelligence support. The clinical operations section develops, recommends, and submits priority intelligence requirements and essential elements of friendly information for information impacting clinical operations (to include the potential enemy use of CBRN weaponry and toxic industrial material releases). This includes health threats within the AO and potential diseases present in and the health status of enemy forces who may become EPW or retained/detained personnel (to include new or exotic diseases in enemy forces).
- The S-3 for operational planning and medical regulating support. The clinical operations section monitors current operations and assists in planning future operations by providing clinical input into the development of Army Health System estimates and plans. They must evaluate proposed courses of action for their impact on clinical capabilities and activities and recommend whether they are feasible from a clinical viewpoint. Further, the clinical operations section must closely monitor medical regulating activities, bed status and/or OR delays, if any, of subordinate hospitals, patient movement items requirements, delays in the timely evacuation of patients to and from MEDBDE MTFs, and requirements for providing medical attendants for en route patient care on USAF evacuation assets, if critical care air transport team support is not available. The clinical operations section recommends clinical capabilities (task-organized) required to be deployed forward to support EAB personnel deployed to the division to provide direct support. The patient administration officer assigned to the intratheater patient movement center serves as a consultant to the clinical operations section when issues concerning medical record management arise.
- The S-4 for MEDLOG support of critical Class VIII items required for patient care, to include medical supplies, pharmaceuticals, medical equipment, and blood. The clinical operations section monitors the blood distribution and reporting processes (Technical Manual [TM] 8-227-12) to determine the impact on clinical operations of shortages and delays. Further, they monitor the status of medical supplies, medical equipment, and medical equipment maintenance and repair to ensure that sufficient quantities are on hand and/or on order to sustain patient care activities within the command. They also work closely with the S-4 in identifying and obtaining pharmaceuticals to treat diseases (to include biological warfare agents) not usually present in US forces (such as for EPWs). This section also advises the command on the management and disposition of captured enemy medical supplies and equipment. The pharmacy officer assigned to the S-4 serves as a consultant to the clinical operations section on all issues pertaining to pharmaceuticals.
- The S-6 for information management, automation requirements, and CE support.
- The S-9 for support to stability operations and interactions with the civilian community.
- The command judge advocate section for all medical-legal matters to include the determination of eligibility for medical care in US MTFs (Appendix A). Further, the command judge advocate section provides guidance on the provisions of the Geneva Conventions as they affect medical personnel, equipment, evacuation platforms, and Class VIII supplies. He also provides guidance on any legal issues involving care to EPW, retained, and detained personnel.
- The unit ministry team on religious matters that affect AHS operations to include faith-based dietary restrictions and assistance in COSC programs and activities.

TECHNICAL SUPERVISION

3-117. The chief, professional services, exercises his technical supervision of all HSS/FHP clinical activities through his staff. As the senior physician in the command, he develops policies, procedures, and protocols for clinical activities within subordinate MTFs. Treatment protocols implemented in the command are developed according to Defense Medical Standardization Board standards and requirements, Army regulations, appropriate doctrinal publications, and sound medical practice. He ensures that investigational new drug protocols are followed. He also monitors the use of chemoprophylaxis, pretreatments, immunizations, and barrier creams. He ensures credentialing policies are in place and are being adhered to. He further ensures that a quality assurance program is implemented. He monitors the medical evacuation/medical regulating activities to ensure necessary medical requirements and clearances for patients being evacuated are accomplished and develops patient preparation protocols for patients

entering the USAF evacuation system, as required. He monitors the area support mission of assigned/attached Role 2 MTFs to ensure adequate AHS support to transient troop populations within the MEDBDE AO. He compiles and analyzes wounded in action data to determine trends in wounding patterns, to forecast specialized care requirements, and to recommend protective measures as appropriate. He identifies medical issues which require medical research and development. The duties and functions of his staff include the—

- Chief nurse, who is the senior nurse in the command and who provides technical supervision of the MEDBDE subordinate MTFs nursing personnel (officer and enlisted). He establishes nursing policies and reviews and monitors nursing practices. He monitors staffing levels, personnel shortages, and advises the chief, professional services on the impact of nursing shortfalls on the capability to provide required patient care. He recommends to the chief, professional services priority of assignment for nursing care personnel. The chief nurse also ensures educational and training requirements are met and monitors in-service training activities of subordinate MTFs. The chief nurse monitors mass casualty planning of subordinate MTFs, provides consultation to subordinate MTF mass casualty coordinators during rehearsals of the mass casualty plan, and ensures that if training shortfalls are identified that appropriate refresher/sustainment training is provided. He ensures that documentation of medical treatment provided is appropriately documented in the individual health record using the prescribed forms and/or electronic media. He directs routine reporting requirements and establishes format and frequency of all formal nursing reports.
- Preventive medicine officer, environmental science officer, and senior PVNTMED NCO monitor all PVNTMED activities and requirements of the command (FM 4-02.17 and FM 4-02.18). The PVNTMED officer establishes reporting requirements and frequency of reports (such as the weekly DNBI report). He consolidates subordinate unit DNBI reports and analyzes the data submitted to identify trends and to compare incoming data with already established base-lines. If trends are identified, he recommends and develops effective medical countermeasures and disseminates this information to all subordinate, adjacent, and higher headquarters. The PVNTMED officer and environmental science officer analyze the data for indicators of the potential exposure of US forces to enemy employment of biological warfare and chemical warfare agents (increases in endemic disease rates in one specific geographic location or the appearance of diseases which can be weaponized and are not endemic to the AO) and to OEH hazards. He receives, monitors, reviews, and forwards supporting laboratory analysis of CBRN samples/specimens and chain of custody actions for CBRN samples/specimens (FM 4-02.7). He ensures that medical surveillance and OEH health surveillance activities are developed and implemented for the health threat present in the AO. He monitors pest management, potable water inspection, and inspection of field feeding/dining facility sanitation activities, toxic industrial materials sources and hazards, and further ensures the procedures for the disposal of medical waste are being adhered to. The PVNTMED NCO ensures that field hygiene and sanitation training and unit field sanitation team training for subordinate units and personnel is current and adequate. The veterinary PVNTMED officer, the veterinary services technician, and the veterinary NCO are responsible for monitoring the implementation of programs for the inspection of food and food sources for procurement, quality assurance, security, and sanitation. He also monitors animal medical care activities and identifies MEDLOG shortfalls that will impact on animal medical care activities. The veterinary NCO also monitors veterinary PVNTMED activities.
- Psychiatrist and the mental health NCO monitor all COSC activities and the treatment of BH and NP cases within subordinate MTFs. The psychiatrist ensures that all treatment programs for combat and operational stress are founded on proven principles of combat psychiatry and are established and administered in accordance with current doctrinal principles (FM 4-02.51 and FM 6-22.5). He monitors the stress level of subordinate unit medical personnel and provides consultation on traumatic event management support to health care providers after mass casualty situations or other high stress events. He coordinates policies, procedures, and protocols for the treatment of BH and NP disorders with the senior subordinate unit psychiatrist and provides consultation on the requirements for the medical evacuation of psychiatric patients.

- Dietitian and senior nutrition NCO monitor the status of medical diet supplement rations, hospital food service operations, and command health promotion program. The dietitian provides consultation to subordinate hospitals on special diet requirements and preparation. He further coordinates with the unit ministry team on faith-based dietary restrictions. In foreign humanitarian assistance operations, he provides consultation and advice on refeeding operations for malnourished children and adults, refugee or displaced person populations, and victims of man-made or natural disasters. He also provides consultation on special dietary requirements for patients being evacuated through the USAF evacuation system.
- The chief, dental services, monitors dental activities for the command. He receives reports from subordinate units and consolidates this data for forwarding to higher headquarters. The chief, dental services establishes and coordinates policies, procedures, and protocols for the treatment of dental conditions and preventive dentistry programs.

3-118. Not all functional specialties are fully represented on the MEDBDE headquarters staff. Therefore the clinical operations section coordinates with subordinate medical units for expertise in the following areas—

- The senior subordinate surgeon serves as the principal consultant to the chief, professional services on all matters pertaining to surgical policy and employment of forward surgical teams. He maintains visibility of the joint trauma system patient treatment issues, wounding patterns, and weapons effects in order to ensure subordinate MTFs are informed, equipped, and supplied to provide appropriate treatment. Additionally, the chief, professional services can consult with the surgical consultant on the MEDCOM (DS) staff.
- The senior subordinate medical laboratory officer serves as the principal consultant to the chief, professional services on all matters pertaining to clinical laboratory support. He advises the chief, professional services on blood banking and storage capabilities of Roles 2 and 3 MTFs within the command. The senior medical laboratory NCO on the MEDBDE staff monitors the performance of MEDBDE medical laboratories, identifies deficiencies, and recommends solutions. Issues arising that exceed his skill set are referred to the senior subordinate medical laboratory officer for resolution. This officer monitors the performance of MEDBDE medical laboratories, to include area medical laboratory activities (including CBRN sample/specimen processing and chain of custody requirements) and MTF clinical laboratory practices. He advises the chief, professional services on blood banking and storage capabilities of Roles 2 and 3 MTFs within the command. He monitors Class VIII support as it impacts on medical laboratory capabilities and advises the chief, professional services of any shortfalls which adversely impact on the performance of laboratory procedures.
- The senior subordinate optometry officer serves as the principal consultant to the chief, professional services on all matters pertaining to optometric support and optical laboratory support. If no optometry personnel are assigned to the command, the chief, professional services coordinates with the optometry officer on the MEDCOM (DS) staff.
- The senior subordinate nuclear science officer serves as a consultant to the chief, professional services on all nuclear medicine issues. For a discussion of the duties of a nuclear science officer refer to paragraph 2-133. If there are no nuclear medicine officers assigned to subordinate units, the chief, professional services coordinates for this support with the MEDCOM (DS) staff.
- When required, the PVNTMED officer coordinates for support from subordinate PVNTMED units for entomology and environmental engineering support. Refer to paragraphs 2-155 and 2-157 for a discussion of entomology and environmental engineering support. If these PVNTMED specialties are not available in subordinate units, the PVNTMED officer coordinates with the MEDCOM (DS) PVNTMED section for this support.

3-119. The clinical operations section coordinates with the higher and, when appropriate, adjacent medical headquarters on any clinical issues which cannot be resolved at this level or that will adversely impact clinical operations in other adjacent or higher commands. The clinical operations section monitors medical specialty capabilities of subordinate hospitals and coordinates with its higher headquarters when medical specialty augmentation team support is required.

3-120. The clinical operations section coordinates with and provides consultation to the medical section of the theater internment facility and resettlement facilities established within the MEDBDE AO for the treatment and hospitalization of EPW, retained, and detained personnel.

3-121. To facilitate monitoring clinical operations of subordinate MTFs, the clinical operations section determines what reports are required, format to be used, and at what frequency the reports will be submitted. The intratheater patient movement center receives bed status reports and requests for medical regulating/evacuation which should include the clinical operations section on distribution. The S-4 receives medical supply status from all subordinate facilities which the clinical operations section must review to determine if the medical supply status of subordinate facilities will adversely impact patient care. Additionally, he may develop a medical situation report for the clinical aspects of subordinate MTF operations to remain apprised of daily/weekly operations. The clinical operations section also receives medical situation reports from forward deployed FSTs to determine if reconstitution/replacement/ reinforcement of these assets is required. This report also provides information on the types of surgical cases that will require follow-on surgery at subordinate MEDBDE hospitals.

SECTION II — EARLY ENTRY MODULE, HEADQUARTERS AND HEADQUARTERS COMPANY, MEDICAL BRIGADE (SUPPORT)

MISSION AND ASSIGNMENT

3-122. The positions that make up the medical support MEDBDE early entry module are identified in TOE 08422GA00. The early entry module provides scalable, expeditionary medical C2 capability for assigned and attached medical functional plugs task-organized under the medical support MEDBDE in support of deployed forces.

CAPABILITIES AND LIMITATIONS

3-123. This early entry module provides—

- A rapidly responsive early entry C2, module that can quickly integrate into the early entry deployment sequence for crisis management.
- Full spectrum continuous C2 in support of all Army BCTs and US and multinational forces.
- Operational medical plugs augmentation to Role 2 BCT medical companies.
- Medical staff planning, operational and technical supervision, and administrative assistance for MMBs and hospitals operating in the EAB area of operations.
- Medical consultation services in the following areas—
  - Preventive medicine (medical surveillance, environmental health, sanitary engineering, and medical entomology).
  - Behavioral health to include COSC and NP care.
  - Advice and recommendations for the conduct of CMO.
  - Control and supervision of Class VIII supply and resupply movement to include blood management. When designated by the GCC, serves as the SIMLM.
  - Command and control capability that can be joint with the appropriate assets.
  - Serves as the executive agent for veterinary services.
  - Coordinates Army support to other Services for the ship-to-shore/shore-to-ship medical evacuation mission.
  - Designate the minimum mission essential wartime requirement for personnel and equipment.
  - Assist individuals in the coordinated defense of the unit's area or installation.
  - This unit performs field maintenance on all organic equipment, except CE and COMSEC equipment.

ORGANIZATION AND FUNCTIONS

3-124. Section II provides a description of the operational elements in the early entry module. A full description of the MEDBDE, including personnel and capabilities in all three modules combined, is provided in Section I.

S-1 SECTION

3-125. The S-1 section (Table 3-17) provides overall administrative services for the command, to include personnel administration, and coordinates with elements of supporting agencies for finance, personnel, legal, and administrative services.

Table 3-17. S-1 section (early entry module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-1 section (early entry module)	70F67	O3	Health services personnel manager	MS
	420A0	W2	Military personnel technician	WO
	42A5O	E8	Senior human resources sergeant	NC
	42A3O	E6	Human resources sergeant	NC
	42A2O	E5	Human resources sergeant	NC
	42A1O	E4	Human resources specialist	
	42F1O	E4	Human resources information system management specialist	

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
WO warrant officer

S-2 SECTION

3-126. The S-2 section (Table 3-18) performs all source intelligence analysis and estimates for the command. It advises the commander and staff on nuclear/chemical surety and CBRN operations.

Table 3-18. S-2 section (early entry module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-2 section (early entry module)	70H67	O4	S-2	MS

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps

S-3 SECTION

3-127. The S-3 section (Table 3-19) is responsible for plans and operations, deployment, relocation and redeployment of the MEDBDE, and supervising medical evacuation operations for both air and ground.

Table 3-19. S-3 section (early entry module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-3 section (early entry module)	70H67	O5	S-3	MS
	68W1O	E3	Health care specialist	

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps

S-3 OPERATIONS BRANCH

3-128. The S-3 operations branch (Table 3-20) is responsible for authenticating and publishing plans and orders. It exercises staff supervision over HSS/FHP activities, advises the commander and staff on nuclear/chemical surety, and CBRN operations.

Table 3-20. S-3 operations branch (early entry module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-3 operations branch (early entry module)	70H67	O4	Chief medical operations branch	MS
	70H67	O3	Medical operations officer	MS
	68W4O	E7	Operations sergeant	NC
	74D3O	E6	Nuclear, biological, and chemical noncommissioned officer	NC
	68W2O	E5	Health care sergeant	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-3 PLANS BRANCH

3-129. The S-3 plans branch (Table 3-21) is responsible for the current planning in the MEDBDE AO, to include deliberate and crisis planning. Additionally, it plans for future operations in the excess of 72 hours and prepares major regional contingency plans for the MEDBDE. Further, it prepares, authenticates, and publishes medical plans and OPLANs to include the integration of annexes and appendixes prepared by other staff sections.

Table 3-21. S-3 plans branch (early entry module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-3 plans branch (early entry module)	70H67	O3	Plans officer	MS

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

INTRATHEATER PATIENT MOVEMENT CENTER

3-130. The intratheater patient movement center (Table 3-22) is responsible for maintaining 24-hour coordination and oversight for patient regulating and administration within the MEDBDE AO.

Table 3-22. Intratheater patient movement center (early entry module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Intratheater patient movement center (early entry module)	67J00	O4	Aeromedical evacuation officer	MS
	70E67	O4	Medical regulating officer	MS
	68G3O	E6	Patient administration noncommissioned officer	NC
	68G2O	E5	Patient administration noncommissioned officer	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-4 SECTION

3-131. The S-4 section (Table 3-23) monitors, coordinates, and facilitates MEDLOG operations within the command. This includes Class VIII supply and resupply, blood management and distribution, medical equipment maintenance and repair, medical gases, optical lens fabrication, and spectacle fabrication and repair.

Table 3-23. S-4 section (early entry module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-4 section (early entry module)	70K67	O4	Chief logistics operations branch	MS
	670A0	W4	Brigade maintenance officer	WO
	68J4O	E7	Medical logistics sergeant	NC

LEGEND
AOC area of concentration
NC noncommissioned officer
MOS military occupational specialty
MS Medical Service Corps
WO warrant officer

S-6 SECTION

3-132. The S-6 section (Table 3-24) provides for all aspects of automation and CE for the command. It determines C2 signal requirements, capabilities, and operations. It also provides advice and consultation on medical automates systems in use within the MEDBDE.

Table 3-24. S-6 section (early entry module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-6 section (early entry module)	70D67	O4	S-6	MS
	25A00	O3	Signal officer	SC
	254A0	W2	Signal systems technician	WO
	25U5O	E8	Signal support system chief	NC
	25B2O	E5	Senior information system specialist	NC
	25B1O	E4	Information system specialist	
	25U1O	E4	Radio retransmission operator	
	25U1O	E3	Radio retransmission operator	

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
WO warrant officer

S-9 SECTION

3-133. The S-9 section (Table 3-25) is responsible for the integration of CMO planning within the MEDBDE. It conducts area assessments and estimates on the impact of the local populace on MTFs to include the assessment of the host/foreign national medical infrastructure in planning for and executing health care delivery.

Table 3-25. S-9 section (early entry module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-9 section (early entry module)	38A00	O4	S-9	CA

LEGEND
AOC area of concentration
CA civil affairs
MOS military occupational specialty

CLINICAL OPERATIONS SECTION

3-134. The clinical operations section (Table 3-26) serves as the commander's principal consultants and technical advisors for the command in general medicine, PVNTMED, to include NP care, COSC, and BH.

Table 3-26. Clinical operations section (early entry module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Clinical operations section (early entry module)	60A00	O6	Chief professional services	MC
	60C00	O5	Preventive medicine officer	MC
	68X4O	E7	Mental health noncommissioned officer	NC

LEGEND
AOC area of concentration
MC Medical Corps
MOS military occupational specialty
NC noncommissioned officer

COMPANY HEADQUARTERS

3-135. The company headquarters (Table 3-27) provides C2 of the company. It develops the occupation plan, training and morale, welfare, and recreation activities, life support activities, sanitation, and supply for headquarters personnel. It provides filed feeding and unit vehicle maintenance organic to or allocated for use by the headquarters.

Table 3-27. Company headquarters (early entry module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Company headquarters (early entry module)	68W5M	E8	First sergeant	NC
	92Y3O	E6	Supply sergeant	NC
	91B1O	E4	Wheeled vehicle mechanic	
	92G1O	E4	Cook	

LEGEND
AOC area of concentration
MOS military occupational specialty
NC noncommissioned officer

SECTION III — EXPANSION MODULE, HEADQUARTERS AND HEADQUARTERS COMPANY, MEDICAL BRIGADE (SUPPORT)

MISSION AND ASSIGNMENT

3-136. The positions that make up the expansion module of the MEDBDE are identified on TOE 08422GB00. The expansion module augments the early entry module and provides a more robust C2 element to the HHC, MEDBDE.

CAPABILITIES AND LIMITATIONS

3-137. The expansion module provides—

- A rapidly responsive early entry C2, module that can quickly integrate into the early entry deployment sequence for crisis management.
- Full spectrum continuous C2 in support of all Army BCT, EAB, and multinational forces.

- Operational medical plugs augmentation to Role 2 medical companies.
- Medical staff planning, operational and technical supervision, and administrative assistance for MMBs and hospitals operating in the EAB AO.
- Medical consultation services in the following areas—
  - Preventive medicine (medical surveillance, environmental health, sanitary engineering, and medical entomology).
  - Behavioral health to include COSC and NP care.
  - Advice and recommendations for the conduct of CMO.
  - Control and supervision of Class VIII supply and resupply movement to include blood management. When designated by the GCC, serves as the SIMLM.
  - A joint-capable C2 capability when augmented with appropriate joint assets.
  - Serve as the executive agent for veterinary services.
  - Coordinate Army support to other Services for the ship-to-shore/shore-to-ship medical evacuation mission.
  - Quantities designate the minimum mission essential wartime requirements for personnel and equipment.
  - Individuals of this organization can assist in the coordinated defense of the unit's area or installation.
  - This unit performs field maintenance on all organic equipment, except CE and COMSEC equipment.

ORGANIZATION AND FUNCTIONS

3-138. Section III provides a description of the operational elements in the expansion module. A full description of the MEDBDE, including personnel and capabilities in all three modules combined, is provided in Section I.

COMMAND SECTION

3-139. The command section (Table 3-28) provides C2 and management for all MEDBDE operations, activities, and services.

Table 3-28. Command section (expansion module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Command section (expansion module)	05A00	O6	Commander	IMM
	00Z5O	E9	Command sergeant major	NC
	68W2O	E5	Health care sergeant	NC
	68W1O	E4	Health care specialist	

LEGEND
AOC area of concentration
IMM immaterial
MOS military occupational specialty
NC noncommissioned officer

S-2 SECTION

3-140. The S-2 section (Table 3-29) augments all-source intelligence assessments and estimates for the command. It analyzes and evaluates intelligence, to include health threat information and medical and OEH surveillance data.

Table 3-29. S-2 section (expansion module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-2 section (expansion module)	68W5O	E8	Intelligence medical sergeant	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
NC noncommissioned officer

S-3 SECTION

3-141. The S-3 section (Table 3-30) increases the early entry module capability for plans and operations, deployments, relocation and redeployment of the MEDBDE, and supervising medical evacuation operations for both air and ground.

Table 3-30. S-3 section (expansion module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-3 section (expansion module)	68Z5O	E9	Chief operations sergeant	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
NC noncommissioned officer

S-3 OPERATIONS BRANCH

3-142. The S-3 operations branch (Table 3-31) increases the early entry module capability for plans and operations, deployment, relocation and redeployment of the MEDBDE; supervising medical evacuation operations both air and ground.

Table 3-31. S-3 operations branch (expansion module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-3 operations branch (expansion module)	74B00	O3	Chemical officer	CM

LEGEND
AOC area of concentration
CM Chemical Corps]
MOS military occupational specialty

S-3 PLANS BRANCH

3-143. The plans branch (Table 3-32) is responsible for authenticating and publishing plans and orders. It exercises staff supervision over HSS/FHP activities, advises the commander and staff on nuclear/chemical surety, and CBRN operations.

Table 3-32. S-3 plans branch (expansion module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-3 plans branch (expansion module)	68W5O	E8	Plans noncommissioned officer	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
NC noncommissioned officer

S-3 PATIENT MOVEMENT BRANCH

3-144. The S-3 patient movement branch (Table 3-33) increases the early entry module capability for maintaining 24-hour coordination and oversight responsibility for patient regulating and administration within the MEDBDE.

Table 3-33. S-3 patient movement branch (expansion module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-3 patient movement branch (expansion module)	68G4O	E7	Patient administration noncommissioned officer	NC
	68G1O	E4	Patient administration specialist	
	68G1O	E3	Patient administration specialist	

LEGEND
AOC area of concentration
MOS military occupational specialty
NC noncommissioned officer

S-4 SECTION

3-145. The S-4 section (Table 3-34) increases the early entry module S-4 capability for its function to plan, coordinate, and manage medical and general logistics for subordinate units and other units in the MEDBDE AO. It has primary responsibility for monitoring logistics support for units of the MEDBDE.

Table 3-34. S-4 section (expansion module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-4 section (expansion module)	70K67	O5	S-4	MS
	91Z5O	E8	Senior maintenance supervisor	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-4 LOGISTICS OPERATIONS BRANCH

3-146. The S-4 logistics operations branch (Table 3-35) monitors, coordinates, and facilitates MEDLOG operations within the command. This includes Class VIII supply and resupply, blood management and distribution, medical equipment maintenance and repair, medical gases, optical lens fabrication, and spectacle fabrication and repair.

Table 3-35. S-4 logistics operations branch (expansion module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-4 logistics operations branch (expansion module)	67E00	O3	Pharmacy officer	MS

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps

S-4 LOGISTICS PLANS BRANCH

3-147. The S-4 logistics plans branch (Table 3-36) plans for the MEDLOG mission to include the SIMLM, when designated. It coordinates with and provides MEDLOG support to the MEDBDE subordinate elements and to all Services deployed in the AO when designated as the SIMLM.

Table 3-36. S-4 logistics plans branch (expansion module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-4 logistics plans branch (expansion module)	68J5O	E8	Medical logistics sergeant	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
NC noncommissioned officer

S-6 SECTION

3-148. The S-6 section (Table 3-37) increases the S-3 early entry module capability to provide for all aspects of automation and CE for the MEDBDE. It determines C2 signal requirements, capabilities, and operations.

Table 3-37. S-6 section (expansion module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-6 section (expansion module)	25U1O	E4	Signal support specialist	

LEGEND
AOC area of concentration
MOS military occupational specialty

CLINICAL OPERATIONS SECTION

3-149. The clinical operations section (Table 3-38) augments the clinical services early entry module to increase the capability to serve as the commander's principal consultants and technical advisors for the MEDBDE in general medicine, dentistry, PVNTMED, COSC and BH (to include NP care), veterinary services, and medical laboratory services.

Table 3-38. Clinical operations section (expansion module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Clinical operations section (expansion module)	66N00	O6	Chief nurse	AN
	60W00	O5	Chief dental services	DC
	64B00	O5	Veterinary preventive medicine officer	VC
	68Z5O	E9	Chief clinical noncommissioned officer	NC
	68K4O	E7	Medical laboratory noncommissioned officer	NC
	68W1O	E4	Health care specialist	

LEGEND
AOC area of concentration
AN Army Nurse Corps
DC Dental Corps
MOS military occupational specialty
NC noncommissioned officer
VC Veterinary Corps

COMPANY HEADQUARTERS

3-150. The company headquarters (Table 3-39) augments the company headquarters early entry module to better provide C2 of the company. It increases its capability to develop the occupation plan, training, moral, welfare, and recreation activities, life support activities, field sanitation, and supply for headquarters personnel.

Table 3-39. Company headquarters (expansion module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Company headquarters (expansion module)	92G3O	E6	Food operations sergeant	NC
	92G1O	E4	Cook	
Company headquarters (expansion module) (continued)	92G1O	E3	Cook	

LEGEND
AOC area of concentration
MOS military occupational specialty
NC noncommissioned officer

SECTION IV — CAMPAIGN MODULE, HEADQUARTERS AND HEADQUARTERS COMPANY, MEDICAL BRIGADE (SUPPORT)

MISSION AND ASSIGNMENT

3-151. The positions that make up the campaign module of the MEDBDE are identified on TOE 08422GC00. The expansion module augments the early entry and expansion modules and completes the equipping and staffing of the medical support MEDBDE.

CAPABILITIES AND LIMITATIONS

3-152. The campaign module provides—

- A rapidly responsive early entry C2, module that can quickly integrate into the early entry deployment sequence for crisis management.
- Full spectrum continuous C2 in support of all Army BCT, EAB, joint, and multinational forces.
- Operational medical plug augmentation to Role 2 BCT medical companies.
- Medical aspects of their EAB and BCT commanders' operations.
- Medical staff planning, operational and technical supervision, and administrative assistance for MMBs and hospitals operating in the EAB AO.
- Medical consultation services and technical advice in the following areas:
  - Preventive medicine (medical surveillance, environmental health, sanitary engineering, and medical entomology).
  - Behavioral health to include COSC and NP care.
  - Veterinary services (including food safety and inspection, animal medicine, and veterinary PVNTMED services).
  - Nutrition care.
  - Civil military operations advice and recommendations..
  - A joint-capable C2 capability when augmented with appropriate joint assets.
  - Serves as the executive agent for veterinary services.
  - Designate the minimum mission essential wartime requirement for personnel and equipment.
  - Individuals of this organization, except chaplains, can assist in the coordinated defense of the unit's area or installation.
  - This unit performs field maintenance on all organic equipment, except CE and COMSEC.

ORGANIZATION AND FUNCTIONS

3-153. This section provides a description of the operational elements in the campaign module. A full description of the MEDBDE, including personnel and capabilities in all three modules combined, is provided in Section I.

COMMAND SECTION

3-154. The command section (Table 3-40) completes the staffing to enhance the C2 and management for all the MEDBDE operations, activities, and services.

Table 3-40. Command section (campaign module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Command section (campaign module)	67A00	O5	Executive officer	MS
	70C67	O3	Health services comptroller	MS

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps

S-1 SECTION

3-155. The S-1 section (Table 3-41) completes the equipping and staffing to enhance the overall administrative services for the MEDBDE to include personnel administration, mail distribution, awards, and leaves.

Table 3-41. S-1 section (campaign module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-1 section (campaign module)	70F67	O4	S-1	MS
	42A3O	E6	Human resources sergeant	NC
	42A2O	E5	Human resources sergeant	NC
	42F2O	E5	Human resources information system management sergeant	NC
	42A1O	E4	Human resources specialist	

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-2 SECTION

3-156. The S-2 section (Table 3-42) completes the equipping and staffing to enhance all-source intelligence assessments and estimates for the MEDBDE. It also advises the commander and staff on nuclear/chemical surety and CBRN operations.

Table 3-42. S-2 section (campaign module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-2 section (campaign module)	68W4O	E7	Intelligence sergeant	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
NC noncommissioned officer

S-3 OPERATIONS BRANCH

3-157. The S-3 operations branch (Table 3-43) completes the staffing to enhance the authenticating and publishing plans and orders. It exercises staff supervision over HSS/FHP activities, advises the commander and staff on nuclear/chemical surety and CBRN operations.

Table 3-43. S-3 operations branch (campaign module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-3 operations branch (campaign module)	70H67	O3	Medical operations officer	MS
	68W4O	E7	Operations sergeant	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-3 PLANS BRANCH

3-158. The S-3 plans branch (Table 3-44) completes the equipping and staffing to enhance current planning in the MEDBDE AO, to include deliberate and crisis planning.

Table 3-44. S-3 plans branch (campaign module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-3 plans branch (campaign module)	70H67	O4	Chief medical plans branch	MS
	68W4O	E7	Plans sergeant	NC
	68W4O	E7	Health care noncommissioned officer	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-3 PATIENT MOVEMENT BRANCH

3-159. The patient movement branch (Table 3-45) is responsible for maintaining 24-hour coordination and oversight responsibility for patient regulating and administration within the MEDBDE AO.

Table 3-45. S-3 patient movement branch (campaign module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-3 patient movement branch (campaign module)	70E67	O3	Patient administration officer	MS
	68G2O	E5	Patient administration noncommissioned officer	NC
	68G1O	E4	Patient administration specialist	

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-4 SECTION

3-160. The S-4 section (Table 3-46) increases the expansion module S-4 capability in its function to plan, coordinate, and manage medical and general logistics for subordinate units and other units in the MEDBDE AO. It has primary responsibility for monitoring logistics support for units of the MEDBDE.

Table 3-46. S-4 section (campaign module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-4 section (campaign module)	92Z5O	E9	Senior supply supervisor	NC
	92Y2O	E5	Property book noncommissioned officer	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
NC noncommissioned officer

S-4 LOGISTICS PLANS

3-161. The S-4 logistics plans branch (Table 3-47) completes the staffing to enhance the monitoring, coordinating, and facilitating of MEDLOG operations within the MEDBDE. This includes Class VIII supply and resupply, blood management and distribution, medical equipment maintenance and repair, medical gases, optical lenses fabrication, and spectacle fabrication and repair.

Table 3-47. S-4 logistics plans branch (campaign module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-4 logistics plans branch (campaign module)	70K67	O3	Chief logistics plans branch	MS

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps

S-6 SECTION

3-162. The S-6 section (Table 3-48) completes the staffing to enhance the aspects of automation and CE for the MEDBDE. It determines C2 signal requirements, capabilities, and operations.

Table 3-48. S-6 section (campaign module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-6 section (campaign module)	25U1O	E4	Signal information services specialist	

LEGEND
AOC area of concentration
MOS military occupational specialty

CLINICAL OPERATIONS SECTION

3-163. The clinical operations section (Table 3-49) completes the staffing to enhance the commander's principal consultants and technical advisors for general medicine, dentistry, PVNTMED, to include NP, COSC and BH, veterinary services, and medical laboratory services.

Table 3-49. Clinical operations section (campaign module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Clinical operations section (campaign module)	65C00	O4	Dietician	SP
	72D67	O4	Environmental science officer	MS
	640A0	W2	Veterinary services technician	WO
	68S4O	E7	Preventive medicine noncommissioned officer	NC

LEGEND
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
SP Army Medical Specialist Corps
WO warrant officer

COMMAND JUDGE ADVOCATE SECTION

3-164. The command judge advocate section (Table 3-50) completes the staffing to enhance providing legal advice and services to the commander, staff, and personnel.

Table 3-50. Command judge advocate section (campaign module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Command judge advocate section (campaign module)	27A00	O4	Command judge advocate	JA
	27D2O	E5	Paralegal noncommissioned officer	NC
	27D1O	E3	Paralegal specialist	

LEGEND
AOC area of concentration
JA Judge Advocate Corps
MOS military occupational specialty
NC noncommissioned officer

COMPANY HEADQUARTERS

3-165. The company headquarters (Table 3-51) completes the staffing to C2 for the company. It develops the occupation plan, training, morale, welfare, recreation, activities, life support activities, field sanitation, and supply for headquarters personnel.

Table 3-51. Company headquarters (campaign module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Company headquarters (campaign module)	05A00	CPT	Commander	IMM
	42A1O	E4	Human resources specialist	
	92Y1O	E4	Armorer	
	68W1O	E3	Health care specialist	

LEGEND
AOC area of concentration
IMM immaterial
MOS military occupational specialty

UNIT MINISTRY TEAM

3-166. The unit ministry team (Table 3-52) provides religious support and pastoral care ministry for assigned staff and subordinate organizations of the command.

Table 3-52. Unit ministry team (campaign module)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Unit ministry team (campaign module)	56A00	O4	Chaplain	CH
	56M3O	E6	Chaplain assistant noncommissioned officer	NC

LEGEND
AOC area of concentration
CH Chaplain Corps
MOS military occupational specialty
NC noncommissioned officer

Chapter 4
MEDICAL BATTALION (MULTIFUNCTIONAL)

Force structure changes occurring within the Modular Army necessitated a redesign of the functional medical battalions (area support, medical evacuation, and MEDLOG) into a multifunctional organization which can provide the requisite planning, synchronization, and coordination for modular medical companies, detachments, and teams/elements. Modularity has resulted in a smaller deployed medical footprint through enhancing the capability to rapid task organization of scalable medical capabilities. As the medical functions, although distinct, are interrelated and interdependent to enable a seamless health care continuum from the point of injury to the CONUS-support base which facilitates centralized planning for the execution of operations.

SECTION I — HEADQUARTERS AND HEADQUARTERS COMPANY, MEDICAL BATTALION (MULTIFUNCTIONAL)

MISSION AND ASSIGNMENT

4-1. The mission of the MMB (TOE 08485G00) is to provide scalable, flexible, and modular medical C2, administrative assistance, logistical support, and technical supervision capability for assigned and attached medical functional organizations (companies, detachments, and teams) task-organized for support of deployed BCTs and EAB forces. The MMB headquarters is depicted in Figure 4-1.

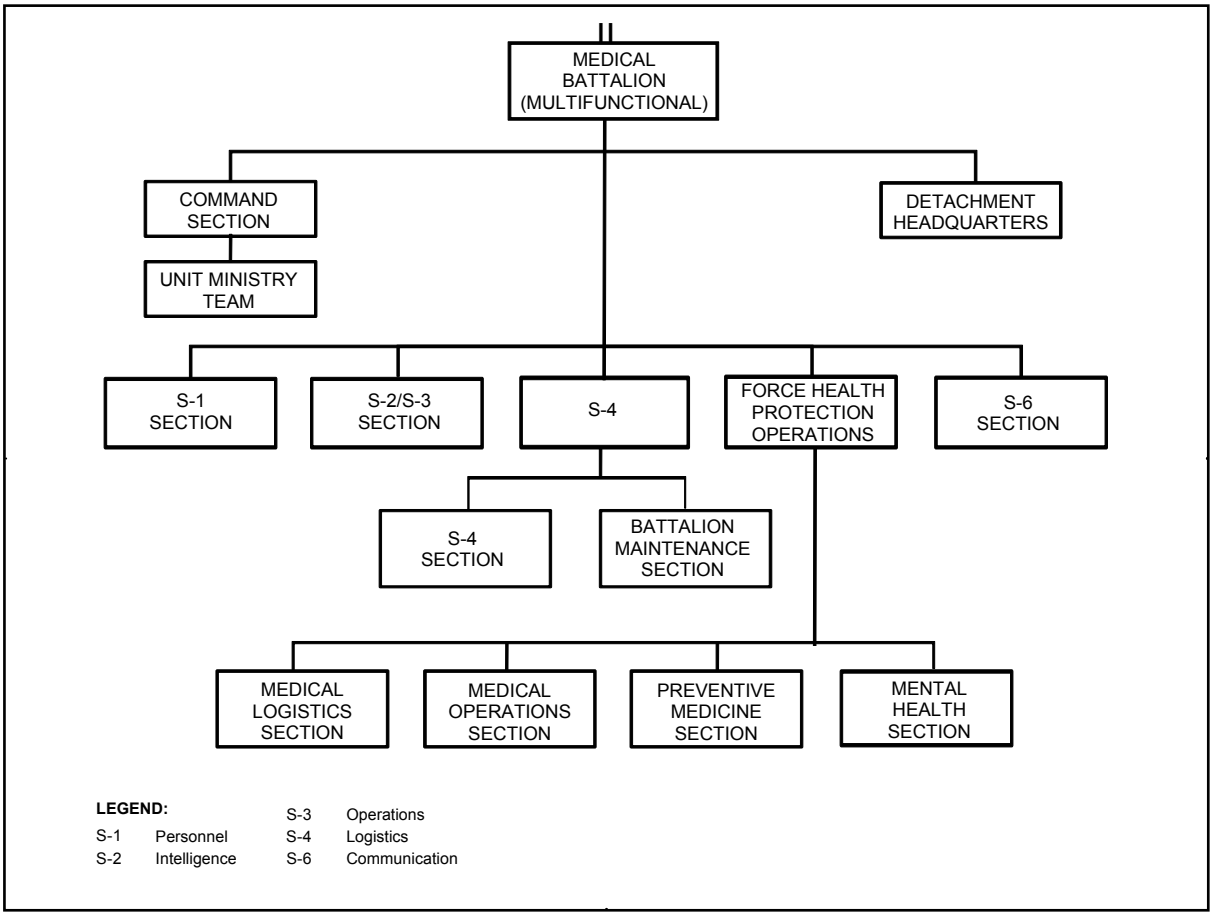

Figure 4-1. The multifunctional medical battalion

4-2. The MMB is the battalion-level medical headquarters in theater.

4-3. The MMB consists of an early entry element (EEE) and a campaign support element (CSE).

CAPABILITIES AND LIMITATIONS

4-4. The MMB is a multifunctional medical C2 organization that replaces the functionally aligned medical battalion, area support; medical battalion, logistics; and medical battalion, evacuation. This multifunctional headquarters is composed of two standard requirement codes identified modules (the EEE and the CSE) to facilitate the deployment and integration of the unit on the Time Phased Force Deployment List. This headquarters conducts operational planning for assigned and attached medical functional companies, detachments, and teams. The MMB headquarters should be deployed as far forward as the division AO. Even in this circumstance the MMB would remain under the direct C2 of the MEDBDE and not directly attached to the BCT. Detachments/teams assigned or attached to the MMB may be further attached to the medical company (brigade support battalion) to augment or reconstitute BCT medical elements. The array of health care units assigned and attached will vary depending upon METT-TC. When fully manned, it provides—

- Medical C2, staff planning, supervision of operations, medical and general logistics support as required, and administration of the activities of subordinates to accomplishing the AHS mission.
- Task organization of EAB health care assets to meet the projected patient workload.
- Advice to senior commanders in the AO on the health care aspects of their operations.

- Coordination of medical regulating and patient movement with the MEDBDE intratheater patient movement center or the MEDCOM (DS) TPMC, as required.
- Monitoring, planning, and coordinating of medical ground and air medical evacuation within the MMB AO. Coordinating requests with the supporting aviation unit air medical evacuation support requirements and synchronization of the medical air evacuation plan into the overall medical evacuation plan.
- Guidance for facility site selection and area preparation.
- Consultation and technical advice on PVNTMED (medical entomology, medical and OEH surveillance, and sanitary engineering), pharmacy procedures, COSC and BH, medical records administration, veterinary services, nursing practices and procedures, and medical laboratory procedures to supported units. Monitors and provides advice and consultation on dental support activities within the MMB AO.
- Monitoring and supervision of MEDLOG operations, to include Class VIII supply/resupply, medical equipment maintenance and repair support, optical fabrication and repair support, and blood management.
- Planning and coordination of Role 1 and Role 2 medical treatment, to include staff advice on an area support basis for EAB units without organic health care assets.
- Unit-level maintenance for wheeled vehicles and power generation equipment, and wheeled vehicle recovery operations support to assigned or attached units.
- Organizational communications equipment maintenance support for the battalion.
- Food service support for staff and other medical elements dependent upon the battalion for food service.
- Maintenance of a consolidated property book for assigned units.
- Religious support for the battalion staff, unit personnel of assigned/attached medical elements, and casualties in subordinate MTFs in the MMB AO.

ORGANIZATION AND FUNCTIONS

4-5. This TOE will be assigned to the MEDBDE or the MEDCOM (DS). The MMB is allocated as one MMB per combination of three to seven medical companies or ten to fifteen medical detachments or teams. This basis of allocation is computed on the aggregate of total companies, detachments, and teams assigned or attached. This unit is designed a Category II unit. (For unit categories, see AR 71-32.)

INTERNAL STAFF AND OPERATIONS

4-6. The MMBs coordinating staff (S-staff) and special staff sections manage the command's internal operations through coordination with staffs of higher, lower, and adjacent units. The staff's efforts support the commander and subordinate units. The staff supports the commander by providing accurate and timely information. It produces estimates, recommendations, plans and orders, and monitors execution. The staff streamlines cumbersome or time-consuming procedures by ensuring that all activities contribute to mission accomplishment. Within the MMB headquarters, staff sections coordinate their staff actions with other headquarters staff sections as required.

EXTERNAL COORDINATION

4-7. The MMB must coordinate internally with the MEDBDE/MEDCOM (DS) and in early entry operations when a senior medical command headquarters is not present, with the sustainment brigade staff, corps staff, corps major subordinate commands, and other supported units to accomplish the medical mission. This coordination is conducted mainly through command surgeon channels for synchronization of the medical plan. External coordination with the combat aviation brigade for medical evacuation is critical.

BATTALION COMMAND SECTION

4-8. The battalion command section (Table 4-1) provides C2 of assigned and attached medical companies and detachments.

Table 4-1. Battalion command section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Battalion command section	67A00	O5	Commander	MS
	67A00	O4	Executive officer**	IMM
	00Z5O	E9	Command sergeant major**	NC
	68W1O	E3	Vehicle driver	

LEGEND
** Campaign Support Element, Headquarters and Headquarters Detachment, Medical Battalion (Multifunctional) Staff
AOC area of concentration
IMM immaterial
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Commander

4-9. The commander (LTC/O5, AOC 67A00) provides C2 of assigned and attached medical companies and detachments. The commander deploys with the EEE.

Executive Officer

4-10. The executive officer (MAJ/O4, AOC 67A00) also serves as the commander of the CSE. He must remain informed of the operations so he can assume command, if necessary. The executive officer assumes command functions as directed by the commander or in his absence. The executive officer deploys with the CSE.

Command Sergeant Major

4-11. The CSM (CSM/E9, MOS 00Z5O), is the principal enlisted representative to the commander. He advises the commander and staff on all matters pertaining to the welfare and morale of enlisted personnel in terms of assignment, reassignment, promotion, and discipline. He provides counsel and guidance to NCOs and other enlisted personnel of the MMB. He is also responsible for the reception of newly assigned enlisted personnel into the unit. The CSM evaluates the implementation of individual Soldier's training on Warrior tasks and supervises the MMB's NCO professional development. The command sergeant major deploys with the CSE.

Vehicle Driver

4-12. The vehicle driver (PFC/E3, MOS 68W1O) operates the wheeled vehicles in the command section for the commander. The vehicle driver deploys with the EEE.

S-1 SECTION

4-13. This S-1 section (Table 4-2) provides overall administrative services for the command, to include personnel administration, and coordinates with elements of supporting agencies for finance, legal, and administrative services.

Table 4-2. S-1 section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-1 section	70F67	O3	S-1	MS
	42A4O	E7	Senior human resources sergeant	NC
	42A3O	E6	Human resources sergeant**	NC
	42A2O	E5	Human resources sergeant	NC
	42A1O	E4	Human resources specialist**	
	27D1O	E4	Paralegal specialist	
	42A1O	E3	Human resources specialist**	

LEGEND
** Campaign Support Element, Headquarters and Headquarters Detachment, Medical Battalion (Multifunctional) Staff
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-1

4-14. The S-1 (CPT/O3, AOC 70F67) coordinates with other staff sections, subordinate companies, and the MEDBDE for all personnel core competencies of personnel readiness management; personnel accounting and strength reporting; personnel information management; reception, replacement, return to duty, rest and recuperation, and redeployment; casualty operations; legal issues; essential personnel services; postal operations; and morale, welfare and recreation operations. The S-1 also prepares and participates in the personnel estimate process, and coordinates with other staff sections. The S-1 deploys with the EEE.

Senior Human Resources Sergeant

4-15. The senior HR sergeant (SFC/E7, MOS 42A4O) performs duties and supervises the functions of subordinates to include the quality assurance of tasks performed and products prepared. He advises the S-1 and other staff members on personnel administration activities and supervises subordinate HR personnel. The HR sergeant deploys with the EEE.

Human Resources Sergeant

4-16. The HR sergeant (SSG/E6, MOS 42A3O) performs duties at preceding skill levels and provides technical guidance to subordinate Soldiers in accomplishment of these duties. The HR sergeant deploys with the CSE.

4-17. The HR sergeant (SGT/E5, MOS 42A2O) performs duties as discussed in paragraph 4-15. The HR sergeant deploys with the EEE.

Human Resources Specialist

4-18. The HR specialist (SPC/E4, MOS 42A1O) prepare and processes awards, evaluations, promotions, officer/enlisted personnel records, classification/reclassification actions, retention, casualty documents, letters of sympathy, transfers, reassignments, discharges, retirement, qualifications for special assignment,

orders, and request for orders. He processes applications for officer candidate school, WO flight training/other training, identification cards/tags, leaves, passes, line of duty determinations, military personnel data, temporary duty, travel, personnel/transition processing, security clearances, training and reassignment, military and special pay programs, personnel accounting, meal cards, training file, and unit administration. He prepares personnel accounting and strength reports. The specialist requisitions and maintains office supplies, blank forms, and publications, military and nonmilitary correspondence in draft/final copy. Further, he maintains files, posts changes to Army regulations/publications, and initiates actions for passports and visas. He monitors appointment of line of duty officer/investigations, survivor assistance, and summary court officers. The HR specialist deploys with the CSE.

Paralegal Specialist

4-19. The paralegal specialist (SPC/E4, MOS 27D1O) monitors and reviews legal actions to ensure accuracy and timely dispatch or disposition. The paralegal specialist deploys with the EEE.

Human Resources Specialist

4-20. The HR specialist (PFC/E3, MOS 42A1O) performs duties as discussed in paragraph 4-18. The HR specialist deploys with the CSE.

S-2/S-3 SECTION

4-21. The S-2/S-3 section (Table 4-3) is responsible for security, plans and operations, deployment, relocation, and redeployment of the battalion and its assigned and attached units.

Table 4-3. S-2/S-3 section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-2/S-3 section	70H67	O3	S-2/S-3	MS
	68W5O	E8	Operations noncommissioned officer	NC
	68W4O	E7	Intelligence sergeant	NC
	68W4O	E7	Plans sergeant**	NC
	74D3O	E6	Chemical, biological, radiological, and nuclear noncommissioned officer	NC
	25C2O	E5	Senior radio operator-maintainer	NC
	25C1O	E4	Radio operator-maintainer	

LEGEND
** Campaign Support Element, Headquarters and Headquarters Detachment, Medical Battalion (Multifunctional) Staff

AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-2/S-3 Mission Essential Task List

4-22. The S-2/S-3 (CPT/O3, AOC 70H67) is responsible for planning future operations, plans and operations, deployment, relocation, and deployment of the MMB and its assigned units. He prepares broad planning guidance, policies, and programs for command organizations, operations, and functions. He assists the commander in developing and training the unit's mission essential task list. He identifies

training requirements, based on medical missions and the unit's training programs, directives, and orders. He maintains the unit status reports for each subordinate unit. He performs intelligence assessments and estimates for the command. Further, he advises the commander and staff on nuclear/chemical, issues, postures, and CBRN operations. He acquires, analyzes, and evaluates intelligence to include health threat information and medical OEH surveillance data. The S-2/S-3 deploys with the EEE.

Operations Noncommissioned Officer

4-23. The operations NCO (MSG/E8, MOS 68W5O) is responsible to the S-2/S-3 for preparation of OPORDs and map overlays. He is responsible for operations and training functions of the MMB. He supervises the establishment and operation of the tactical operations center and is involved in the planning for and relocation of each element. He assists in the formulation of the TSOP and production of OPORDs. The operations NCO deploys with the EEE.

Intelligence Sergeant

4-24. The intelligence medical sergeant (SFC/E7, MOS 68W4O) is responsible for the acquisition and analysis of medical intelligence information. He provides tactical intelligence products relevant to the MMB AO. He functions as the operations security and COMSEC NCO for the MMB. The intelligence sergeant deploys with the EEE.

Plans Sergeant

4-25. The plans sergeant (SFC/E7, MOS 68W4O) is responsible to the S-2/S-3 and assists in the formulation of the OPLANS and analysis of the battalion planning factors. The plans sergeant deploys with the CSE.

Chemical, Biological, Radiological, and Nuclear Noncommissioned Officer

4-26. The CBRN NCO (SSG/E6, MOS 74D3O) is the technical advisor to the S-2/S-3 on matters pertaining to CBRN operations. He plans CBRN defensive operations and advises the MMB on contamination avoidance and equipment decontamination operations. The CBRN NCO deploys with the EEE.

Senior Radio Operator-Maintainer

4-27. The senior radio operator-maintainer (SGT/E5, MOS 25C2O) is responsible to the S-2/S-3 for the planning, supervising, coordinating, and providing technical assistance in the installation, operation, management, and operator-level maintenance of radio, field wire, and switchboard communications systems. The senior radio operator-maintainer deploys with the EEE.

Radio Operator-Maintainer

4-28. The radio operator-maintainer (SPC/E4, MOS 25C1O) is responsible for the operation and operator-level maintenance of radio, field wire, and switchboard communications systems. The radio operator-maintainer deploys with the EEE.

S-4 SECTION

4-29. The S-4 section (Table 4-4) is responsible for coordination, control, and management of logistics for assigned and attached units.

Table 4-4. S-4 section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-4 section	70K67	O3	S-4**	MS
	92Y4O	E7	Supply plans/operations noncommissioned officer	NC
	92Y2O	E5	Property book noncommissioned officer	NC

LEGEND
** Campaign Support Element, Headquarters and Headquarters Detachment, Medical Battalion (Multifunctional) Staff
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-4

4-30. The S-4 (CPT/O3, AOC 70K67) plans, coordinates, controls, and manages general logistics for the MMB and its assigned or attached units. He monitors internal MEDLOG support and readiness in conjunction with the MEDLOG section. The S-4 deploys with the CSE.

Supply Plans/Operations Noncommissioned Officer

4-31. The supply plans/operations NCO (SFC/E7, MOS 92Y4O) performs supervisory and management duties of battalion logistics, logistical planning, stock control, property management, and storage activities. The supply plans/operations NCO deploys with the EEE.

Property Book Noncommissioned Officer

4-32. The property book NCO (SGT/E5, MOS 92Y2O) is responsible for the maintenance of a consolidated property book for assigned units. The property book NCO is deployed with the EEE.

FORCE HEALTH PROTECTION OPERATIONS SECTION

4-33. The FHP operations section (Table 4-5) coordinates and monitors the execution of the area medical support, medical evacuation, and dental support within the MMB AO. The section is responsible for existing and future medical planning in the MMB AO, to include deliberate and crisis planning. Additionally, it plans future operations in excess of 72 hours and prepares major regional contingency plans for the MMB. Further, it prepares, authenticates, and publishes medical plans and OPLANs to include the integration of annexes and appendixes prepared by other staff sections. This section supervises the activities of the MEDLOG, medical operations, PVNTMED, and mental health sections. The section coordinates with each internal staff organization planning activities and support requirements for subordinate medical functional companies, detachments, and teams assigned and attached to the MMB.

Table 4-5. Force health protection operations section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Force health protection operations section	67A00	O4	Health services officer	MS
	68Z5O	E9	Chief operations sergeant**	NC

LEGEND
** Campaign Support Element, Headquarters and Headquarters Detachment, Medical Battalion (Multifunctional) Staff
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Health Services Officer

4-34. The health services officer (MAJ/O4, AOC 67A00) is responsible for the planning, coordination, and execution of the medical mission within the MMB AO. He supervises the operations of the MEDLOG operations, PVNTMED, and mental health section. The health service officer deploys with the EEE.

Chief Operations Sergeant

4-35. The chief operations sergeant (SGM/E9, MOS 68Z5O) supervises the establishment and operation of the CSE operations center and is involved in the planning for and relocation of the element. He assists in the formulation of the tactical TSOP and production of OPORDs. The chief operations sergeant deploys with the CSE.

MEDICAL LOGISTICS SECTION

4-36. The MEDLOG section (Table 4-6) is responsible for the planning, coordination, and execution of the Class VIII mission within the MMB AO. This includes blood and medical maintenance management.

Table 4-6. Medical logistics section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Medical logistics section	70K67	O3	Stock control officer	MS
	70K67	O3	Health services materiel officer	MS
	670A0	W3	Battalion maintenance officer	WO
	68J5O	E8	Medical logistics sergeant	NC
	68Q4O	E7	Pharmacy noncommissioned officer	NC
	68A4O	E7	Biomedical equipment noncommissioned officer**	NC
	68H4O	E7	Senior optical laboratory noncommissioned officer**	NC
	68K4O	E7	Medical laboratory noncommissioned officer**	NC
	68J3O	E6	Medical logistics sergeant	NC
	68J3O	E6	Medical logistics sergeant (2)**	NC
	25C2O	E5	Senior radio operator-maintainer	NC
	25C1O	E4	Radio operator-maintainer	

LEGEND
** Campaign Support Element, Headquarters and Headquarters Detachment, Medical Battalion (Multifunctional) Staff
AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
WO warrant officer

Stock Control Officer

4-37. The stock control officer (CPT/O3, AOC 70K67) is responsible for the maintenance of a consolidated property book for assigned units. The stock control officer is deployed with the EEE.

Health Services Materiel Officer

4-38. The health services materiel officer (CPT/O3, AOC 70K67) is responsible for unit logistics and maintenance planning and operations. The health services materiel officer deploys with the EEE.

Battalion Maintenance Officer

4-39. The battalion maintenance officer (CWO/W3, MOS 670A0) performs duties as the specially trained motor maintenance officer in the battalion. He manages maintenance requirements by applying technical knowledge and technical management skills. He supervises the technical and tactical performance of many different maintainer MOSs. This CWO manages maintenance operations of various types and size. Further, he advises on equipment systems compatibility, replacement, and economical retention. He also evaluates performance and quality of equipment through an analysis of maintenance indicators. The battalion maintenance officer deploys with the EEE.

Medical Logistics Sergeant

4-40. The MEDLOG sergeant (MSG/E8, MOS 68J5O) assists in the execution of MEDLOG support operations and the SIMLM mission. He facilitates reception, staging, onward movement, and integration operations; resolves aerial port of debarkation/sea port of debarkation transportation, shipping, cross-docking, and delivery issues. He coordinates battalion distribution of medical supplies with subordinate MEDLOG units. The MEDLOG sergeant deploys with the EEE.

Pharmacy Noncommissioned Officer

4-41. The pharmacy NCO (SFC/E7, MOS 68Q4O) is responsible for monitoring pharmacy operations within the battalion to ensure compliance with regulatory requirements, establishing policy and procedures for dispensing over-the-counter drugs, monitoring proficiency of enlisted pharmacy personnel, and establishing training programs as required. The pharmacy NCO deploys with the EEE.

Biomedical Equipment Noncommissioned Officer

4-42. The biomedical equipment NCO (SFC/E7, MOS 68A4O) performs technical and administrative management, coordination, control, and operational duties as the principal medical maintenance NCO. He reviews quality control procedures relevant to the performance of medical maintenance operations. He reviews technical training procedures and advises subordinates on technical training issues. He writes, develops, and coordinates command-wide regulations and policies relating to AMEDD logistical materiel maintenance programs. He serves as advisor on medical maintenance operations to subordinate units. The biomedical equipment NCO deploys with the CSE.

Senior Optical Laboratory Noncommissioned Officer

4-43. The senior optical laboratory NCO (SFC/E7, MOS 68H4O) directs, plans, coordinates, and implements the quality assurance program for all optical fabrication production within the MMB AO. He provides reports and capabilities assessments. He coordinates all external support and monitors internal production capabilities. The senior optical laboratory NCO is deployed with the CSE.

Medical Laboratory Noncommissioned Officer

4-44. The medical laboratory NCO (SFC/E7, MOS 68K4O) assists with the management of blood and blood products. He coordinates for area medical laboratory services and provides consultation services and technical advice for medical laboratory operations. The medical laboratory NCO deploys with the CSE.

Medical Logistics Sergeants

4-45. The MEDLOG sergeants (SSG/E6, MOS 68J3O) assist the senior MEDLOG sergeant with his duties. One MEDLOG sergeant deploys in the EEE and two with the CSE.

Senior Radio Operator-Maintainer

4-46. The senior radio operator-maintainer (SGT/E5, MOS 25C2O) is responsible for the operator-level maintenance of radio, field wire, and switchboard communications systems. The senior radio operator-maintainer deploys with the EEE.

Radio Operator-Maintainer

4-47. The radio operator-maintainer (SPC/E4, MOS 25C1O) provides support to the senior radio operator-maintainer. The radio operator-maintainer deploys with the EEE.

MEDICAL OPERATIONS SECTION

4-48. The medical operations section (Table 4-7) is responsible for the planning, coordination, and execution of the medical area support mission within the MMB AO. This includes the management of area medical support.

Table 4-7. Medical operations section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Medical operations section	70H67	O3	Medical operations officer**	MS
	67J00	O3	Aeromedical evacuation officer	MS
	70E67	O3	Patient administration officer	MS
	68W5O	E8	Operations noncommissioned officer	NC
	68W5O	E8	Senior practical nurse noncommissioned officer	NC
	68E4O	E7	Dental noncommissioned officer**	NC
	68W4O	E7	Plans sergeant	NC
	68W4O	E7	Plans sergeant**	NC
	68W4O	E7	Operations sergeant**	NC
	68G3O	E6	Patient administration noncommissioned officer**	NC

LEGEND
** Campaign Support Element, Headquarters and Headquarters Detachment, Medical Battalion (Multifunctional) Staff

AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Medical Operations Officer

4-49. The medical operations officer (CPT/O3, AOC 70H67) is responsible for staff planning, supervision of operations and administration of the assigned and attached units conducting medical operations in its supported AO. He is responsible for the operations and training functions of the MMB. He supervises all AHS support operations in support of tactical operations conducted by the MMB to include planning and relocation of each element. He is responsible for the formulation of the TSOP and production of OPORDs. The medical operations officer deploys with the CSE.

Aeromedical Evacuation Officer

4-50. The aeromedical evacuation officer (CPT/O3, AOC 67J00) is responsible for monitoring, planning, and coordinating medical ground and air medical evacuation within the MMB AO. He coordinates requests with the supporting aviation unit aeromedical evacuation support and coordinates the requirements and synchronization of the aeromedical evacuation plan into the overall medical evacuation plan. The aeromedical evacuation officer deploys with the EEE.

Patient Administration Officer

4-51. The patient administration officer (CPT/O3, AOC 70E67) is responsible for planning, organizing, directing, and controlling the patient movement and the administrative aspects of the MMB. He advises the commander on patient administration matters. The patient administration officer deploys with the EEE.

Operations Noncommissioned Officer

4-52. The operations NCO (MSG/E8, MOS 68W5O) is responsible to the medical operations officer for operational planning and medical regulating support. The operations NCO deploys with the EEE.

Senior Practical Nurse Noncommissioned Officer

4-53. The senior practical nurse NCO (MSG/E8, MOS 68W5O) is the principal NCO who supervises and performs related duties as the senior advisor to the operations NCO. He advises the medical operations officer on any issues arising with enlisted nursing personnel. He provides advice and consultation to subordinate units on policies and procedures relating to nursing care and practices. The senior practical nurse NCO deploys with the EEE.

Dental Noncommissioned Officer

4-54. The dental NCO (SFC/E7, MOS 68E4O) is the principal NCO who supervises and performs related duties as the senior enlisted dental advisor to the operations NCO. He monitors dental activities in subordinate medical units and compiles appropriate statistical data and reports. The dental NCO deploys with the CSE.

Plans Sergeant

4-55. The plans sergeants (SFC/E7, MOS 68W4O) are responsible to the operations NCO for operational planning and medical regulating support in the EEE and CSE. They monitor existing operations and assist in planning future operations by providing input into the development of medical estimates and plans. One plans sergeant deploys with the EEE and one with the CSE.

Operations Sergeant

4-56. The operations sergeant (SFC/E7, MOS 68W4O) provides operations support to the operations NCO. The operations sergeant deploys with the CSE.

Patient Administration Noncommissioned Officer

4-57. The patient administration NCO (SSG/E6, MOS 68G3O) is responsible to the patient administration officer for preparing, consolidating, and maintaining medical records and statistics pertaining to patient data in the MMB. The patient administration NCO deploys with the CSE.

PREVENTIVE MEDICINE SECTION

4-58. The PVNTMED section (Table 4-8) is responsible for the planning, coordination, and execution of the PVNTMED mission within the MMB AO. This includes the management of PVNTMED and veterinary assets.

Table 4-8. Preventive medicine section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Preventive medicine section	72D67	O3	Environmental science officer	MS
	68R5O	E8	Chief veterinary noncommissioned officer**	NC
	68R4O	E7	Veterinary services noncommissioned officer	NC
	68S30	E6	Preventive medicine noncommissioned officer**	NC
	68X30	E6	Mental health noncommissioned officer**	NC

LEGEND
** Campaign Support Element, Headquarters and Headquarters Detachment, Medical Battalion (Multifunctional) Staff

AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Environmental Science Officer

4-59. The environmental science officer (CPT/O3, AOC 72D67) advises on or performs professional and scientific work in environmental health and industrial hygiene. His functions include identification, evaluation, and formulation of recommendations for the control of potential health hazards. He develops environmental health and industrial hygiene criteria and standards, policies, programs, practices, and operations directed toward the prevention of disease, illness, and injury. He ensures that the OEH surveillance programs and activities are being implemented, evaluates data, and identifies trends. The environmental science officer deploys with the EEE.

Chief Veterinary Noncommissioned Officer

4-60. The chief veterinary NCO (MSG/E8, MOS 68R5O) provides staff advice and coordination of veterinary activities with other staff sections and subordinate veterinary units. He participates in command review of subordinate unit activities, evaluates training programs and provides recommendations for improvement. He develops budgets, training schedules, and authorization documents. He assists the environmental science officer in strategic planning, composite risk management procedures, and tactical communication plans. The chief veterinary NCO deploys with the CSE.

Veterinary Services Noncommissioned Officer

4-61. The veterinary services NCO (SFC/E7, MOS 68R4O) provides veterinary services support to the chief veterinary NCO. The veterinary services NCO deploys with the EEE.

Preventive Medicine Noncommissioned Officer

4-62. The PVNTMED NCO (SSG/E6, MOS 68S3O) assists the environmental science officer with his duties to include writing, developing, and coordinating battalion-wide regulations and policies relating to PVNTMED services. He participates in command review and approval of subordinate unit activities. He assists in planning and placement of field PVNTMED units. Further, he evaluates training programs and provides recommendations for improvement. He participates in studies and reviews and maintains records of strength, location, and employment of PVNTMED assets. The PVNTMED NCO deploys with the CSE.

Mental Health Noncommissioned Officer

4-63. The mental health NCO (SSG/E6, MOS 68X3O) provides mental health and planning assessments for the environmental science officer. The mental health NCO deploys with the CSE.

MENTAL HEALTH SECTION

4-64. The mental health section (Table 4-9) is responsible for the planning, coordination, and execution of the COSC mission with the MMB AO. The section collects and records social and psychological data.

Table 4-9. Mental health section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Mental health section	68X4O	E7	Mental health noncommissioned officer	NC
	68X3O	E6	Mental health noncommissioned officer**	NC

LEGEND
** Campaign Support Element, Headquarters and Headquarters Detachment, Medical Battalion (Multifunctional) Staff
AOC area of concentration
IMM immaterial
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Mental Health Noncommissioned Officer

4-65. The mental health NCO (SFC/E7, MOS 68X4O) is responsible for the planning, coordination, and execution of the COSC mission within the MMB AO. The mental health NCO deploys with the EEE.

4-66. The mental health NCO (SSG/E6, MOS 68X3O) provides those duties discussed in paragraph 4-63 in the CSE.

S-6 SECTION

4-67. The S-6 section (Table 4-10) is responsible for all aspects of information, management, automation, and CE support to assigned and attached units.

Table 4-10. S-6 section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-6 section	70D67	O3	S-6	MS
	25A00	O3	Signal officer**	SC
	25U4O	E7	Section chief	NC
	25B2O	E5	Senior information system specialist	NC
	25U2O	E5	Team chief	NC
	25B1O	E4	Information system specialist	
	25B1O	E4	Information system specialist**	
	25U1O	E3	Signal support system specialist	
	25U10	E3	Signal support system specialist**	

LEGEND
** Campaign Support Element, Headquarters and Headquarters Detachment, Medical Battalion (Multifunctional) Staff
AOC area of concentration

MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer
SC Signal Corps

S-6

4-68. The S-6 (CPT/O3, AOC 70D67) is responsible for automation and communications. He ensures that automated systems for MEDLOG management are established and maintained and ensures connectivity to other medical-centric programs such as the US Transportation Command Regulating and Command and Control Evacuation System and Defense Health Information Management System. He also ensures connectivity of medical platforms deployed in supported BCT areas are adequately equipped with systems such as Force XXI battle command—brigade and below or blue force tracker. The S-6 deploys with the EEE.

Signal Officer

4-69. The signal officer (CPT/O3, AOC 25A00) coordinates with each internal staff section to determine connectivity and information management requirements. The signal officer deploys with the CSE.

Section Chief

4-70. The section chief (SFC/E7, MOS 25U4O) manages personnel and equipment assets associated with AIS and IP networks to include the internetworking of systems. The section chief deploys with the EEE.

Senior Information System Specialist

4-71. The senior information system specialist (SGT/E5, MOS 25B2O) supports the section chief in the management of equipment assets associated with AIS and IP networks to include the internetworking of systems. The senior information system specialist deploys with the EEE.

Team Chief

4-72. The team chief (SGT/E5, MOS 25U2O) is responsible for planning, supervising of enlisted personnel, coordinating, and providing technical assistance in the installation, operation, management, and operator-level maintenance of radio, field wire, and switchboard communications systems. The team chief deploys with the EEE.

Information System Specialists

4-73. The information system specialists (SPC/E4, MOS 25B1O) are responsible for equipment assets associated with AIS, and IP networks to include the internetworking of systems in the EEE and the CSE. One information specialist deploys with the EEE and one deploys with the CSE.

Signal Support System Specialists

4-74. The signal support system specialists (PFC/E3, MOS 25U1O) are responsible for operator-level maintenance of radio, field wire, and switchboard communications systems in the EEE and CSE. One signal support system specialist deploys with the EEE and one with the CSE.

DETACHMENT HEADQUARTERS

4-75. The detachment headquarters (Table 4-11) provides for billeting, field feeding, discipline, security, training, and administration for personnel assigned to the headquarters.

Table 4-11. Detachment headquarters

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Detachment headquarters	70B67	O2	Commander	MS
	68W4O	E7	Detachment sergeant	NC
	92G4O	E7	Senior food operations sergeant	NC
	92G2O	E5	First cook	NC
	92Y2O	E5	Armorer/supply sergeant	NC
	74D1O	E4	Chemical, biological, radiological, and nuclear decontamination specialist**	
	92G1O	E4	Cook	
	92G1O	E4	Cook**	
	92G1O	E3	Cook	
	92G1O	E3	Cook**	

LEGEND
** Campaign Support Element, Headquarters and Headquarters Detachment, Medical Battalion (Multifunctional) Staff

AOC area of concentration
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

Commander

4-76. The commander (Lieutenant/O2, AOC 70B67) is responsible for Soldiers assigned to the battalion headquarters. He is responsible for ensuring local headquarters security, to include constructing defensive positions; arranging for and moving the headquarters; training; conducting MWR activities for headquarters personnel; obtaining or providing food service, quarters, health care, field sanitation, and supply for headquarters personnel; providing and prioritizing motor transportation support (organic to or allocated for use by the headquarters); and maintaining equipment organic to or allocated for use by the headquarters. The commander deploys with the EEE.

Detachment Sergeant

4-77. The detachment sergeant (SFC/E7, MOS 68W4O) is responsible to the company commander for all enlisted matters. He also assists in supervising company administration and training activities. He provides guidance to the enlisted members of the company and represents them to the company commander. The detachment sergeant deploys with the EEE.

Senior Food Operations Sergeant

4-78. The senior food operations sergeant (SFC/E7, MOS 92G4O) coordinates with the troop issue subsistence activity, facility engineers, and veterinary activity. He plans and implements menus to ensure nutritionally balanced meals. He ensures the accuracy of accounting and equipment records. He develops and initiates standing operating procedures and safety, energy, security, and fire prevention programs. He evaluates contract food service operations and ensures contractor compliance in food service contract operations. The senior food operations sergeant deploys with the EEE.

First Cook

4-79. The first cook (SGT/E5, MOS 92G2O) provides technical guidance to lower grade personnel in field kitchen operations. He ensures that proper procedures, temperatures, and time periods are adhered to during food preparation. He directs safety, security, and fire prevention procedures. Further, he performs limited supervisory and inspection functions including shift supervision. The first cook deploys with the EEE.

Armorer/Supply Sergeant

4-80. The armorer/supply sergeant (SGT/E5, MOS 92Y2O) receives, inspects, inventories, loads, unloads, segregates, stores, issues, delivers and turns-in organization and installation supplies and equipment. He prepares all unit/organizational supply documents. He maintains the automated supply system for accounting of organizational and installation supplies and equipment. He issues and receives small arms to include pistols, rifles, and squad automatic weapons. He secures and controls weapons and ammunition in security areas. He schedules and performs preventive and organizational maintenance on weapons. The armor/supply sergeant deploys with the EEE.

Chemical, Biological, Radiological, and Nuclear Decontamination Specialist

4-81. The CBRN decontamination specialist (SPC/E4, MOS 74D1O) plans CBRN defensive operations and advises on contamination avoidance and equipment decontamination operations. The CBRN specialist deploys with the CSE.

Cooks

4-82. The cooks (SPC/E4, MOS 92G1O) perform preliminary food preparation procedures in the EEE and CSE. They prepare and/or cook menu items listed on the production schedule. They bake, fry, braise, boil, simmer, steam, and sauté foods as prescribed by Army recipes. They set up serving lines, garnish food items, and apply food protection and sanitation measures in field environments. They receive and store subsistence items and perform general housekeeping duties. They operate, maintain, and clean field

kitchen equipment. They also erect, strike, and store all types of field kitchens. They perform preventive maintenance on field kitchen equipment. One cook deploys with the EEE and one with the CSE.

4-83. The cooks (PFC/E3, MOS 92G1O) perform duties in the EEE and CSE as described in paragraph 4-82. One cook deploys with the EEE and one with the CSE.

BATTALION MAINTENANCE SECTION

4-84. The battalion maintenance section (Table 4-12) is under the staff supervision of the battalion S-4. This section provides unit-level maintenance for wheeled vehicles assigned to the headquarters and headquarters detachment and assigned or attached units without unit level maintenance capability.

Table 4-12. Battalion maintenance section

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Battalion maintenance section	915A0	W2	Automotive maintenance warrant officer**	WO
	91B3O	E6	Motor sergeant	NC
	91B2O	E5	Wheeled vehicle mechanic**	NC
	91B1O	E4	Recovery vehicle operator	
	52D1O	E4	Power-generator equipment repairman	
	92A1O	E4	Equipment record/parts specialist	
	91B1O	E3	Wheeled vehicle mechanic	

LEGEND
** Campaign Support Element, Headquarters and Headquarters Detachment, Medical Battalion (Multifunctional) Staff

AOC area of concentration
MOS military occupational specialty
NC noncommissioned officer
SC Signal Corps

Automotive Maintenance Warrant Officer

4-85. The automotive maintenance WO (CWO/W2, MOS 915A0) performs duties as the specially trained motor maintenance officer. He manages maintenance requirements by applying technical knowledge and management skills and supervises the technical and tactical performance of many different maintainer MOSs. He manages maintenance operations of various types and sizes and provides advice on equipment systems compatibility, replacement, and economical retention. This WO evaluates performance and quality of equipment through an analysis of maintenance indicators. The automotive maintenance WO deploys with the CSE.

Motor Sergeant

4-86. The motor sergeant (SSG/E6, MOS 91B3O) performs technical and administrative management, coordination, control, and operational duties as the principal motor maintenance NCO. He reviews quality control procedures relevant to the performance of maintenance, operator training, and dispatching operations. He reviews technical training procedures and advises subordinates on technical training issues. The motor sergeant supervises the activities of the unit motor pool. The motor sergeant deploys with the EEE.

Wheeled Vehicle Mechanic

4-87. The wheeled vehicle mechanic (SGT/E5, MOS 91B2O) is responsible to the motor sergeant for those mechanical duties within their scope of responsibility in the CSE. He also performs driver operator duties. The wheeled vehicle mechanic deploys with the CSE.

Recovery Vehicle Operator

4-88. The recovery vehicle operator (SPC/E4, MOS 91B1O) is responsible for wheeled vehicle recovery operations support to assigned or attached units. The recovery vehicle operator deploys with the EEE.

Power-Generator Equipment Repairman

4-89. The power-generator equipment repairman (SPC/E4, MOS 52D1O) is responsible to the motor sergeant for those mechanical duties within their scope of responsibility. He also performs driver operator duties. The power-generator equipment repairman deploys with the EEE.

Equipment Record/Parts Specialist

4-90. The equipment records/parts specialist (SPC/E4, MOS 92A1O) is responsible to the motor sergeant for maintaining equipment records and repair parts lists and performing maintenance control duties. The equipment records/parts specialist deploys with the EEE.

Wheeled Vehicle Mechanic

4-91. The wheeled vehicle mechanic (PFC/E3, MOS 91B1O) is responsible to the motor sergeant for those mechanical duties within their scope of responsibility in the EEE. He also performs driver operator duties. The wheeled vehicle mechanic deploys with the EEE.

UNIT MINISTRY TEAM

4-92. The unit ministry team (Table 4-13) provides religious support and pastoral ministry for assigned staff and patients.

Table 4-13. Unit ministry team

PARAGRAPH TITLE	*AOC/MOS*	*Grade*	*Title*	*Branch*
Unit ministry team	56A00	O3	Chaplain**	CH
	56M1O	E4	Chaplain assistant**	

LEGEND
** Campaign Support Element, Headquarters and Headquarters Detachment, Medical Battalion (Multifunctional) Staff

AOC area of concentration
MOS military occupational specialty
CH Chaplain Corps

Chaplain

4-93. The chaplain (CPT/O3, AOC 56A00) advises the commander on all matters in which religion impacts on command programs, personnel, policy, and procedures. He provides for the spiritual well-being and morale of headquarters personnel. He also provides religious services and pastoral counseling to Soldiers in the AO. The chaplain deploys with the CSE.

Chaplain Assistant

4-94. The chaplain assistant (SPC/E4, MOS 56M1O) is responsible to the chaplain for the support of religious operations. He prepares the chapel for worship and prepares sacraments. The chaplain assistant deploys with the CSE.

SECTION II — HEADQUARTERS AND HEADQUARTERS COMPANY, MEDICAL BATTALION (MULTIFUNCTIONAL), EARLY ENTRY ELEMENT

MISSION AND ASSIGNMENT

4-95. The mission and assignments of the EEE (TOE 08486GA00), headquarters detachment, medical battalion (multifunctional) is to provide a scalable, flexible and modular medical C2, administrative assistance, logistical support, and technical supervision capability for assigned and attached medical organizations (companies and detachments) task-organized in support of deployed forces.

CAPABILITIES AND LIMITATIONS

4-96. The EEE conducts early entry operations.

CAPABILITIES

4-97. The EEE provides medical C2, staff planning, supervision of operations, medical and general logistics support as required, and administration of the assigned and attached units conducting medical operations in its supported AO.

4-98. The EEE is allocated on the basis of one element per medical battalion (multifunctional).

4-99. The EEE provides planning, controlling, and coordinating capability to early entry operations. The EEE provides—

- Task organization of medical assets.
- Advice to senior commanders in the AO on the medical aspects of their operations.
- Coordination of medical regulating and patient movement with the AO.
- Monitoring, planning, and coordination for ground and air evacuation with the MMB AO. Coordinating air evacuation support requirements with the supporting aviation unit, and synchronizing the air evacuation plan into the overall medical evacuation plan.
- Consultation and technical advice on PVNTMED (medical entomology, medical and OEH surveillance, and sanitary engineering), COSC and BH, medical records administration, veterinary services, nursing practices and procedures, dental services, and automated medical information systems to supported units.
- Guidance for facility site selection and area preparation.
- Monitoring and supervision for MEDLOG operations, to include Class VIII supply-resupply.
- Maintaining a battalion consolidated property book.
- Unit-level maintenance for wheeled vehicles and power generation equipment and wheeled vehicle recovery operations support to assigned or attached units.
- Organizational communications equipment maintenance support for the MMB.
- Food service support for staff and assign/attached medical units.

LIMITATIONS

4-100. The EEE is dependent on—

- Sustainment for legal, administration, finance, HRs, transportation services, area damage control, CBRN decontamination assistance, mortuary affairs, and laundry and bath services.
- The quartermaster supply company or equivalent for Class I ration.

- The engineer company or equivalent for site selection, waste disposal, and minor construction.
- The movement control battalion or equivalent for supplemental transportation requirements.

MOBILITY

4-101. The EEE is capable of transporting 75,970 pounds of TOE equipment with organic vehicles.

4-102. The EEE has 29,446 pounds of TOE equipment requiring transportation.

ORGANIZATION AND FUNCTIONS

4-103. Organization and functions provide a description of the EEE. This section provides a brief description of the EEE of the MMB. See Section I for a full description of the composition and capabilities of the MMB.

BATTALION COMMAND SECTION

4-104. The battalion command section (Table 4-14) provides C2 of assigned and attached medical companies and detachments.

Table 4-14. Battalion command section (early entry element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Battalion command section (EEE)	67A00	O5	Commander	MS
	68W1O	E3	Vehicle driver	

LEGEND
AOC area of concentration
EEE early entry element
MOS military occupational specialty
MS Medical Service Corps

S-1 SECTION

4-105. The S-1 section (Table 4-15) provides overall administrative services for the command, to include personnel administration, and coordinates with elements of supporting agencies for finance, personnel, legal, and administrative services.

Table 4-15. S-1 section (early entry element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-1 section (EEE)	70F67	O3	S-1	MS
	42A4O	E7	Senior human resources sergeant	NC
	42A2O	E5	Human resources sergeant	NC
	27D1O	E4	Paralegal specialist	

LEGEND
AOC area of concentration
EEE early entry element
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-2/S-3 SECTION

4-106. The S-2/S-3 section (Table 4-16) is responsible for security, plans and operations, deployment, relocation, and redeployment of the battalion and its assigned and attached units. The MMBs primary net control station is in this section.

Table 4-16. S-2/S-3 section (early entry element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-2/s-3 section (EEE)	70H67	O3	S-2/S-3	MS
	68W5O	E8	Operations noncommissioned officer	NC
	68W4O	E7	Intelligence sergeant	NC
	74D3O	E6	Chemical, biological, radiological, and nuclear noncommissioned officer	NC
	25C2O	E5	Senior radio operator-maintainer	NC
	25C1O	E4	Radio operator-maintainer	

LEGEND
AOC area of concentration
EEE early entry element
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

S-4 SECTION

4-107. The S-4 section (Table 4-17) is responsible for coordination, control, and management of logistics for assigned and attached units.

Table 4-17. S-4 section (early entry element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-4 section (EEE)	92Y4O	E7	Supply plans/operations noncommissioned officer	NC
	92Y2O	E5	Property book noncommissioned officer	NC

LEGEND
AOC area of concentration
EEE early entry element
MOS military occupational specialty
NC noncommissioned officer

FORCE HEALTH PROTECTION OPERATIONS SECTION

4-108. The FHP operations section (Table 4-18) is responsible for the planning, coordination, and execution of the AHS mission within the MMB AO. It supervises the operations of MEDLOG, operations, PVNTMED, and BH.

Table 4-18. Force health protection operations (early entry element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
FORCE HEALTH PROTECTION OPERATIONS SECTION (EEE)	67A00	O4	Health services officer	MS

LEGEND
AOC area of concentration
EEE early entry element
MOS military occupational specialty
MS Medical Service Corps

MEDICAL LOGISTICS SECTION

4-109. The MEDLOG section (Table 4-19) is responsible for the planning, coordination, and execution of the Class VIII mission within the MMB AO. This includes blood and medical maintenance management.

Table 4-19. Medical logistics section (early entry element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Medical logistics section (EEE)	70K67	O3	Stock control officer	MS
	70K67	O3	Health services materiel officer	MS
	670A0	W3	Battalion maintenance officer	WO
	68J5O	E8	Medical logistics sergeant	NC
	68Q4O	E7	Pharmacy noncommissioned officer	NC
	68J3O	E6	Medical logistics sergeant	NC
	25C2O	E5	Senior radio operator-maintainer	NC
	25C1O	E4	Radio operator-maintainer	

LEGEND
AOC area of concentration
EEE early entry element
MOS military occupational specialty
NC noncommissioned officer
MS Medical Service Corps
WO warrant officer

MEDICAL OPERATIONS SECTION

4-110. The medical operations section (Table 4-20) is responsible for the planning, coordination, and execution of the area medical support mission within the MMB AO. This includes the management of area medical support (Roles 1 and 2), medical evacuation, and area dental support.

Table 4-20. Medical operations section (early entry element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Medical operations section (EEE)	67J00	O3	Aeromedical evacuation officer	MS
	70E67	O3	Patient administration officer	MS
	68W5O	E8	Operations noncommissioned officer	NC
	68W5O	E8	Senior practical nurse noncommissioned officer	NC
	68W4O	E7	Plans sergeant	NC

LEGEND
AOC area of concentration
EEE early entry element
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

PREVENTIVE MEDICINE SECTION

4-111. The PVNTMED section (Table 4-21) is responsible for the planning, coordination, and execution of the PVNTMED mission within the MMB AO. This includes management of PVNTMED and veterinary assets.

Table 4-21. Preventive medicine section (early entry element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Preventive medicine section (EEE)	72D67	O3	Environmental science officer	MS
	68R4O	E7	Veterinary services noncommissioned officer	NC

LEGEND
AOC area of concentration
EEE early entry element
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

MENTAL HEALTH SECTION

4-112. The mental health section (Table 4-22) is responsible for the planning, coordination, and execution of the COSC mission within the MMB AO. It collects and records social and psychological data.

Table 4-22. Mental health section (early entry element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Mental health section (EEE)	68X4O	E7	Mental health noncommissioned officer	NC

LEGEND
AOC area of concentration
EEE early entry element
MOS military occupational specialty
NC noncommissioned officer

S-6 SECTION

4-113. The S-6 section (Table 4-23) is responsible for all aspects of information management, automation, and CE support to assigned and attached units.

Table 4-23. S-6 section (early entry element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-6 section (EEE)	70D67	O3	S-6	MS
	25U4O	E7	Section chief	NC
	25B2O	E5	Senior information system specialist	NC
	25U2O	E5	Team chief	NC
	25B1O	E4	Information system specialist	
	25U1O	E3	Signal support system specialist	

LEGEND
AOC area of concentration
EEE early entry element
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

DETACHMENT HEADQUARTERS

4-114. The detachment headquarters (Table 4-24) provides for billeting, field feeding, discipline, security, training, and administration for personnel assigned to the headquarters and headquarters detachment.

Table 4-24. Detachment headquarters (early entry element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Detachment headquarters (EEE)	70B67	O2	Commander	MS
	68W4O	E7	Detachment sergeant	NC
	92G4O	E7	Senior food operations sergeant	NC
	92G2O	E5	First cook	NC
	92Y2O	E5	Armorer/supply sergeant	NC
	92G1O	E4	Cook	
	92G1O	E3	Cook	

LEGEND
AOC area of concentration
EEE early entry element
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

BATTALION MAINTENANCE SECTION

4-115. The battalion maintenance section (Table 4-25), under the staff supervision of the battalion S-4, this section provides unit level maintenance for wheeled vehicles assigned to the headquarters and headquarters detachment and assigned or attached units without unit level maintenance capability.

Table 4-25. Battalion maintenance section (early entry element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Battalion maintenance section (EEE)	91B3O	E6	Motor sergeant	NC
	91B1O	E4	Recovery vehicle operator	
	52D1O	E4	Power-generator equipment repairman	
	92A1O	E4	Equipment record/parts specialist	
	91B1O	E3	Wheeled vehicle mechanic	

LEGEND
AOC area of concentration
CSE campaign support element
MOS military occupational specialty
NC noncommissioned officer

SECTION III — HEADQUARTERS AND HEADQUARTERS COMPANY, MEDICAL BATTALION (MULTIFUNCTIONAL), CAMPAIGN SUPPORT ELEMENT

MISSION AND ASSIGNMENT

4-116. The mission and assignments of the CSE (TOE 08486GB00), headquarters detachment, medical battalion (multifunctional) is to complete the staffing of the headquarters of the battalion to enhance the delivery of campaign-quality health care to the deployed forces. It provides a scalable, flexible and modular, C2, administrative assistance, logistical support, and technical supervision capability for assigned and attached medical organizations (companies and detachments) task-organized for support of deployed forces.

CAPABILITIES AND LIMITATIONS

4-117. The CSE falls in on the EEE to provide a more robust C2 element with additional operational and planning capabilities, increased MEDLOG staff, and a more diverse and robust clinical staff.

CAPABILITIES

4-118. The CSE provides augmentation of C2 in personnel, logistics, health care, medical operations, PVNTMED, mental health, automation, maintenance, and food service to the EEE.

4-119. The CSE is allocated one per MMB.

LIMITATIONS

4-120. The CSE is dependent on the headquarters for legal, administrative, finance, HRs, religious, food service, transportation services, area damage control, CBRN decontamination assistance, mortuary affairs, and laundry and bath services.

MOBILITY

4-121. The CSE is capable of transporting 13,000 pounds of TOE equipment with organic vehicles.

4-122. The CSE has 3,145 pounds of TOE equipment requiring transportation.

ORGANIZATION AND FUNCTIONS

4-123. Organization and functions provides a description of the CSE. This section provides a description of the CSE only. See Section I of this chapter for a full description of the composition and capabilities of the MMB.

BATTALION COMMAND SECTION

4-124. The battalion command section (Table 4-26) provides C2 of assigned and attached medical companies and detachments.

Table 4-26. Battalion command section (campaign support element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Battalion command section (CSE)	67A00	O4	Executive officer	IMM
	00Z5O	E9	Command sergeant major	NC

LEGEND
AOC area of concentration
CSE campaign support element
IMM immaterial
MOS military occupational specialty
NC noncommissioned officer

S-1 SECTION

4-125. The S-1 section (Table 4-27) provides limited personnel, administrative services for the command in coordination with the S-1 of the EEE.

Table 4-27. S-1 section (campaign support element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-1 section (CSE)	42A3O	E6	Human resources sergeant	NC
	42A1O	E4	Human resources specialist	
	42A1O	E3	Human resources specialist	

LEGEND
AOC area of concentration
CSE campaign support element
MOS military occupational specialty
NC noncommissioned officer

S-2/S-2 SECTION

4-126. The S-2/S-3 section (Table 4-28) coordinates with the S-2/S-3 section of the EEE in the plans and operations support to subordinate organizational elements.

Table 4-28. S-2/S-3 section (campaign support element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-2/s-3 section (CSE)	68W4O	E7	Plans sergeant	NC

LEGEND
AOC area of concentration
CSE campaign support element
MOS military occupational specialty
NC noncommissioned officer

S-4 SECTION

4-127. The S-4 section (Table 4-29) is responsible for coordination, control, and management of logistics for assigned and attached units.

Table 4-29. S-4 section (campaign support element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-4 section (CSE)	70K67	O3	S-4	MS

LEGEND
AOC area of concentration
CSE campaign support element
MOS military occupational specialty
MS Medical Service Corps

FORCE HEALTH PROTECTION OPERATIONS

4-128. The FHP operations (Table 4-30) plans and coordinates the health care mission within the MMB AO when collocated with the EEE. It provides advice on the operation of MEDLOG, operations, PVNTMED, and mental health in the support provided to supported organizations.

Table 4-30. Force health protection operations (campaign support element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Force health protection operations (CSE)	68Z5O	E9	Chief operations sergeant	NC

LEGEND
AOC area of concentration
CSE campaign support element
MOS military occupational specialty
NC noncommissioned officer

MEDICAL LOGISTICS SECTION

4-129. The MEDLOG section (Table 4-31) plans and organizes Class VIII supply support (including blood and medical equipment management) in coordination with the MEDLOG section of the EEE.

Table 4-31. Medical logistics section (campaign support element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Medical logistics section (CSE)	68A4O	E7	Biomedical equipment noncommissioned officer	NC
	68H4O	E7	Senior optical laboratory noncommissioned officer	NC
	68K4O	E7	Medical laboratory noncommissioned officer	NC
	68J3O	E6	Medical logistics sergeant (2)	NC

LEGEND
AOC area of concentration
CSE campaign support element
MOS military occupational specialty
NC noncommissioned officer

MEDICAL OPERATIONS SECTION

4-130. The medical operations section (Table 4-32) plans and coordinates the medical area support mission to include management of the area medical and dental support (Roles 1 and 2).

Table 4-32. Medical operations section (campaign support element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Medical operations section (CSE)	70H67	O3	Medical operations officer	MS
	68E4O	E7	Dental noncommissioned officer	NC
	68W4O	E7	Operations sergeant	NC
	68W4O	E7	Plans sergeant	NC
	68G3O	E6	Patient administration noncommissioned officer	NC

LEGEND
AOC area of concentration
CSE campaign support element
MOS military occupational specialty
MS Medical Service Corps
NC noncommissioned officer

PREVENTIVE MEDICINE SECTION

4-131. The PVNTMED section (Table 4-33) plans and coordinates PVNTMED/veterinary support to subordinate organizations.

Table 4-33. Preventive medicine section (campaign support element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Preventive medicine section (CSE)	68R5O	E8	Chief veterinary noncommissioned officer	NC
	68S3O	E6	Preventive medicine noncommissioned officer	NC

LEGEND
AOC area of concentration
CSE campaign support element
MOS military occupational specialty
NC noncommissioned officer

MENTAL HEALTH SECTION

4-132. The mental health section (Table 4-34) plans and coordinates mental health support to subordinate organizations.

Table 4-34. Mental health section (campaign support element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Mental health section (CSE)	68X3O	E6	Mental health noncommissioned officer	NC

LEGEND
AOC area of concentration
CSE campaign support element
MOS military occupational specialty
NC noncommissioned officer

S-6 SECTION

4-133. The S-6 section (Table 4-35) provides advice and support to subordinate organizations for CE support and information management.

Table 4-35. S-6 section (campaign support element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
S-6 section (CSE)	25A00	O3	Signal officer	SC
	25B1O	E4	Information system specialist	
	25U1O	E3	Signal support system specialist	

LEGEND
AOC area of concentration
CSE campaign support element
MOS military occupational specialty
NC noncommissioned officer
SC Signal Corps

DETACHMENT HEADQUARTERS

4-134. The detachment headquarters (Table 4-36) provides coordination with the EEE in support of the field feeding and administration mission of the detachment headquarters.

Table 4-36. Detachment headquarters (campaign support element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Detachment headquarters (CSE)	74D1O	E4	Chemical, biological, radiological, and nuclear decontamination specialist	
	92G1O	E4	Cook	
	92G1O	E3	Cook	

LEGEND
AOC area of concentration
CSE campaign support element '
MOS military occupational specialty

BATTALION MAINTENANCE SECTION

4-135. The battalion maintenance section (Table 4-37) provides unit level maintenance management support to assigned and attached units in coordination with the battalion S-4 and the battalion maintenance section of the EEE.

Table 4-37. Battalion maintenance section (campaign support element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Battalion maintenance section (CSE)	915A0	W2	Automotive maintenance warrant officer	WO
	91B2O	E5	Wheeled vehicle mechanic	NC

LEGEND
AOC area of concentration
CSE campaign support element
MOS military occupational specialty
NC noncommissioned officer
WO warrant officer

UNIT MINISTRY TEAM

4-136. The unit ministry team (Table 4-38) provides religious support and pastoral ministry for assigned staff and patients.

Table 4-38. Unit ministry team (campaign support element)

Paragraph title	*AOC/MOS*	*Grade*	*Title*	*Branch*
Unit ministry team (CSE)	56A00	O3	Chaplain	CH
	56M1O	E4	Chaplain assistant	

LEGEND
AOC area of concentration
CSE campaign support element
CH Chaplain Corps
MOS military occupational specialty

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Chapter 5

Army Health System Operations

The MEDCOM (DS) is the medical force provider for the theater. As the medical force provider it identifies HSS and FHP requirements throughout the AO and task-organizes and deploys the required medical resources to accomplish the complex challenges faced by the health care delivery mission in a deployed theater. The MEDCOM (DS) also provides subordinate medical units the ability to obtain information, resources, and personnel from the medical generating force in CONUS or other safe havens. Army operations are inherently joint in nature and often times are conducted with multinational forces. The MEDCOM (DS) may also be tasked to conduct multinational operations with the armed forces of other nations in pursuit of common objectives. Each multinational operation is unique, and key considerations involved in planning and conducting multinational operations vary with the international situation and perspectives, motives, and values of the organization's members. See Appendix D for information for medical planning considerations for both joint and multinational medical operations. This chapter provides a brief overview of the AHS and discusses operations plan and directed by the MEDCOM (DS).

SECTION I — OPERATIONAL THEMES

CHARACTER OF THE OPERATION

5-1. An operational theme describes the character of the dominant major operation being conducted at anytime within the land force commander's AO. The operational theme helps convey the nature of the major operation to the force to facilitate common understanding of how the commander broadly intends to operate. For an in-depth discussion of operational themes refer to FM 3-0.

5-2. As all major operations are joint in nature, the operational themes can be used to group similar types of activities under the predominant theme. Major operations normally are characterized by the offense and defense but may also include stability operations. Further within the operational environment all three types of operations can be occurring simultaneously. There are five operational themes which span full spectrum operations. They are discussed in ascending order of violence.

PEACETIME MILITARY ENGAGEMENT

5-3. The purpose of *peacetime military engagement* is to shape the operational environment and to support the commander's objectives within the security cooperation plan. This operational theme encompasses activities such as multinational training events and exercises; security assistance; joint combined exchange training; recovery operations; arms control; and counterdrug activities.

5-4. Medical **support to counterdrug operations** is limited and is generally directed to supporting US forces in the AO. The veterinary service provides care and treatment of the MWD used in these operations. Further, the veterinary support may become involved in developing animal husbandry programs which can, in turn, lead to the economic growth of the host nation and reduce its dependence on income generated by drug-related agriculture. United States Army medical evacuation resources may also be used to evacuate injured, ill, or wounded Soldiers involved in these operations.

5-5. Through **security assistance programs**, the US provides defense materiel, and military training. Security assistance programs employ medical civic action teams and small detachments to fulfill specific mission requests. Ideally, this force would be specially trained, area-oriented, mostly language qualified, and available for immediate deployment. Health service support/FHP augmentation to the foreign internal defense augmentation force can be provided to some extent in all of the AMEDD functions. Particularly effective in this arena are medical treatment, nursing, PVNTMED services, dental, and veterinary resources.

LIMITED INTERVENTION

5-6. The commander uses *limited interventions* to achieve an end state that is clearly defined and limited in scope. Activities included in this category are noncombatant evacuation operations, strikes, raids, shows of force, foreign humanitarian assistance, consequence management, sanction enforcement, and elimination of weapons of mass destruction.

5-7. During **noncombat evacuation operations**, those persons who are injured, wounded, or ill are treated and stabilized by the medical element accompanying the noncombatant operations force. Once stabilized, they are evacuated by the force. During these types of operations conducted in a permissive environment, when there is no apparent physical threat to the evacuees, sick, injured, or wounded persons should be evacuated on dedicated medical evacuation platforms, if at all possible. In an uncertain or hostile environment, the transportation assets used to insert and extract the noncombatant evacuation force are normally used to evacuate the patients. The medical personnel accompanying the force provide en route medical care until the force reaches an intermediate staging base or safe haven. Those evacuees requiring medical care are provided the required care or are stabilized for further evacuation to MTFs capable of providing the required care.

5-8. Medical support for **show of force** follows the traditional role of providing HSS/FHP to a combat force.

5-9. **Foreign humanitarian assistance** programs can relieve or reduce the results of natural or man-made disasters or other conditions such as human pain, disease, hunger, or deprivation that present a serious threat to life or result in great property damage or loss. Humanitarian assistance provided by US forces is limited in scope and duration. It is designed to supplement or complement the efforts of host nation civil authorities or agencies that may have primary responsibility for providing foreign humanitarian assistance. Most of these operations are conducted as joint or multinational operations and is funded by the Department of State and are in compliance with Title 10 of the US Code.

PEACE OPERATIONS

5-10. The category of *peace operations* encompasses a number of various types of activities that are focused on keeping the violence from spreading, containing the violence that has already occurred, and reducing tensions among the factions. These activities include peacekeeping operations, peace building, peacemaking, peace enforcement, and conflict prevention.

5-11. The AHS role in **peace operations** is to provide HSS/FHP to the US-lead peacekeeping force. This force may consist of elements from the other Services or may be a multinational force. It may also include US government civilian employees, civilian contractors, and United Nations officials.

IRREGULAR WARFARE

5-12. *Irregular warfare* is a violent struggle among state and nonstate actors for legitimacy and influence over a population. Special operations forces conduct most of the irregular warfare operations. This broad grouping includes foreign internal defense, support to an insurgency, counterinsurgency, combating terrorism, and unconventional warfare.

Foreign Internal Defense

5-13. In determining the HSS/FHP needs for **foreign internal defense**, the AHS planner must tailor support of the foreign internal defense programs to the environment and to the specific needs of the supported host nation. The goals and objectives of military HSS/FHP in this environment are defined in the commander's regional strategy. Each host nation has circumstances which differ from its neighbors' and are unique to its own situation. These characteristics include social, economic, cultural, military, and political realities within the host nation. The AHS planner needs to develop specific goals and objectives for each country within the region.

Support for Insurgencies and Counterinsurgencies

5-14. The arena of **support for insurgencies and counterinsurgencies** provides the greatest challenge and is the most complex program in stability operations. In this area, the possibility exists that the traditional roles and methods of employment of US military forces may be reversed (sustainment elements entering the AO prior to the combat units). The uniqueness of these settings requires thoroughly coordinated planning and flexibility on the part of the medical planner to successfully accomplish his mission. Agencies of the federal government (other than DOD) normally exercise overall direction of efforts in support for insurgency. The US military actions serve a supporting role. Once legally tasked by the President and the Secretary of Defense for commitment to support or defeat an insurgency, US military forces assist either host nation governments or insurgent movements.

Support for Insurgencies

5-15. In the establishment of a viable medical infrastructure to attend to the medical needs of the insurgents the HSS/FHP organization supporting the insurgents is normally minimally staffed. It must provide, on a limited basis, all facets of the health care spectrum from emergency medical treatment at the point of injury through hospitalization and convalescent care. Medical personnel may serve as trainers emphasizing those skills necessary for emergency medical treatment, triage, mass casualty management, and nursing aspects of pre- and postoperative management. These nurses may also provide first-aid training to the insurgent personnel.

5-16. One of the key factors in maintaining high morale among Soldiers is the knowledge that if wounded, medical care will be available. Depending on the tactical situation, terrain, and other environmental conditions, treatment stations may be housed in caves, tunnels, existing buildings, or temporary shelters. Due to the fluidity of these operations, the treatment facility established should be no larger than that necessary to accomplish the mission. It should be 100 percent mobile.

5-17. The medical requirements in support of these operations, must be quickly identified. They are determined by—

- Needs of the insurgent movement.
- Political, social, and economic issues involved.
- Resources available.
- Existence of clear, legal authority.

5-18. Refer to FM 4-02.43 and FM 8-42 for additional information.

Counterinsurgencies

5-19. *Counterinsurgency* is those military, paramilitary, political, economic, psychological, and civic actions taken by a government to defeat insurgency (JP 1-02). In counterinsurgency, host-nation forces and their partners operate to defeat armed resistance, reduce passive opposition, and establish or reestablish the host-nation government's legitimacy.

5-20. In support of counterinsurgency operations quality of life issues, such as the availability of health care, can be prominent issues that motivate insurgents to demand change. A thoroughly planned and coordinated strategy (which implements the needed health care reforms and focuses on other quality of life issues) can motivate the population to support the host nation government rather than the insurgent group.

Health care programs can enhance the legitimacy of the host nation government while undermining the legitimacy of the insurgent group.

Combating Terrorism

5-21. The tactics used by terrorists include bombings, hijackings, assassinations, and kidnappings. Terrorism is a tactic that is used across all civilian and military continuums. The AHS commander must plan for and conduct active programs which reduce his unit's vulnerability to terrorist actions. A balance must be reached that maintains an appropriate level of vigilance, security, and confidence. This balance should not adversely impact on the mission and result in undue suspicion and stress. The AHS planner must be aware of the terrorist threat in the AO. He must incorporate appropriate safeguards and considerations into the HSS/FHP OPLAN.

- *Antiterrorism* consists of those defensive measures used to reduce the vulnerability of personnel, Family members, facilities, and equipment to terrorist acts. This includes the collection and analysis of information to accurately assess the magnitude of the threat.
- *Counterterrorism* is comprised of those offensive measures taken to prevent, deter, and respond to terrorism. Medical elements are not directly involved in the counterterrorism aspects of an operation. However, these medical elements provide traditional AHS support to US and friendly forces engaged in these operations.

5-22. Army Health System commanders must be well-versed in the existing threat (both the health threat and the general threat) in the AO. They must be aware of the tactics used by terrorists at incidents sites because first responders are often the target of terrorists. The terrorist creates the initial incident and plans a follow-on strike on the first responders which creates more casualties and sensationalizes the incident creating more media coverage. Further, terrorists do not adhere to the provisions of the Geneva Conventions and will intentionally target medical personnel, units, transports, and facilities. The display of the Geneva Conventions Emblem will not deter an attack and could, in fact, make the medical units and their transports a more lucrative target. Since one of the main goals of a terrorist is to bring attention to his cause or belief, the more audacious and the more sensational the target, the more likely the event will be covered by the media.

Unconventional Warfare

5-23. The goals of HSS/FHP operations in support of **unconventional warfare** are to conserve the guerrilla forces fighting strength and to assist in securing local population support for US and guerrilla forces operating within joint special operations areas. Medical elements supporting the guerrilla forces must be mobile, responsive, and effective in preventing disease and returning the sick and wounded to duty. There is no safe rear area where the guerrilla takes his casualties for treatment. Wounded and ill personnel become a tactical rather than a logistical problem.

5-24. In an unconventional warfare situation, indigenous medical personnel may provide assistance during combat operations by establishing casualty collecting points. This permits the remaining members of the guerrilla force to continue fighting. Casualties at collecting points are later evacuated to the guerrilla base or to a guerrilla medical facility. As the operation develops, evacuation of the more seriously wounded, injured, or diseased personnel to friendly areas is accomplished by establishing clandestine evacuation nets if security does not permit using aeromedical evacuation. Medical requirements within the joint special operations area differ from those posed by conventional forces. In unconventional warfare, battle casualties are normally fewer and the incidence of disease and malnutrition is often higher. Overlaying conventional military medical assets on unconventional warfare operations can only be accomplished if it does not compromise the security of the mission.

5-25. For additional information on conventional medical force support to these types of operations, refer to FM 4-02.43.

SECTION II — ARMY MEDICAL DEPARTMENT COMMAND AND CONTROL OPERATIONS

5-26. The most important component of the tactical commander's weapons systems is the Soldier. The AMEDD's mission to conserve the fighting strength focuses on the promotion of wellness, the prevention of DNBIs, the provision of acute trauma care, and the provision of definitive, rehabilitation, and convalescent care for our injured or ill Warriors. Providing effective and timely health care to our deployed forces requires the synchronization of a myriad of personnel, organizations, and materiel resources across the AMEDD, the MHS, and the Department of Veterans Affairs. The highly technical nature of providing medical care requires the synchronization of support across all medical disciplines and ancillary services. Highly trained medical professionals have the requisite knowledge and skills to leverage support from a multitude of different resources to maximize the effectiveness of the care provided and to optimize patient outcome. In addition to the direct support to the Soldier, the MEDCOM (DS) must also have a regional focus to fully support and facilitate the GCC's theater engagement plan for his area of responsibility.

5-27. Based on the effectiveness, timeliness, and seamlessness of medical care, to rapidly clear the battlefield of casualties and to reduce the killed in action rate of our Soldiers, the Soldier sees a highly efficient but, on the surface at least, simple system of dedicated professionals doing what they do best—caring for our Soldiers. Since our health care delivery system is synchronized and effective, it is transparent to the Soldier and appears to be almost effortless. This impression of simplicity and transparency is deceiving. As discussed in paragraph 1-9, the AHS is a complex system of systems which requires extensive knowledge and skill within the Army, DOD, and civilian medical communities to be able to capture the diverse and highly scientific resources needed to provide state-of-the-art care to our deployed forces. The ten medical functions are essential considerations at all roles of the health care continuum, however, the organic AHS assets in the BCTs are focused on rapidly locating, acquiring, treating, and evacuating battlefield casualties, providing essential casualty prevention services, and providing the MEDLOG support required to facilitate AHS operations. Within BCTs, the AHS assets are limited not only in numbers but also in the type, scope, and complexity of medical conditions that can be treated. Any patients who cannot recover from their wounds or illness within 3 days are rapidly evacuated from the forward area to an MTF that is staffed and equipped to provide the requisite specialty care. Further, as the AMEDD mission is to conserve the fighting strength of the tactical commander, medical issues which cannot be resolved by the multifunctional logistics command and control organization in the BCT, are referred to the medical technical channel for assistance and resolution. This places the responsibility on the MEDCOM (DS) commander, who is the medical force pool provider, to rapidly task-organize a medical augmentation support package and to reallocate his resources to resolve issues arising in the forward areas. The MEDCOM (DS) commander must have an intimate knowledge of the intricacies of the health care delivery system to be able to rapidly pinpoint and leverage the necessary capabilities to provide a timely resolution to battlefield medical issues.

5-28. Medical C2 of medical elements in an AO allows disseminated knowledge management systems to capture, analyze, and transform health reporting from multiple sources both horizontally and vertically for organizational situational awareness and decision support. This builds tailored responsiveness to the changing operational environment that is sustainable over the future event horizon. Medical C2 reduces the cost of MHS knowledge management. Medical C2 is networked to communicate a common operating picture, horizontally integrated to share the analysis of reported information, and with authority to act on this analysis at the operator level. The medical C2 organization uses communications interconnectivity to provide collaboration across disciplines, organizations, and facilitates and optimizes the sharing of scarce, unique resources. Medical C2 is structured to establish and manage contracting for services, public-private partnerships, and public partnerships from multiple agencies and multiple layers of government.

5-29. It is essential that C2 of medical units rests with the senior medical headquarters. The noncontiguous nature and fluidity of the current and future operational environment has dictated a redesign of combat formations to enhance mobility, agility, scalability, and versatility. This, in turn, requires that the AHS concept of support and the continued refinement of organizational designs evolve to support the tactical commander's concept of operation and scheme of maneuver. The full breadth of medical specialty

expertise and services are provided to the tactical commander by the medical force provider in the theater and the CONUS-support base. In order to synchronize the provision of responsive, effective, and efficient medical specialty care to the BCT and EAB commanders and to capitalize on the myriad of medical specialty expertise and resources resident in the MHS (Figure 5-1), the vertical and horizontal integration of the AHS from the point of injury to the CONUS-support base is not only crucial but also critical. To navigate this highly complex and interdependent system which crosses Service, DOD, interagency, and civilian boundaries and leverage the support required to satisfy theater requirements, a leader-developed medical commander is required. As the number of medical specialty providers and support staffs deployed to the theater decrease, the medical command presence must remain within the theater and be placed at strategic points to best orchestrate and control AHS support operations is paramount.

VERTICAL AND HORIZONTAL INTEGRATION

5-30. Just as maintaining a common operational picture is essential to the successful prosecution of tactical operations, the medical commander and his staff must be fully cognizant of all health threats and events which impact the health of the command. As increased modularity diminishes the size of professional, operational, and planning staffs of functional modules, the situation becomes increasingly more important to have medical commanders vertically and horizontally integrated at decisive points within the theater. These medical commanders and their professional staffs can analyze, assess, and evaluate the aggregate of real-time health data generated in their AO to identify trends of adverse health impacts and deploy or reallocate the necessary resources to mitigate the effects and maintain the health of the command. Deviations from base-line health data may be the first indication to the tactical commander that an adversary has employed, for example, a biological warfare agent against US forces.

5-31. The dispersion of forces within future operational environments will pose significant challenges toward ensuring a seamless AHS is continually provided to the Soldier. The ability of the medical commander to rapidly organize functional modules and deploy the right mix of medical specialties based on METT-TC is enhanced through the vertical and horizontal integration of AHS resources. Current and future medical information systems will enable the medical force provider to reallocate resources to anticipate shifting centers of patient density and to tailor the medical force package with greater accuracy and speed.

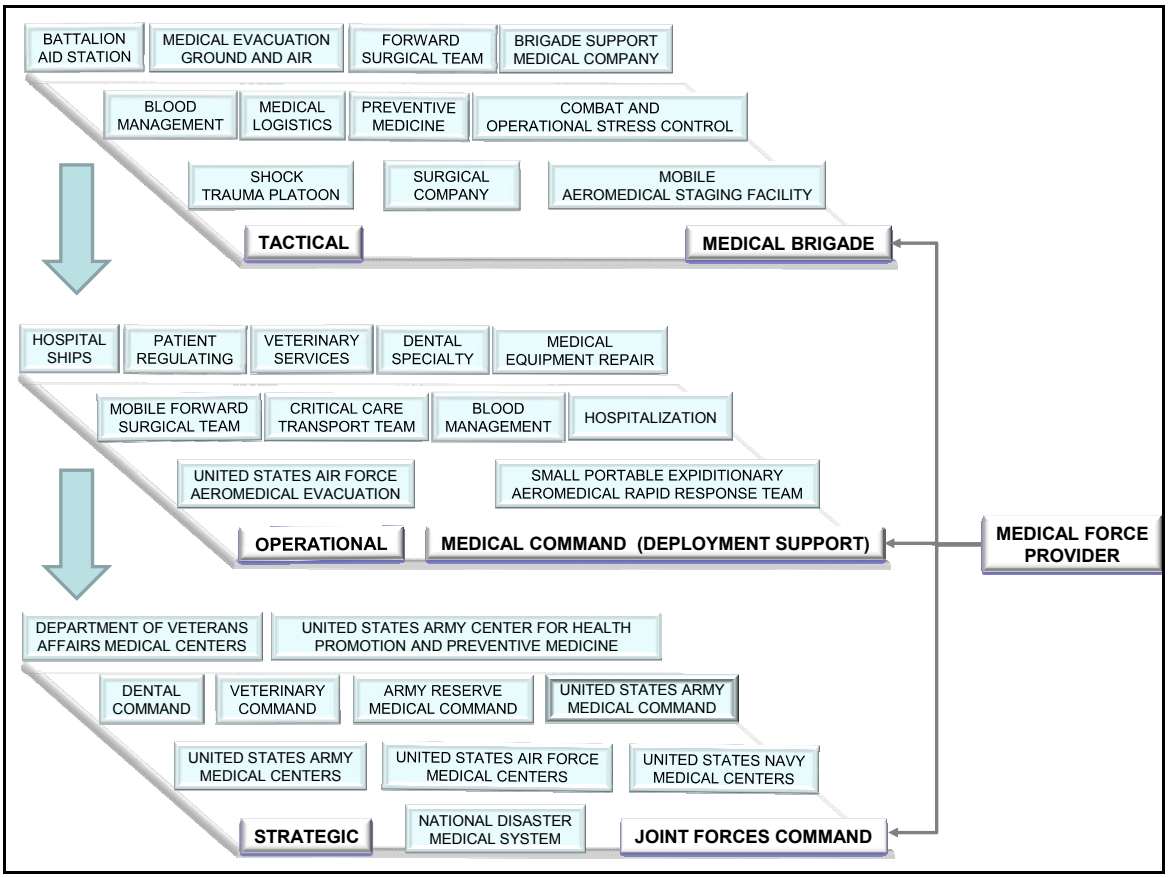

Figure 5-1. Integrated Military Health System

BATTLE RHYTHM

5-32. The AMEDD battle rhythm coincides with that of the tactical commander. As the tactical commander engages the enemy, AHS resources are employed to rapidly clear the battlefield enabling the tactical commander to capitalize on opportunities as they present themselves during the fight. Human physiology is fragile and perishable, Soldiers receiving traumatic injuries on the battlefield must receive timely and effective lifesaving interventions as close to the time of wounding as is possible. Therefore, unlike other sustainment assets, the AMEDD cannot wait for lulls in the battle to locate, acquire, treat, and evacuate battlefield casualties; they must act quickly to find, triage, and stabilize the patient and evacuate him to an MTF that can provide him essential care to save life, to reduce morbidity and mortality, and to potentially reduce long-term disability. To do otherwise would be measured in the loss of the lives of our Soldiers. Through innovations in emerging medical technologies, enhanced medical training, protective equipment, and advances in vaccines and immunizations, the AMEDD has been able to increase the survivability of the battlefield casualty while projecting a smaller footprint in the deployed theater. The ability and authority of the medical commander to rapidly task-organize the scarce medical resources to ensure that the right mix of medical specialties is available at the right time and place is essential. Expeditionary medical operations will further test the agility of the AHS until the theater matures to a more campaign-quality infrastructure. The medical commander must be able to cross-level MEDLOG and shift assets to the points of patient density within the AO. As the entire focus of the AMEDD is to save the lives of our wounded and ill Soldiers, the medical commander does not have the luxury to wait for logistical supplies that are due out or delayed. The medical commander must have the ability and authority to reposition his resources within the operational environment even if it must be accomplished across command boundaries.

DIRECT ACCESS TO THE TACTICAL COMMANDER

5-33. One of the most important aspects of medical C2 is that the medical commander, as a functional command commander, has direct and unfettered access to the tactical commander. This access is fundamental to the medical commander's ability to understand and appreciate the tactical commander's intent and concept of the operation. The medical commander must not only be cognizant of the overall plan and mission objectives, he must be able interpret the nuisances of what is said and what is left unsaid to be able to accurately forecast emerging medical requirements and the implications of the various courses of action on the health of the command. For example, the tactical plan indicates that the battle will be fought on relatively flat, open terrain and due to the technologically advanced weapons and superior number of friendly forces, it is anticipated that the enemy will be defeated quickly. During the planning process, however, the commander mentions that should any enemy forces escape the battle ground he intends to pursue them and defeat them where he finds them. Although the battle ground is flat, open terrain it borders a rugged mountainous area to the north and a marshy, swamp-like area to the east. For the medical commander, this is extremely important information as the character of the injuries Soldiers are likely to receive and the medical equipment and supplies required to treat them varies significantly as the topography changes. As Soldiers enter rugged mountainous terrain, they will incur more crush injuries and fractured bones than forces operating on flat terrain. Additionally, whereas evacuation of casualties on flat terrain may be efficiently conducted by both ground and air evacuation assets, evacuation from mountainous areas poses many obstacles. Injured or wounded Soldiers who might be ambulatory on flat terrain, become litter patients in rugged terrain as they cannot transverse the obstacle laden paths. This requires that the medical commander must augment his deployed medical personnel with additional splinting and casting materials, personnel to perform litter evacuations, and possibly additional tenting and supplies to provide a patient holding capability in the event evacuation is delayed. Should the enemy decide to flee into the swamp-like area, the medical commander is faced with a different set of medical treatment requirements which include immersion injuries, infections, potential for injury from toxic flora and fauna, and increased evacuation requirements, because injured and wounded ambulatory Soldiers will not be able to navigate this hostile terrain either and will become litter patients.

5-34. The medical commander provides the tactical commander with relevant, timely, and critical information during the concept development and planning process for military operations on medical aspects of his operations. This is not limited only to the AHS concept of support for developed OPLANs, but rather encompasses health risk communications on the potential health threats, the impact of physical and psychological stressors on human physiology and mental well-being, and the potential detrimental effects of various courses of action on the health of the command. The medical commander with his extensive education and training in human physiology can rapidly recognize, distinguish, and articulate the potential detrimental effects on the health of command of proposed actions or situations. The medical commander can anticipate potential outcomes and quickly advise the tactical commander on measures to mitigate or reduce the potential adverse impacts. For example, in one sector of the AO the supply routes have been interdicted and the vehicles carrying the resupply of rations have been destroyed. This will necessitate that the affected units will have to go to half rations until the destroyed rations can be replaced. Depending upon the length of delay this situation can create significant morale issues with the affected troops. The medical commander can quickly deploy a COSC team to the affected units to assist the unit commanders in alleviating and managing the stress resulting from this situation.

5-35. When the medical commander's access to the tactical commander is limited by intermediate layers of command, the tactical commander will not receive the same quality of timely and comprehensive advice on the medical aspects of his operations as he receives when his medical commander has direct access. It takes the trained mind of a medical professional to be able to rapidly recognize, analyze, and mitigate potential detrimental impacts on the health of the command. The more layers of an organization for which information must be sifted, the less detailed and complete the information becomes. The more detailed the information that the medical commander is provided, the more accurate, thorough, and timely the analysis of the potential adverse impacts will be and the smaller the number of US forces experiencing potentially disabling illness or injuries will be. As discussed previously, to be responsive to the tactical commander and to be able to be proactive and rapidly responsive to the dynamics of the battlefield, the medical commander must have direct access to the tactical commander. Layering medical resources under a

logistics staff diffuses the focus of the medical effort, results in a longer response time, and can adversely impact the timely care provided to our wounded Soldiers. Although a staff surgeon assigned to a nonmedical staff (such as a sustainment command) can monitor ongoing AHS operations and can provide advice and can assist in planning for future operations, he is not empowered to act decisively to resolve emerging medical requirements. He serves in an advisory capacity where he must recommend courses of action and await the decision of a nonmedical commander. This layering of the medical C2 structure under a sustainment command, effectively negates the medical commander's ability to affect change rapidly through task organization of his assets and the reallocation of critical medical personnel and equipment to keep pace with the emerging medical requirements on the battlefield.

5-36. The Geneva Conventions affords protections to medical personnel and nonmedical personnel assigned to medical units who are *exclusively engaged* in the search for, or the collection, transport, or treatment of the wounded or sick, or in the prevention of disease, (and) staff *exclusively engaged* in the administration of medical units and establishments. Medical personnel, who by their profession and training are entitled to these protections, but who are assigned to the staff of a nonmedical unit are not afforded these protections as they do not meet the *exclusively engaged* criteria required for protection. Medical personnel assigned to nonmedical staffs who fall into the hands of the enemy are not considered retained personnel but rather are prisoners of war and may not be permitted to provide medical care to their fellow prisoners. Refer to FM 4-02 for a detailed discussion

5-37. The tactical commander is responsible for ensuring that his Title 10 responsibilities are successfully accomplished. In regards to the health of his command and the provision of AHS support on the battlefield, he can only be assured that he is fulfilling these duties by having a medical commander who is decisive and who has the authority to execute the AHS mission unencumbered by staff processes.

EMPLOYMENT OPTIONS

5-38. The medical C2 organizations (Figure 5-2) to support the Army modular force were designed to provide the theater commander with various employment options and provide the flexibility to incrementally deploy medical resources as required by emerging battlefield requirements. Theater task organization is ultimately the ASCC commander's decision. This decision is based on METT-TC and relevant operational considerations. The medical commander must have direct access to the tactical commander to be able to identify the AHS support requirements and to ensure that the AHS plan is synchronized with the maneuver operations.

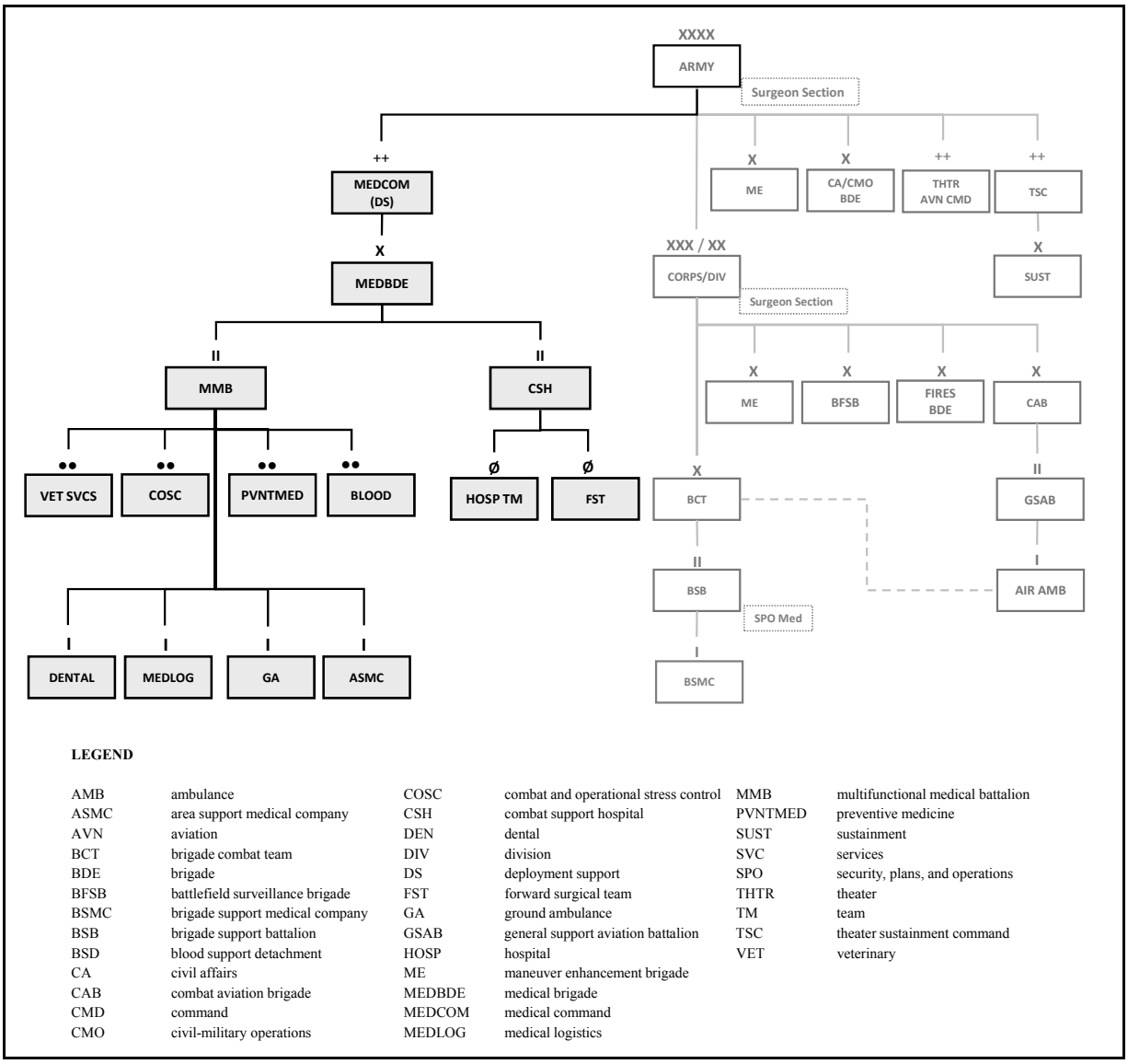

Figure 5-2. Army Medical Department command and control organizations for support to the modular force

5-39. Each of the medical C2 organizations (MEDCOM [DS], MEDBDE, and multifunctional medical battalion) was designed to provide scalable and tailored medical C2 modules for early entry and expeditionary operations which could be expanded and augmented as the theater matures and a campaign-quality health care infrastructure is established. This flexibility in employment, the ability to adjust the medical force to the theater's health care delivery requirements, and the ability to leverage and capitalize on medical resources throughout, not only the Army but the joint MHS, enables the AMEDD to maintain the smallest deployed medical footprint in history while facilitating a reduction of the killed in action rate and sustaining the highest casualty survival rate to yet be recorded.

Regional Focus

5-40. For a discussion of the regional focus of the MEDCOM (DS) refer to paragraphs 2-4 through 2-7.

Direct Support

5-41. The most effective support relationship is for the medical force pool provider (MEDCOM [DS]) to provide a MEDBDE and associated medical units in direct support of the division or corps. This arrangement provides the greatest flexibility to support major combat operations and also simultaneously execute stability operations within the AO. It provides the MEDCOM (DS) commander with the ability to task-organize the theater's scarce medical resources and to rapidly reallocate medical resources in response to changing conditions on the battlefield. It also ensures that the medical specialty expertise on both the staff of the MEDCOM (DS) and MEDBDE is fully engaged in the resolution of complex medical issues arising in the division and corps AOs. The MEDCOM (DS) and MEDBDE have experienced staffs of medical subject matter experts who know how to leverage the medical expertise resident in the CONUS-support base or MHS and can provide the reach capability to obtain needed support from US Army Medical Command's TDA organizations specializing in research, materiel development, OEH hazard assessment, and an immense number of other medical centers of excellence.

Attached/Under the Operational Control to a Division/Corps

5-42. Attaching or placing the MEDBDE under the operational control of the division headquarters provides the unfettered access of the medical commander to the tactical commander. However, it does limit the ability of the medical commander to rapidly task-organize and reallocate his resources across command lines as dictated by the tactical situation. It also limits the medical force pool from which he can draw support should the medical requirements exceed the workload recognized by the rules of allocation for those units. In this arrangement, the medical commander and the command surgeon have a unity of purpose and direction as they both work for the same commander. This arrangement also increases the visibility of ongoing AHS operations within the division.

SECTION III — OFFENSE

OFFENSIVE OPERATIONS

5-43. Offensive operations are operations which aim at destroying or defeating an enemy. They impose US will on the enemy and achieve decisive victory. Commanders carry the fight to the enemy by seizing, retaining, and exploiting the initiative to attack enemy forces, territory, and vital resources. Table 5-1 describes the primary tasks and purposes of offensive operations.

Table 5-1. Offensive operations—primary tasks, purposes, and key medical considerations

Primary tasks	*Purposes*	*Key medical considerations*
● Movement to contact ● Attack ● Exploitation ● Pursuit	● Dislocate, isolate, disrupt, and destroy enemy forces ● Seize key terrain ● Deprive the enemy of resources ● Develop intelligence ● Deceive and divert the enemy ● Create a secure environment for stability operations ● Create a secure environment for stability operations	● All medical functions fully synchronized by medical command and control. ● Medical information management to document health threat exposures and medical encounters, to report health surveillance data and information on the health of the command, and to accomplish medical regulating and patient tracking operations. ● Trauma care, forward resuscitative care, and en route medical care to sustain the patient through medical evacuation to the appropriate role of care. ● Responsive medical logistics which facilitates and sustains the treatment of combat casualties during the fight. ● Theater hospitalization to provide essential care in theater to all categories of patients.

ARMY HEALTH SYSTEM SUPPORT TO THE OFFENSE

5-44. When considering the AHS plans to support an offensive action, the medical planner must consider many factors (FM 8-55). The forms of maneuver, as well as the enemy's capabilities, influence the character of the patient workload and its time and space distribution. The analysis of this workload determines the allocation of AHS resources and the location or relocation of MTFs.

5-45. The higher casualty rates associated with offensive operations increase the burden on medical resources. Combat support hospitals may move forward to prepare for offensive operations. If the increased numbers of casualties overwhelm medical resources, nonmedical transportation assets may be needed for evacuation. Following an offensive operation, combat and operational stress casualties may be more prevalent and require deploying COSC teams into the maneuver area.

5-46. Army Health System support of offensive operations must be responsive to several essential characteristics. As operations achieve success, the areas of casualty density move away from the supporting facilities. This causes the routes of medical evacuation to lengthen. Heaviest patient workloads occur during disruption of enemy main defenses, at terrain or tactical barriers, during the assault on final objectives, and during enemy counterattacks.

5-47. In traditional combat operations, the major casualty area of the BCT is normally the zone of the main attack. As the main attack accomplishes the primary objective of the BCT, it receives first priority in the allocation of combat power. The allocation of combat forces dictates roughly the areas which are likely to have the greatest casualty density. As a general rule, all brigade MTFs are located initially as close to the supported troops as combat operations permit. This allows the maximum use of these MTFs before lengthening evacuation lines force their displacement.

5-48. In combat operations in noncontiguous areas, significant challenges to maintaining a seamless continuum of care from the point of injury, through successive roles of care, to definitive and rehabilitative care in the CONUS-support base or other safe haven will exist.

5-49. On the noncontiguous battlefield, unsecured and unassigned areas may limit the effectiveness and range of ground evacuation assets and they may be required to move as a part of a convoy outside of forward operating bases. This will result in a heavier reliance on rotary-wing evacuation platforms. As rotary-wing aircraft use is limited in some environmental conditions and the enemy's air defense capability, the medical evacuation plan must be continually synchronized to ensure that if patients cannot be moved by using one mode of evacuation, medical evacuation operations will continue to move through the seamless continuum of care from the point of injury.

SECTION IV — DEFENSE

DEFENSIVE OPERATIONS

5-50. Defensive operations are operations that defeat an enemy attack, buy time, economize forces, or develop conditions favorable for offensive or stability operations (Table 5-2). They can create conditions for a counteroffensive that allows Army forces to regain the initiative or for stability operations to create conditions for a stable peace. Defensive operations counter enemy offensive operations. They defeat attacks, destroying as many attackers as necessary. Defensive operations preserve control over land, resources, and populations. They retain terrain, guard populations, and protect critical capabilities. Defensive operations also buy time and economize forces to allow the conduct of offensive operations elsewhere. Defensive operations not only defeat attacks but also create the conditions necessary to regain the initiative and go on the offensive or execute stability operations.

Table 5-2. Defensive operations—primary tasks, purposes, and key medical considerations

Primary tasks	*Purposes*	*Key medical considerations*
● Mobile defense ● Area defense ● Retrograde	● Deter or defeat enemy offensive operations ● Gain time ● Achieve economy of force ● Retain key terrain ● Protect the populace, critical assets, and infrastructure ● Develop intelligence	● All medical functions fully synchronized by medical C2. ● Medical information management to document health threat exposures and medical encounters, to report health surveillance data and information on the health of the command, and to accomplish medical regulating and patient tracking operations. ● Emphasis is placed on the rapid acquisition, stabilization, and evacuation of patients generated by units in contact. This enhances the mobility of supporting medical units and facilitates the tactical commander's ability to exploit opportunities and leverage the momentum to mount a counterattack or perform other maneuvers. ● Responsive medical logistics which facilitates and sustains the treatment of combat casualties during the fight. ● Theater hospitalization to provide essential care in theater to all categories of patients.

ARMY HEALTH SYSTEM SUPPORT TO THE DEFENSE

5-51. The provision of timely and effective AHS presents challenges to the medical planner in defensive operations. The patient load reflects lower casualty rates, but forward area patient acquisition is complicated by enemy actions and the maneuver of combat forces. Medical personnel are permitted much less time to reach the patient, complete vital emergency medical treatment, and remove the patient from the point of injury. Increased casualties among exposed medical personnel further reduce the medical treatment and evacuation capabilities. Heaviest patient workloads, including those produced by enemy artillery and CBRN weapons, may be expected during the preparation or initial phase of the enemy attack and in the counterattack phase. The enemy attack may disrupt ground and air routes and delay evacuation of patients to and from treatment elements. The depth and dispersion of the defense create significant time and distance problems for evacuation assets. Combat elements may be forced to withdraw while carrying their remaining patients with them. The enemy exercises the initiative early in the operation which may preclude accurate prediction of initial areas of casualty density. This makes the effective integration of air assets into the evacuation plan essential.

SECTION V — STABILITY OPERATIONS

5-52. As discussed in JP 3-0, stability operations encompass various military missions, tasks, and activities conducted outside the US in coordination with other instruments of national power to maintain or reestablish a safe and secure environment, provide essential government services, emergency infrastructure reconstruction, and humanitarian relief. The primary tasks relating to the conduct of stability operations are discussed in Table 5-3.

Table 5-3. Stability operations—primary tasks, purposes, and key medical considerations

Primary tasks	*Purposes*	*Key medical considerations*
● Civil security ● Civil control ● Restore essential services ● Support to governance ● Support to economic and infrastructure development	● Provide a secure environment ● Secure land areas ● Meet the critical needs of the populace ● Gain support for host-nation government ● Shape the environment for interagency and host nation success	● Regionally focused medical command and control to promote unity of purpose of all engaged medical assets. ● Medical information management to provide health risk communications, coordinate multinational force and interagency medical interoperability issues, and document health encounters. ● Traditional medical support to a deployed force engaged in these operations. ● Medical expertise and consultation to enhance medical capacity building in the public, private, and military health sectors of the host nation. ● Development of regional theater security cooperation plans aimed at mitigating or resolving the underlying causes of health issues prevalent within the region.

ARMY HEALTH SYSTEM SUPPORT TO STABILITY OPERATIONS

5-53. Historically, the AMEDD has planned, participated in, and executed stability-type operations across the full spectrum of conflict. Many regions in the world are medically underserved and when US forces deploy to these areas requirements to assist the host nation military and civilian medical infrastructure and to reduce human suffering through the provision of foreign humanitarian assistance occur. The AMEDD has always responded to and planned for the increased workload which could potentially occur during these operations. By anticipating these requirements and planning for the additional workload, the medical commander has been able to mitigate the adverse impact of diverting scarce medical assets from the primary mission of supporting the Soldier. With the publication of DODI 3000.05 and FM 3-0, the importance of these operations to the national strategic strategy and the successfully accomplishment of the national strategic goals was recognized and emphasized. In an era of persistent conflict, it is essential that the tactical commander can influence and mitigate or resolve the underlying causes and factors which contribute to the instability in the region. One of principle means, he has to shape the environment, is to provide assistance in the form of military-to-military and military-to-civilian medical capacity building to enhance the host nation's ability to provide effective and responsive health care to its population, to reduce human suffering, and to improve the host nation quality of life. In some scenarios, the assistance will extend to restoring the essential services in the host nation that have been destroyed as a result of military action, terrorist attacks, or man-made or natural disasters. Prompt and responsive support in this arena ensures that the situation in the area will not deteriorate because of epidemic disease outbreaks caused by disrupted sanitation services, unavailability of potable water, and lack of medical care to include immunizations.

5-54. The GCC's theater engagement plan provides the blueprint for conducting stability operations within the deployed AO. Civil Affairs is the proponent for conducting CMO within the Army and the MEDCOM (DS) and MEDBDE staffs have CA staff members to assist in providing advice and consultation to the supporting ASCC G-9 in determining the feasibility of and planning for proposed health care activities and programs. Stability operations are normally conducted in an interagency, multinational force, and NGO environment and the responsibilities for and the execution of specific missions must be clearly articulated and carefully synchronized to ensure the maximum effectiveness of all assets are achieved and that duplication of the same services by different agencies does not occur. Military medicine provides the initial lifeline for the continuation of essential medical care during transition operations and response to major medical emergencies, but these services are then transitioned to the host nation or are provided by other governmental and civilian agencies.

5-55. The AMEDD participates across all of the primary tasks within stability operations as it provides AHS support to all US Army forces involved in the operation, however, its direct support in certain tasks is limited to the traditional support to our forces, such as in civil control and civil security. Medical support and medical capacity building are major contributors to the three remaining primary tasks and, may in fact, be the principle tool in shaping the environment, as military medicine assistance is often times more readily accepted by the host nation. For a detailed to discussion of stability operations, refer to FM 3-0, FM 3-07, and FM 8-42.

SECTION VI — CIVIL SUPPORT OPERATIONS

CIVIL SUPPORT OPERATIONS

CIVIL SUPPORT OPERATIONS

5-56. Civil support operations use Army forces to assist civil authorities, foreign and domestic, as they prepare to respond to crises and relieve suffering within the US and its territories. In civil support operations, Army forces provide essential support, services, assets, or specialized resources to help civil authorities deal with situations beyond their capabilities (Table 5-4). The purpose of civil support operations is to meet the immediate needs of designated groups for a limited time, until civil authorities can

do so without Army assistance. In civil support operations, Army forces always support civil authorities—local, state, and federal. For additional information on support operations refer to FM 3-0.

Table 5-4. Civil support operations—primary tasks, purposes, and key medical considerations

Primary tasks	*Purposes*	*Key medical considerations*
● Provide support in response to disaster or terrorist attack ● Support civil law enforcement ● Provide other support as required	● Save lives ● Restore essential services ● Maintain or restore law and order ● Protect infrastructure and property ● Maintain and restore local government ● Shape the environment for interagency success	● Medical command and control to coordinate, integrate, and synchronize Army Health System resources into the interagency efforts. Further, providing medical expertise to identify and analyze critical needs emerging within the operational area. ● Medical information management to facilitate medical regulating of victims to facilities outside of the disaster/incident site and to document medical treatment. ● Support is provided to assist affected medical infrastructure in saving lives, reducing long-term disability, and alleviating human suffering. ● Support is provided to assist the local government in conducting rescue operations and providing medical evacuation of victims to facilities capable of providing the required care. ● Preventive measures to respond to and resolve emerging health threats caused by the disaster/incident.

5-57. Army support to civil support operations supplements the efforts and resources of state and local governments and organizations. A presidential declaration of a major disaster or emergency usually precedes civil support operations. Civil support operations require extensive coordination and liaison among many organizations—interagency, joint, active Army, reserve, and National Guard units—as well as with state and local governments. The *National Response Framework* provides a national level architecture to coordinate the actions of all supporting federal agencies. The National Response Framework uses the foundation provided by the *Homeland Security Act*, Homeland Security Presidential Directive-5, and the *Robert T. Stafford Disaster Relief and Emergency Assistance Act* (*Stafford Act*) to provide a comprehensive, all-hazards approach to domestic incident management. For more information on CBRN response guidelines, refer to the *National Response Framework*, DODI 2000.18 and FM 4-02.7.

5-58. The Constitution permits the use of Army forces to protect the states against invasion and, upon request of a state, to provide the nation with critical capabilities, such as missile defense, necessary to secure and defend the homeland. It is the responsibility of civil authorities to preserve public order and carry out governmental operations within their jurisdiction. Restrictions on the use of Army forces providing assistance to civil authorities are contained in the *Posse Comitatus Act*, as amended, and the *Stafford Act*. The primary reference for military assistance to civil authorities is DODD 3025.15. It is wide-ranging, addressing such actions as civil disturbance control, counterdrug activities, combating terrorism, and law enforcement.

CIVIL SUPPORT MISSIONS

5-59. During civil support operations, Army forces perform relief operations, support to CBRN consequence management, support to civil law enforcement, and community assistance.

Relief Operations

5-60. Relief operations may be required in response to natural or man-made disasters. Civil authorities are responsible for restoring essential services in the wake of the incident. To assist the civil authorities in accomplishing this action, the President can deploy Army forces. Relief operations consist of—

- Disaster relief. Disaster relief involves the restoration of critical infrastructure such as hospitals and other health care facilities, water and sewage systems, electricity, and communications capabilities. It includes establishing and maintaining the minimum safe working conditions necessary to protect relief workers and the affected population.
- Humanitarian relief. This focuses on those lifesaving measures that alleviate the immediate needs of the population in crisis. Civilian relief organizations (governmental or nongovernmental) are best suited to provide this type of relief. Army forces conducting humanitarian relief usually facilitate civil relief efforts. Activities within these types of operations include the provision of medical care and medications, food, water, clothing, blankets, and shelter.

Support to Civil Chemical, Biological, Radiological, and Nuclear Consequence Management

5-61. Support to CBRN incidents may be required due to the deliberate or unintentional events involving a release or use of CBRN agents that produce catastrophic loss of life and property.

Civil Preparedness

5-62. This encompasses all activities that prepare the nation to rapidly respond to natural or man-made disasters and to terrorist or weapons of mass destruction incidents. The pillars of civil preparedness include training, exercises, expert assistance, and response.

Protection of Critical Assets

5-63. Hostile forces (including terrorists) may attack facilities essential to society, the government, and the military. These assaults can disrupt civilian commerce, government operations, and military capabilities. In order for the Army to conduct full spectrum operations, this infrastructure must be protected. In conjunction with civil law enforcement, Army forces may protect these assets and temporarily restore lost capability.

Response to Chemical, Biological, Radiological, and Nuclear Incidents

5-64. The National Response Framework is the key plan that affects the use of Army forces in CBRN incidents. The resources required to deal with CBRN incidents differ from those needed during conventional disasters. Mass casualties may require decontamination and a surge of medical resources (to include MEDLOG, such as antidotes, vaccines, and antibiotics). The sudden onset of a large number of casualties may pose public health threats related to food, vectors, water, waste, and mental health. Damage to chemical and industrial plants and secondary hazards such as fires may cause toxic environmental hazards. Mass evacuation may be necessary. The Army possesses capabilities suited to respond to CBRN incidents. The MEDCOM has the capability, through its experienced clinicians, planners, and support staffs to accomplish assessments, triage, medical treatment (for conventional and CBRN casualties), hospitalization, and follow-up care, and provide consultation and advice.

Support to Civil Law Enforcement

5-65. Support to civil law enforcement involves activities related to counterterrorism, counterdrug operations, military assistance to civil disturbances, and general support. Although the AMEDD does not

directly participate in these operations, they do provide medical support to those forces participating. Further, veterinary personnel may also be required to support government-owned animals engaged in these operations.

Community Assistance

5-66. Community assistance is a broad range of activities that provide support and maintain a strong connection between the military and civilian communities. Community assistance activities provide effective means of projecting a positive military image, providing training opportunities, and enhancing the relationship between the Army and American public. They should fulfill community needs that would not otherwise be met.

ARMY MEDICAL DEPARTMENT ACTIVITIES IN CIVIL SUPPORT OPERATIONS

5-67. The AMEDD may have numerous support roles in civil support operations. Some of the major AMEDD areas of participation are:

- In coordination with federal, state, and local health organizations, the AMEDD annually teaches courses in the medical management of CBRN casualties.
- Army Medical Department resources can provide direct care capabilities.
- Each Army MTF develops and supports their installation with emergency medical management plans in coordination with the installation commander.
- The US Army Center for Health Promotion and Preventive Medicine in coordination with other federal agencies, such as the US Environmental Protection Agency, develops appropriate products (reports, protocols, and enhanced monitoring) to enhance security of the Army's critical infrastructure and to develop appropriate guidance to counter acts of bioterrorism. Further, the US Army Center for Health Promotion and Preventive Medicine is a reachback center for medical information on CBRN incidents and is capable of providing specialists in the medical arena, if required.
- Army Medical Department resources can assist in conducting vulnerability assessments of drinking water systems.

5-68. Refer to FM 4-02.7 and FM 8-42 for additional information on AMEDD support to civil support operations.

SECTION VII — EXPEDITIONARY AND CAMPAIGN-QUALITY MEDICAL OPERATIONS

5-69. Expeditionary capability is the ability to promptly deploy combined arms forces worldwide into any operational environment and operate effectively upon arrival. Expeditionary operations require the ability to deploy quickly with little notice, shape conditions in the operational area, and operate immediately on arrival. Uncertainty as to the operational area, the possibility of a very austere environment, and the need to match forces to available lift drive expeditionary capabilities.

5-70. Expeditionary capabilities assure friends, allies, and foes that the Nation is able and willing to deploy the right combination of Army forces to the right place at the right time. Forward-deployed units, forward positioned capabilities, peacetime military engagement, and force projection—from anywhere in the world—all contribute to expeditionary capabilities. Expeditionary capabilities enable the Army to respond rapidly under conditions of uncertainty to areas with complex and austere operational environments with the ability to fight not only on arrival but also through successive operations. Fast deploying and expansible Army forces provide the means to introduce operationally significant land forces into a crisis on short notice, providing preemptive options to deter, shape, fight and win if deterrence fails, and to sustain these options for the duration necessary to achieve success. Providing joint force commanders with expeditionary capability requires forces organized and equipped to be modular, versatile, and rapidly deployable with agile institutions capable of supporting them. Rapidly deployed expeditionary force packages provide immediate options for seizing or retaining the operational initiative. With their modular

capabilities, these forces can be swiftly deployed, employed, and sustained for extended operations without an unwieldy footprint. These forces are tailored for the initial phase of operations, easily task-organized, and highly self-sufficient. Army installations worldwide serve as support platforms for force projection, providing capabilities and information on demand.

5-71. Expeditionary capabilities are more than physical attributes; they begin with a mindset that pervades the force. Soldiers with an expeditionary mindset are ready to deploy on short notice. They are confident that they can accomplish any mission. They are mentally and physically prepared to deploy anywhere in the world at any time in any environment against any adversary. Leaders with an expeditionary mindset are adaptive. They possess the individual initiative needed to accomplish missions through improvisation and collaboration. They are mentally prepared to operate within different cultures in any environment. An expeditionary mindset requires developing and empowering adaptive thinkers at all levels, from tactical to strategic.

EXPEDITIONARY MEDICAL OPERATIONS

5-72. The operational environment of today is joint and multinational in nature. Army units are employed in concert with the forces from each of the Services, combatant commands, and often with multinational forces. Multinational forces will encounter some unique problems in terms of providing and structuring the medical support. Instead of being able to establish an integrated structure of roles of care with consistent quality and a seamless continuum, the US military will potentially face a cobbled together medical force which may contain holes and gaps and be of variable capacity. Therefore, AHS planners must understand not only the capabilities and limitations of Army medical units, but must also understand what capabilities are present in the joint and multinational forces employed in the AO, capabilities of the host nation, and what support requirements will be generated. Coordination and planning must emphasize the interdependence of these units in the concerted effort to support the GCC's OPLAN and to ensure mission success.

TASK ORGANIZATION OF MEDICAL UNITS/ELEMENTS

5-73. Significant advances are being made toward fielding a responsive field medical force that is modular, mobile, and adaptive to the AHS mission requirements. Providing the best care possible at the right place and at the right time for every wounded or injured Soldier is the goal of AMEDD. In addition to medical organizations, medical staff elements located at battalion-, brigade-, corps-, and Army-levels are essential for planning, coordinating synchronizing AHS support for their respective organizations. Developing the AHS plan is a coordinated effort and requires timely reporting and frequent updates on the status of medical units/elements. Our medical staff elements should be staff-trained and thoroughly integrated into the planning and operations process of their headquarters. Running estimates by subordinate medical units/elements and the frequent exchanges of operations information are essential to maintaining a common operating picture for the surgeons, medical planners, MEDLOG officers, medical commanders, and medical leaders. All medical units/elements operating in the AO must be integrated into the theater AHS and be included into the planning and operations process. The MEDCOM (DS) as the senior medical headquarters and medical force pool provider in theater must ensure that the vertical and horizontal integration of medical resources is achieved to ensure a seamless continuum of care from the point of injury through the essential care provided in theater, and if required, to the definitive and rehabilitative care in the CONUS-support base.

5-74. Essential to successful task organization is a thorough understanding of existing command and control relationships. Command and control relationships are discussed in FMs 3-0 and 6-0. Recent operations have resulted in units receiving support from or providing support to units that have not traditionally provided/received this support. Therefore, medical commanders and planners must ensure that C2 relationships are clearly articulated in OPLANs and OPORDs and that these are disseminated to the lowest level. Whether support is received from traditional organizations or it is received from new sources, such as from another Service or multinational force, it is paramount that the flow of support services is continuous. If each Soldier and organization knows where to expect the support, it facilitates the process, avoids confusion, and enables those on the ground to establish the contacts and procedures to

make it happen. Clearly articulating these support relationships assists both the planner and the operator in accomplishing the mission.

5-75. Medical units must be prepared to operate in areas where traditional support bases are either absent or not fully developed. Due to the humanitarian nature of medical operations, medical assets may be deployed to areas ahead of other sustainment units/resources. For example, refugees fleeing areas of combat may spontaneously establish camps in remote areas. If the GCC directs that humanitarian assistance be provided, medical units may deploy PVNTMED, medical treatment, and medical evacuation assets to support this population before signal support can be established in the area. Therefore, medical planners must foresee and plan for such a contingency to ensure continuing requirements can be communicated and follow-on resupply in areas where logistical bases have not been established. Although communications may not be a problem in this scenario, transportation routes may not be established and innovative measures may be required to move resupply items to the forward areas. The modes of transportation used to move supplies and equipment may also be inadequate; for example, host nation buses, trucks, and pack animals may have to be used to distribute medical supplies and equipment around the AO.

5-76. Task organization has traditionally been accomplished by selecting whole units with the required capabilities to form a task force. Due to troop ceiling limitations, availability of transportation assets, and size of the population to be supported, task organization of units can also involve using unit increments or selected capabilities. Further, task organization can be done by combining incremental assets from units from different Services to achieve a composite mix of medical specialties that is the right size for the operation. For example, the Army FST is a 20-man team which provides a far forward surgical intervention capability. The FST is not, however, a self-sufficient unit. It is designed to be collocated with a medical company. The medical company provides the x-ray, laboratory, patient administration, and patient holding capability for the team, as well as some of its power generation requirements. In some scenarios, it may be determined that the footprint of these two units is too large. To reduce the size of the footprint, a support package that includes the required capabilities that are not as robust as the medical company may be task-organized to support the FST. The assets used for this support may be provided by another Service. The requirements for the use of medical assets and resources will vary on the type and duration of the operation and the availability of medical resources.

CAMPAIGN-QUALITY MEDICAL OPERATIONS

5-77. Campaign capability, a joint construct, is the ability to sustain operations as long as necessary to conclude operations successfully. Many conflicts are resolved only by altering the conditions that prompted the conflict. This requires combat power and time. The campaign capability extends its expeditionary capability well beyond deploying combined arms forces that are effective upon arrival. It is an ability to conduct sustained operations for as long as necessary, adapting to unpredictable and often profound changes in the operational environment as the major operations battles and engagements unfold. Army forces are organized, trained, and equipped for endurance. Their endurance stems from the ability to generate, protect, and sustain landpower—regardless of how far away it is deployed, how austere the environment, or how long the GCC requires it. It includes taking care not only of Soldiers but also of Families throughout the complete cycle of deployment, employment, and redeployment. This involves anticipating requirements across the entire Army and making the most effective use of all available resources—deployed or not. Finally, major operations battles and engagements capability draws on iterative and continuous learning based on operational experience. This requirement extends to training at all echelons, from individual Soldier skills to operational-level collective tasks. Campaign-quality medical operations combines the medical resources of the deployed Services, synchronizes the delivery of care across Services boundaries, and facilitates reachback support to the MHS. Campaign-quality medical operations maximizes the use of scarce medical resources and enables access to all deployed medical specialty care.

5-78. Campaigning requires a mindset and vision that complements expeditionary requirements. Soldiers understand that no matter how long they are deployed, the Army will take care of them and their Families. They are confident that the loyalty they pledge to their units will be returned to them, no matter what

happens on the battlefield or in what condition they return home. Tactical leaders understand the effects of protracted land operations on Soldiers and adjust the tempo of operations whenever circumstances allow. Senior commanders plan effective campaigns and major operations. They provide the resources needed to sustain operations, often through the imaginative use of joint capabilities.

5-79. The Army's preeminent challenge is to balance expeditionary agility and responsiveness with the endurance and adaptability needed to complete a campaign successfully, no matter what form it eventually takes. Landpower is a powerful complement to the global reach of American airpower and sea power. Prompt deployment of landpower gives joint force commanders options—for either deterrence or decisive action. Once deployed, landpower may be required for months or years. The initially deployed Army force will evolve constantly as the operational environment changes. Operational success depends on flexible employment of Army capabilities together with varying combinations of joint and interagency capabilities.

5-80. The MEDCOM (DS) ensures campaign-quality medical operations are established and implemented as the theater matures from early entry expeditionary-style operations to a sustained presence. They accomplish this by continually identifying, assessing, and evaluating health care requirements of the deployed force and, when directed of multinational forces and host nation personnel. The MEDCOM (DS) provides operational reach to the Generating Force to leverage the resources (personnel, infrastructure, and materiel) of the US Army Medical Command and its subordinate research, educational, and training institutions and assets to ensure deployed Soldiers receive the best possible health care regardless of their geographic location.

SECTION VIII — ENEMY PRISONER OF WAR AND/OR DETAINEE MEDICAL CARE OPERATIONS

5-81. As the senior AHS C2 organization within the theater, the MEDCOM (DS) is responsible for ensuring that the medical care provided to EPWs and other personnel in US custody such as detained or retained personnel is provided in compliance with international and US law and military policies and regulatory guidance. The MEDCOM (DS) plans for and coordinates support for internment facilities located within its AO. The MEDCOM (DS) commander or his designee (normally the deputy commander, professional services) serves as the detainee operations medical director and provides oversight, guidance, and policy on medical ethics issues, standards and availability of care, requirements for field hygiene and sanitation, nutrition and maintenance of weigh-in registers, and all other medical aspects of confinement health care. For specific information on the conduct of these operations, refer to FMI 4-02.46.

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Appendix A

Eligibility Determination for Medical/Dental Care

During interagency and multinational operations, one of the most pressing questions is who is eligible for care in a US Army established MTF and the extent of care authorized. Numerous categories of personnel seek care in US facilities that are located in austere areas where the host nation civilian medical infrastructure is not sufficient to provide adequate care. A determination of eligibility and whether reimbursement for services is required is made at the highest level possible and in conjunction with the supporting SJA. Additionally, Department of State and other military staff sections (such as the assistant chief of staff, plans) may also need to be involved in the determination process. Each operation is unique and the authorization for care is based on the appropriate US and international law, DODD and DODI, ARs, doctrine, and standing operating procedures. Other factors impacting on the determination of eligibility are command guidance, practical humanitarian and medical ethics considerations, availability of US medical assets (in relationship to the threat faced by the force), and the potential training opportunities for medical forces. The sample format provided in paragraph A-5 is just one approach to delineate and disseminate this information to MTF personnel and may not be all inclusive based on specific scenarios.

Note. The examples for the authority to provide treatment are *only illustrative* in nature and should not be used as the basis for providing or denying medical care.

DOCUMENTATION

A-1. Basic documents required for determining eligibility of beneficiaries include AR 40-400; FM 27-10; relevant sections of Title 10, US Code; relevant DODD and DODI; international standardization agreements (ISAs); acquisition and cross servicing agreements; orders from higher headquarters; interagency agreements (memorandum of understanding or agreement); status of forces agreements; and appropriate multinational or international agency guidance for the specific operation. If contractor personnel are present, a copy of the relevant sections of their contracts should be on file to delineate specific medical services to be rendered. Additionally, for contract personnel a point of contact (POC) for the contracting company and a POC for the administration of the contract should be maintained. Finally, the political-military environment of the AO must be taken into account as the medical C2 headquarters and its higher headquarters develop the eligibility matrix.

A-2. The eligibility matrix should be as comprehensive as possible. If necessary, it should include eligibility determination by name (see example in paragraph A-5). If individuals arrive at the emergency medical service section of the MTF who are not included in the medical/dental support matrix, the MTF must always stabilize the individual first, and then determine the patient's eligibility for continued care. The command POC for eligibility determination should be contacted immediately. Further, care will be provided in accordance with the standing operating procedure pending eligibility determination. (For example, a host nation civilian presents himself at the gate and requests medical treatment. Although on the surface it may appear that he is not eligible for care, this determination can only be made after a medical assessment is completed by competent medical personnel. In some cases, the individual may have to be brought into the MTF to accomplish an adequate medical assessment. Conducting a medical

assessment does not obligate the US military to provide the full spectrum of medical care. Although it does obligate the MTF to provide immediate stabilization for life-, limb-, and eyesight-threatening medical conditions and to prepare the patient for evacuation to the appropriate civilian or national contingent MTF when the patient's medical condition permits.)

Note. Any individual requesting medical care should receive a timely medical assessment of his condition. Even though the individual is not eligible for treatment, life-, limb-, or eyesight-saving procedures warranted by the individual's medical condition are provided to stabilize the individual for transfer to the appropriate civilian or other nation medical treatment facility.

KNOWLEDGE OF HEALTH CARE CAPABILITIES

A-3. The MTF staff must be familiar with the medical care available in the AO from other sources. These sources could include multinational or host nation military (tactical and strategic), NGO or international organization (such as the United Nations), and local civilian resources. When appropriate, and by knowing the level and types of care available, the MTF staff can plan for the continued care of the patient after initial stabilization is provided in the US MTF and the patient can be transferred to another facility for continued care.

DISSEMINATION OF ELIGIBILITY FOR CARE INFORMATION

A-4. It is essential that eligibility for medical care guidance is disseminated and understood by the chain of command and all civilians and military members of the deployed force. The AHS commander must be able to articulate the basic concepts for medical eligibility determinations. This means that he will need to condense them into simple, easily understood instructions, and widely disseminate them through electronic means or other media (such as pocket-sized cards). As the chief planner for AHS operations, the AHS commander must ensure that this information is contained in appropriate OPLANs and OPORDs and briefed to the appropriate senior leadership of the command.

SAMPLE ELIGIBILITY OF CARE MATRIX

A-5. Table A-1 provides a sample of an eligibility of care matrix for treatment in a US Army MTF.

Table A-1. Sample eligibility for medical/dental care support matrix

ELIGIBILITY FOR MEDICAL/DENTAL CARE SUPPORT MATRIX (DATE) (THIS DOCUMENT IS SUBJECT TO FURTHER VERIFICATION AND/OR MODIFICATION)		
Category	***Medical/dental***	***Information/authority****
Multinational military personnel	Yes[1]	The following nations have ACSAs and ISAs with the US which are administered by (*combatant command*): *List nations.*
Coalition military personnel	Yes[1]	The following nations have ACSAs and ISAs with the US which are administered by (*combatant command*): *List nations*
DOD civilian employees	Yes	Invitational travel orders (ITOs).
US Government employees (non-DOD)	Yes[2]	ITOs.

Table A-1. Sample eligibility for medical/dental care support matrix (continued)

Category	*Medical/dental*	*Information/authority**
US Embassy personnel	Yes	US citizens on official business.
US Congressional personnel	Yes	US citizens on official business.
Army and Air Force Exchange Service US citizen employees	Yes	ITOs.
Army and Air Force Exchange Service local national employees	Yes[3]	US law.
Nonappropriated fund instrumentality MWR US employees	Yes	ITOs.
Nonappropriated fund instrumentality MWR Local national employees	Yes[3]	US law.
Other persons on DOD ITOs	Yes	ITOs.
US Governmental Agency (such as US Agency for International Development or Drug Enforcement Agency) US citizen employees	Yes	ITOs.
US Governmental Agency (such as US Agency for International Development or Drug Enforcement Agency) non-US citizen employees	Yes[3]	After stabilization, coordinate with the US Governmental Agency POC to evacuate the patient to his country of citizenship. AR 40-400 authorizes limited care. Contact Mr. Bannon, DSN XXX-XXXX.
Contractor employees who are US military retirees	Yes[4]	AR 40-400.
Contracted college instructors	Yes	ITOs.
United Nations personnel (includes all personnel employed by the United Nations and its agencies, such as the United Nations High Commissioner for Refugees)	Yes[3]	US law.
American National Red Cross	Yes[3]	ITOs.
Nongovernmental organizations personnel	Yes[3]	US law.
Contractor #1 expatriate employees POC: Ms. Scott (XXX) XXX-XXXX ADMIN: Mr. Elliott DSN XXX-XXXX	Yes	Have copy of relevant contract.
Contractor #1 local national employees POC: Ms. Scott (XXX)XXX-XXXX ADMIN: Mr. Elliott DSN XXX-XXXX	Yes[3]	Have copy of relevant contract. US law and SOFA.

Table A-1. Sample eligibility for medical/dental care support matrix (continued)

Category	*Medical/dental*	*Information/authority**
Contractor #2 all employees POC: Mr. Franklin (XXX) XXX-XXXX ADMIN: Mr. Elliott DSN XXX-XXXX	Yes[3] No[5]	Contractor did not contract for the provision of medical care by military MTFs. Contractor stated in writing that they contracted with the host nation medical infrastructure for the required care. **NOTE:** A separate determination may be required for individual cases, as the individual may be eligible for care under a different provision. Contact Mr. Bannon, DSN XXX-XXXX if additional information is required.
Contractor #3 Communications Section POC Ms. Jo Alce (XXX) XXX-XXXX ADMIN: Mr. Elliott DSN XXX-XXXX	Yes[3]	ITOs. **NOTE:** This entry for Contractor #3 does not include personnel assisting project XYZ. Those personnel are contracted with a division of the contractor and are subject to separate contract terms. Contractor #3 in support of project XYZ has not submitted any information for determining eligibility for medical care and logistical support of these personnel.
Contractor #4 Mr. Edward Lee (company name classified) POC: Ms. Hannah (XXX) XXX-XXXX ADMIN: Mr. Elliott DSN XXX-XXXX	Yes	Per Mr. Bannon, Mr. Lee is entitled to full medical and dental support without reimbursement. The terms of the contract and the name of the contracting company are classified. Contact Mr. Bannon, DSN XXX-XXXX, if additional information is required.
Contractor #5 Mr. Noah James (company name classified) POC: Ms. Hannah (XXX) XXX-XXXX ADMIN: Mr. Elliott DSN XXX-XXXX	Yes[6]	Per Mr. Bannon, Mr. James is entitled to full medical and dental support, however, this care is reimbursable. The terms of the contract and the name of the contracting company are classified. Contact Mr. Bannon, DSN XXX-XXXX, if additional information is required.
Dependents of US active duty or retired military personnel.	Yes[4]	Only if space is available and appropriate medical services/care are available in the operational setting. AR 40-400. Contact Mr. Bannon, DSN XXX-XXXX, if additional information is required.

Table A-1. Sample eligibility for medical/dental care support matrix (continued)

Category	*Medical/dental*	*Information/authority**
Personnel in custody of US military forces	Yes	US and international law. This category includes personnel in protective custody, EPW, retained, or detained personnel. Extent of care rendered is the same as that provided to US military forces (FM 4-02, FM 27-10, and FMI 4-02.46). Contact Mr. Bannon, DSN XXX-XXXX, if additional information is required.
Individual injured as a result of military operations	Yes	US and international law (FM 27-10) and SOFA. If the US military injures an individual (such as in an automobile accident involving a military vehicle), the US is responsible for providing immediate care (or paying for local care). Coordinate with Mr. Bannon, DSN XXX-XXXX and LTC Brian, support SJA, DSN XXX-XXXX.

LEGEND

* Illustrative in nature only.

1 Multinational forces member nations are provided food, water, fuel, and medical treatment pursuant to reciprocal agreements. The amount of food, water, fuel, and medical care provided must be accounted for by the providing nation to the G-5, multinational liaison. Logistical support is not permitted for those nations with whom the US does not have both an ACSA and ISA. However, the ACSA and ISA requirements may be waived for those nations whom the task force commander, in conjunction with the supporting SJA, feels are supporting the missions of the task force.

2 If not working for, contracted to, or on DOD ITO for logistical support, non-DOD US Government employees must pay for meals received at DOD dining facilities.

3 Emergency medical and dental care only. Emergency care is that care required to save life, limb, or eyesight.

4 Space available.

5 Routine.

6 Reimbursable.

ADMIN administrator
ACSA acquisition and cross servicing agreement
AR Army regulation
DOD Department of Defense
DSN Defense Secure Network
FM field manual
FMI field manual interim
G-5 assistant chief of staff, plans
MTF medical treatment facility
ISA international standardization agreement
ITO invitational travel order
MWR morale, welfare, and recreation
POC point of contact
SOFA status of forces agreement
US United States

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Appendix B

Command Post Operations

SECTION I — COMMAND POST OPERATIONS

The MEDCOM (DS) and/or MEDBDE standing operating procedure establishes the MEDCOM (DS)/MEDBDE CP organization and composition. The CP consists of a main and an alternate location. The alternate locations are planned for in order to enhance the security and survivability of the main CP.

MAIN COMMAND POST

B-1. The main CP consists of those elements of the command group, staff sections, and administrative support personnel required for C2, staff supervision, personnel staff support, and life support. It also includes planning cells or liaison officers from higher and subordinate commands to synchronize AHS support plans. The CP includes the life support and perimeter defense areas.

B-2. The CP configuration reflects broad specialized relationships, continuity of operations, and information flow among sections. The availability of existing facilities and terrain determines actual location of elements and supporting staff sections. The HHC commander plans the physical layout of the CP.

B-3. The life support area includes facilities for providing field feeding, billeting, and organizational supply and maintenance. The HHC commander coordinates these support activities, as well as other essential support services, such as shower, laundry, and latrines. Life support services are incorporated within the base perimeter.

B-4. An alternate CP provides continuity of C2 in case of destruction or incapacitation of the main CP. The MEDCOM (DS)/MEDBDE G-3/S-3 select alternate CP locations. The HHC commander is responsible for establishing the alternate CP.

COMMAND POST SECURITY

B-5. Command posts use several measures to improve the survivability of critical C2 elements. If a chemical/biological protected or nuclear hardened site is not available, CP dispersal enhances survivability, as does reducing the size and signature of the CP.

B-6. The HHC commander is responsible for coordinating internal security and local defense of the main CP. Command post security includes establishing—

- Prepared defensive positions and a warning system.
- Barrier systems and obstacles outside the perimeter.
- Manned guard posts.
- Sentries and guards for local internal security.
- Alternate and supplementary positions.
- Access control.

Note. The Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field does not itself prohibit the use of Article 24 personnel in perimeter defense of nonmedical units such as sustainment areas or base clusters under overall security defense plans, but the policy of the US Army is that Article 24 personnel will not be used for this purpose. Adherence to this policy should avoid any issues regarding their status under the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces due to a temporary change in their role from noncombatant to combatant. Medical personnel may guard their own unit without any concurrent loss of their protected status. For additional information on the medical aspects of the Geneva Conventions refer to FM 4-02.

B-7. Unless the main CP is within the perimeter of a larger secure base, the HHC commander controls access to the main CP. The MEDCOM (DS)/MEDBDE G-3/S-3 operations branch is responsible for preparing and issuing passes. The HHC commander is responsible for employing alarm devices. The CBRN officer designates the location of chemical detectors/alarms. The HHC commander establishes an airborne early warning network and implements an area alert system for ground and/or air attacks. He also notifies the supporting base cluster operations of attacks and immediately forwards requests for quick reaction forces through the MEDCOM (DS)/MEDBDE G-3/S-3.

REPORTS

B-8. One means of maintaining situational understanding is to receive situation and status reports from higher and subordinate AHS units. The C2 headquarters designates what reports are required, what format will be used, period covered by the report, frequency and submission times, and means of transmission. Table B-1 depicts a sample report submission schedule.

Table B-1. Sample report submission schedule

REPORT SUBMISSION SCHEDULE				
Report	***As of***	***Arrive not later than***	***Precedence***	***Sent to***
Medical spot report	As needed	Immediately	Priority	MEDCOM (DS)/MEDBDE/ MMB commander
Medical situation report	0600	1000	Routine	MEDCOM (DS)/MEDBDE/ MMB commander
Medical status report	0600 Daily	1000	Routine	MEDCOM (DS)/MEDBDE/ MMB commander
Disease and nonbattle injury report	2359 Saturday weekly	1200 Monday weekly	Routine	MEDCOM (DS)/MEDBDE/ MMB commander
LEGEND MEDBDE medical brigade			MEDCOM (DS) medical command (deployment support) MMB medical battalion (multifunctional)	

Appendix C

Medical Units Which May Be Assigned or Attached to a Medical Command (Deployment Support), Medical Brigade (Support), or Medical Battalion (Multifunctional)

This appendix provides information on the TOE number, basis of allocation, and assignment of medical units which may be assigned or attached to a MEDCOM (DS), MEDBDE, or MMB. Some units are assigned or attached to subordinate units of the MEDCOM (DS), MEDBDE, or MMB. If the parent headquarters is not deployed, these units could be assigned or attached directly to the deployed MEDCOM (DS), MEDBDE, or MMB.

C-1. Table C-1 depicts units designed under the Medical Reengineering Initiative.

Table C-1. Medical Reengineering Initiative units

TOE Number	*Nomenclature*	*Basis of allocation*	*Assignment*	*Reference*
08411A000	Headquarters and Headquarters Company, Medical Command (Corps)	1 per corps.	Assigned to an ASCC	FM 4-02
08422A100	Headquarters and Headquarters Company, Medical Brigade (Corps)	Up to 4 per corps MEDCOM (DS).	Assigned to MEDCOM (DS)	FM 4-02
08423A000	Medical Detachment (Veterinary Medicine)	1 per 50 to 200 government-owned animals in support of all branches of the military service or other supported units as assigned.	Assigned to a MEDCOM (DS)	FM 4-02.18
08429A000	Medical Detachment (Preventive Medicine)	1 per 17,000 supported personnel in the corps and echelons above corps.	Assigned to a MEDCOM (DS), MEDBDE, or MMB	FM 4-02.17
08440A000	Medical Detachment (Veterinary Services)	1 per 60,000 personnel supported; 1 per 50 MWDs supported.	Assigned to a MEDCOM (DS) or MEDBDE	FM 4-02.18
08453A000	Medical Company (Ground Ambulance)	1 per division.	Assigned to a MEDBDE or MMB	FM 4-02.2
08457A000	Medical Company (Area Support)	1 per 15,000 nondivisional troops in EAB.	Assigned to an MMB	FM 4-02.6
08463A000	Medical Detachment (Combat Stress Control)	1 per division; 1 per theater.	Assigned to a MEDCOM (DS) or MEDBDE	FM 4-02.51

Table C-1. Medical Reengineering Initiative units (continued)

TOE Number	*Nomenclature*	*Basis of allocation*	*Assignment*	*Reference*
08473A000	Dental Company (Area Support)	1 per 43,000 Army population supported in the theater.	Assigned to a MEDCOM (DS) or MEDBDE	FM 4-02.19
08489A000	Medical Detachment (Blood Support)	1 per 100,000 Soldiers in the theater.	Assigned to an MMB	FM 4-02.1
08496A000	Headquarters and Headquarters Detachment, Medical Logistics Battalion	1 per 3-6 subordinate units.	Assigned to a MEDCOM (DS) or MEDBDE	FM 4-02.1
08527AA00	Medical Detachment (Hospital Augmentation Team, Head and Neck)	1 per 650 conventional hospital patients in the theater.	Assigned to a MEDCOM (DS), MEDBDE, or attached to a hospital	FM 4-02.10
08537AA00	Medical Detachment (Hospital Augmentation Team, Pathology)	1 per 2,360 conventional hospital patients in the theater.	Assigned to a MEDCOM (DS), MEDBDE, or attached to a hospital	FM 4-02.10
08538AA00	Medical Detachment (Hospital Augmentation Team, Special Care)	1 per theater.	Assigned to a MEDCOM (DS), MEDBDE, or attached to a hospital	FM 4-02.10
08668A000	Medical Laboratory (Area Laboratory)	1 per theater.	Assigned to a MEDCOM (DS) or MEDBDE	FM 4-02.17
08699A000	Medical Center (Logistics Management)	1 for the Army.	Assigned to a MEDCOM (DS)	FM 4-02.1
08753A000	Medical Detachment (Area Support)	1 unit required in the force.	Assigned to a MEDCOM (DS)	FM 4-02.6
08855A000	Combat Support Hospital (248 Bed) (Echelons Above Corps)	Supports the requirement for all assigned intensive care unit and intermediate care ward bed requirements (50 percent of total bed requirements). To support minimal care beds must be augmented by the medical detachment (minimal care).	Assigned to a MEDCOM (DS) or MEDBDE	FM 4-02.10
08945A000	Combat Support Hospital (248 Bed) (Corps)	3.78/1000 conventional, 3.957/1000 blister, and 1.315/1000 nerve hospital patients in the corps.	Assigned to a MEDCOM (DS) or MEDBDE	FM 4-02.10
08949A000	Medical Detachment, Minimal Care	Supports the requirement for all combat zone minimal care ward bed requirements.	Assigned to a MEDBDE	FM 4-02.10

LEGEND
ASCC Army service component command
EAB echelons above brigade
FM field manual
MEDBDE medical brigade
MEDCOM (DS) medical command (deployment support)
MMB medical battalion (multifunctional)
MWD military working dog

MEDICAL FORCE 2000 UNITS

C-2. The organizations listed in Table C-2 were initially designed under the Medical Force 2000 force design process. Some units were revised under the Medical Reengineering Initiative; however, these units retain the "L" designator. As Medical Reengineering Initiative units and/or newly designed units support the Modular Army are fielded, the Medical Force 2000 TOEs will transition to the new TOEs.

Table C-2. Medical Force 2000 units

TOE Number	*Nomenclature*	*Basis of allocation*	*Assignment*	*Reference*
08422L200	Headquarters and Headquarters Company, MEDBDE (COMMZ)	1 per 3-7 battalion-sized units.	Assigned to a MEDCOM (DS)	FM 8-55
08432L000	Headquarters and Headquarters Company, Medical Group	3 to 4 per HHC, MEDBDE.	Assigned to a MEDBDE	FM 8-55
08463L000	Medical Detachment (Combat Stress Control)	1 per division and 1 per 2 separate brigades.	Assigned to a MEDCOM (DS) or MEDBDE and further attached to the medical company, combat stress control or supported medical company	FM 4-02.51
08467L000	Medical Company, Combat Stress Control	1 per 2 divisions.	Assigned to a MEDCOM (DS) or MEDBDE	FM 4-02.51
08478L000	Medical Company (Dental Services)	1 per each 20,000 troops supported.	Assigned to a MEDCOM (DS) or MEDBDE	FM 4-02.19
08485L000	Medical Battalion (Logistics) (Forward)	1 per corps	Assigned to a MEDBDE	FM 4-02.1
08498L000	Medical Detachment (Preventive Medicine) (Sanitation)	1 per 22,500 personnel and 1 per 50,000 EPWs.	Assigned to a MEDBDE	FM 4-02.17
08499L000	Medical Detachment (Preventive medicine) (Entomology)	1 per 45,000 personnel and 1 per 100,000 EPWs.	Assigned to a MEDBDE	FM 4-02.17
08518LA00	Medical Team (Forward Surgical)	2 per AAST division; 3 per LID and heavy division; 1 per ACR/SOSB.	Assigned to a MEDCOM (DS) or MEDBDE	FM 4-02.25
08518LB00	Medical Team (Forward Surgical) (Airborne)	2 per airborne division; 1 per sustainment brigade special operations.	Assigned to a MEDCOM (DS) or MEDBDE	FM 4-02.25
08527LA00	Medical Detachment (Head and Neck)	.25 per CSH	Assigned to a MEDCOM (DS), MEDBDE, or further attached to a hospital	FM 4-02.10
08527LB00	Medical Detachment (Neurosurgery)	.37 per CSH.	Assigned to a MEDCOM (DS), MEDBDE, or further attached to a hospital	FM 4-02.10
08527LC00	Medical Detachment (Eye Surgery)	.25 per CSH	Assigned to a MEDCOM (DS), MEDBDE, or further attached to a hospital	FM 4-02.10

Table C-2. Medical Force 2000 units (continued)

Toe Number	*Nomenclature*	*Basis of allocation*	*Assignment*	*Reference*
08537LA00	Medical Detachment (Pathology)	1 per theater.	Assigned to a MEDCOM (DS), MEDBDE, or further attached to a hospital	FM 8-55
08537LB00	Medical Detachment (Renal Hemodialysis)	1 per 550 conventional hospital patients in the theater.	Assigned to a MEDCOM (DS), MEDBDE, or further attached to a hospital	FM 4-02.10
08537LC00	Medical Detachment (Infectious Disease)	1 per 800 conventional hospital patients in the theater.	Assigned to a MEDCOM (DS), MEDBDE, or further attached to a hospital	FM 4-02.10
08695L000	Medical Battalion (Logistics) (Rear)	1 per 2 corps.	Assigned to a MEDCOM (DS)	FM 4-02.1
08705L000	Combat Support Hospital	2.4 hospitals per division.	Assigned to a MEDBDE	FM 4-02.10
08903L00	Medical Logistics (Support Detachment)	1 per division or armored cavalry regiment not supported by a MMB; 1 per 25,000 joint service population in the combat zone; 1 per 50,000 joint service population in theater Army area.	Assigned to a MMB	FM 4-02.1

LEGEND
ACR armored cavalry regiment
AAST air assault
COMMZ communications zone
CSH combat support hospital
EPW enemy prisoner of war
ESB separate brigade/enhanced separate brigade
FM field manual
HHC headquarters and headquarters company
LID light infantry division
MEDBDE medical brigade
MEDCOM (DS) medical command (deployment support)
MMB medical battalion (multifunctional)
SOSB special operations support battalion

UNITS TO SUPPORT THE MODULAR ARMY

C-3. The organizations listed in Table C-3 were initially designed to support the Modular Army.

Table C-3. Units designed to support the Modular Army

TOE Number	*Nomenclature*	*Basis of allocation*	*Assignment*	*Reference*
08420G000	Headquarters and Headquarters Company, Medical Brigade (Support)	1 per 2 to 6 subordinate battalions or like units such as CSHs.	Assigned to a MEDCOM (DS)	See Chapter 2, Section I, of this publication.
08443G000	Medical Company, Air Ambulance (HH-60)	1 per general support aviation battalion.	Employed in the division and corps	FM 4-02.2
08485G00	Headquarters and Headquarters Company, Medical Battalion (Multifunctional)	1 per 3 to 6 subordinate company-sized units plus the Blood Detachment	Assigned to a MEDBDE or MEDCOM (DS)	FM 4-02.1
08460G000	Medical Detachment (Combat and Operational Stress Control)	.05 per tactical division/corps; 2 per theater Army.	Employed in the theater of operations in support of tactical division/corps and theater Army	FM 4-02.51
08488A000	Medical Company (Logistics)	1 per 11.1 short tons of Class VIII issued per day.	Assigned to an MMB	FM 4-02.1
08497A000	Medical Company (Logistics Support)	2 per 5 division corps.	Assigned to an MMB	FM 4-02.1
08567GA00	Medical Detachment, Optometry	1 per 15,000 population supported in an AO.	Assigned to a MEDCOM (DS) or MMB	FM 4-02.21
08640G000	Headquarters and Headquarters Company, Medical Command (Deployment Support)	1 per theater.	Assigned to an ASCC	FM 4-02.12
08670G000	Medical Logistics Management Center	1 unit required in the force.	Assigned to a MEDCOM (DS)	FM 4-02.1

LEGEND
AO area of operations
ASCC Army service component commands
CSH combat support hospital
FM field manual
MEDCOM (DS) medical command (deployment support)
MMB medical battalion (multifunctional)

HUMAN DIMENSION TEAM

C-4. The human dimension team conducts field research on Soldier and unit cohesiveness, readiness, morale, and stressors affecting well-being and combat effectiveness. It also provides rapid feedback of results for use in the determination of operational and strategic policy. This team conducts surveys based on standard protocols. It receives focused guidance on human dimensions issues to be investigated through the MEDCOM (DS) commander, the Office of The Surgeon General, US Army Medical Research and Materiel Command, and the DA staff. The human dimension team, supported by US Army Medical Research and Materiel Command—

- Develops questionnaires and survey methodologies.
- Coordinates administration and collection of questionnaires within units.
- Conducts and supervises unit survey interviews of working sections at all levels.

- Analyzes data and transmits data to US Army Medical Research and Materiel Command, US Army Center for Health Promotion and Preventive Medicine, and other appropriate agencies for further analysis.
- Prepares reports and presentations of the findings.
- Gives briefings and disseminates results to user units.
- Publishes findings when appropriate.

C-5. The human dimension team has the capability to have two teams of an officer (research psychologist) and two enlisted personnel conducting mobile surveys in the field while one officer and NCO receive, analyze, and transmit data at the command headquarters. The human dimension team utilizes the COSC assets of the MEDCOM (DS) in collecting data and disseminating results.

Appendix D

Planning Considerations for Joint and Multinational Operations

The information in this appendix is written to provoke thought and is not intended or designed to encompass all situations which may arise during joint and multinational operations. The fundamental planning considerations for all AHS operations must include the requirements for each of 10 medical functions. The type of operation being conducted dictates which aspects of the 10 medical functions will play a primary role in any specific scenario. In joint and multinational operations, although the considerations are generally similar, differences in force structure, capabilities, treatment protocols, and medical equipment dictate that the medical planner and clinician understand variances between the Services and the multinational force. It is essential that chain of command issues be clearly articulated and that coordination between the various participants is ongoing.

SECTION I — PLANNING CONSIDERATIONS FOR JOINT OPERATIONS

MEDICAL PLANNING CHECKLIST FOR JOINT OPERATIONS

GENERAL PLANNING CONSIDERATIONS

D-1. General planning considerations affect the initial factors influencing how the operation will be planned for and implemented. It may include both medical and nonmedical considerations. Army forces that may be designated as a joint task force must be familiar with not only US Army planning procedures but those of the joint Services also. The following list of questions is provided to assist in the planning process.

- What C2 infrastructure will be established for the operation? *(Is a joint task force established? Will specific US Army medical assets be assigned/attached to another Service? Will an ASCC be established? Which Service component command surgeon has been designated as the joint task force surgeon? Does the joint force surgeon have a planning staff designated?)*
- What is the nature of the operation and its anticipated duration? *(What type of operation is being conducted? Will it be short-term in nature? Will it be a long-term commitment of forces [such as in limited interventions]?)*
- What is the anticipated level of violence to be encountered*? (Are the operations being conducted? Combat or stability operations? What is the potential for terrorist attacks/ incidents? Is it anticipated that CBRN weapons will be employed?)*
- What are the capabilities of all Service component medical assets in theater? *(The specific capabilities of all medical assets within theater must be determined to ensure that a duplication of services does not exist and that the use of scarce resources is maximized. Specific considerations are contained within the medical function discussions.)*
- Are communications systems and automation equipment interoperable*? (Do all C2 headquarters have interoperability of communications equipment? If not, how will this be corrected? Are liaison officers and/or teams required? Can automated reports be transmitted to all Services? If not, can reports be completed and transmitted manually? Do all joint task*

force subordinate medical units have the capability to document the electronic medical record with Defense Health Information Medical System?)

- What are the rules of engagement? *(How do the rules of engagement impact medical operations?)*

Note. There are no medical rules of engagement; this is a misnomer. The term, rules of engagement, refers to constraints on the use of force. Some commands use the term eligibility of care determination to delineate the determination of eligible beneficiaries for care in US military MTFs. For a discussion on eligibility determinations see Appendix A.

- What are the protection warfighting function activities/measures for medical activities? *(Are ground ambulances or other medical vehicles required to move in convoys rather than individually? Do medical evacuation [rotary-wing] aircraft require armed escort to perform their missions? Has the composite risk management process been used to determine these requirements?)*
- Is contracting for host nation support feasible for medical activities? *(Can host nation support be used for the support of housekeeping, food service, or other administrative requirements for deployed hospitals?)*

Note. Due to stringent federal requirements for the standards of pharmaceuticals and the provision of medical care, contracting may be restricted to nonmedical functions.

MEDICAL TREATMENT (AREA SUPPORT)

D-2. The medical treatment (area support) considerations are essential in the planning for support for units operating in the joint operational area that do not have organic medical assets. In the joint environment, consideration of all available Service medical assets must be included in the analysis. Army medical planners in the joint environment must ensure that they have a clear understanding of the capabilities and limitations of deployed medical assets. Although the various Service components may use similar naming conventions for their units, the actual capabilities may not be similar. This is often the case with unit mobility, survivability, sustainability, and communications capabilities.

- What units will provide Role 1 and Role 2 medical care? *(Do all Service components have organic assets to provide Roles 1 and 2 medical care? What units do not have organic medical assets and must receive Roles 1 and 2 medical care on an area support basis? Will units providing this support require augmentation to accomplish the mission?)*
- Will troop clinics/dispensaries be established in areas of troop concentrations*? (Which Service component will provide this service? What will the operating hours be? Where do Soldiers go for emergency medical care after troop clinic hours are over? Is this information disseminated to the lowest possible level?)*
- Do any operations security requirements exist which must be accommodated? *(Do special operations forces require Role 2 medical care on an area support basis? Are there existing operations security requirements that impact on providing Role 2 care to special operations forces personnel?)*

DENTAL SERVICE

D-3. Dental services may be provided in austere locations throughout the operational environment. Role 1 MTFs normally only have the ability to provide emergency dental care (emergency procedures to alleviate pain and control infection) as they have no organic dental assets; while other locations in the operational environment can provide the full range of operational care (emergency care and essential care). As the theater matures, comprehensive dental care may become available, but this type of care requires facilities such as those found in a CSH.

- What dental resources are deployed in theater? *(Which Services have dental assets deployed in the theater? Can these assets provide area dental support to the other Services that do not have organic dental capabilities? What categories of dental care will be provided in theater?)*
- Is it anticipated that dental personnel will be required to perform their alternate wartime role during the operation? *(Are mass casualty operations anticipated? Will dental personnel be used to augment medical resources in mass casualty operations? Do dental personnel from all the Services have the training in advanced trauma management to perform the alternate wartime role?)*

Note. Dental personnel have the additional wartime role of augmenting medical personnel during mass casualty situations. Under these circumstances, dental officers and staff may be called upon to augment and assist the MTF staff in treating the sick and injured. The areas where they may be able to provide assistance include: assisting with surgical procedures, forensic dental examinations, treatment of maxillofacial injuries, management of soft tissue wounds, and management of CBRN casualties, treatment of orthopedic injuries, initial burn treatment, and intravenous infusion techniques.

- Where will dental resources be located? *(At the hospitals? In field dental units? In clinics or other outpatient settings?)*

MEDICAL EVACUATION

D-4. The theater evacuation policy is a significant factor in determining what medical infrastructure will be deployed to the theater. The shorter the evacuation policy, the less treatment assets (especially hospitals) will be required in theater. Strategic medical evacuation from Role 3 hospitals is accomplished by the US Transportation Command while medical evacuation from Roles 1 and 2 is a Service component responsibility.

- Is the theater evacuation policy anticipated to change during the operation? *(Are exceptions to the theater evacuation policy permitted [such as for special operations forces]?)*
- What are the specific responsibilities for each Service component? *(Each Service component is responsible for the medical evacuation of their own forces from Roles 1 and 2 to Role 3. Will one Service component be responsible for this medical function for all joint forces within the joint operational area [such as the US Army being designated to provide air and ground medical evacuation support to the joint force?] Army support to the other Services normally encompasses shore-to-ship for US Marine Corps ground forces to hospital ships and/or casualty receiving and treatment ships?)*
- Will a theater patient movement requirements center or a joint patient movement requirements center be activated for the operation? *(Will the joint theater patient movement requirements center and/or joint patient movement requirements center be established to coordinate medical regulating operations? What units will coordinate with the theater patient movement requirements center for medical regulating information [this is normally accomplished by the theater patient movement center of the MEDCOM {DS}, intratheater patient movement center of the MEDBDE, or the medical regulating officer in the MMB; however, a Role 2 MTF may coordinate for this support if other C2 units are not deployed within the AO].)*
- Will a mobile aeromedical staging facility/aeromedical staging facility/aeromedical staging squadron be established for staging patients awaiting medical evacuation aircraft? (*Where will they be located? Is it anticipated that they will be required to relocate during the operation*? *How much time is required to relocate the units? Once patients have arrived at the mobile aeromedical staging facility/aeromedical staging facility/aeromedical staging squadron how long can they be held? If the incoming flight is canceled who will pick up the patients and sustain them until the next scheduled flight?)*
- What other USAF aeromedical evacuation resources will be available in theater? *(This should include a discussion of aeromedical evacuation liaison teams, aeromedical evacuation crews, and critical care air transport teams? Will the USAF have sufficient critical care air transport*

teams to provide en route medical care on the aircraft? Does the Army originating medical facility have to plan on providing medical attendants to provide en route medical care of critical care patients?)

- How will patient movement items be handled? *(How will property exchange between US Army units/organizations be conducted? United States Army and US Marine Corps? United States Army and the USAF [mobile aeromedical staging facility/aeromedical staging facility/aeromedical staging squadron]? United States Army and US Navy? United States Army and US Coast Guard? Refer to JP 4-02 and FM 4-02.1 for additional information on patient movement items.)*
- Are US Army medical air ambulance unit personnel deck-landing qualified for US Navy ships*? (Have pilots received the necessary training and certification to accomplish the shore-to-ship mission?)*

HOSPITALIZATION

D-5. Hospital resources provide essential care within the theater to return Soldiers to duty or to evacuate them from the theater. Hospitalization is one area within joint operations that is often designated for joint use. Joint use of facilities however does not equate to or require joint staffing. Additionally, hospitals often plan to include shared services with other Service component hospitals so that high-dollar specialty medical equipment does not have to be deployed by each Service component.

- What hospital resources will be in the theater? *(Identify hospital units from all Service components within the theater. What is the ratio between medical beds and surgical beds? What ancillary services are provided within the theater [such as physical therapy, occupational therapy, or other convalescence and rehabilitative services]? Are hospital units being phased into the theater as the operation progresses and the theater matures?)*
- What hospitals will be designated for the care of retained persons and EPWs/detainees? *(If significant numbers of retained persons and EPWs/detainees are anticipated, will a hospital or hospitals be designated only to receive these patients? If not, will all hospitals receive and treat retained persons and EPWs/detainees? Will the echelon commander provide security [guards] for EPWs/detainees treated and evacuated through medical channels?)*
- Has an eligibility determination been made for care in US facilities? *(The eligibility determination is made at the highest level possible in coordination with the SJA. The determination should address personnel such as DOD civilian employees and/or contractors, other governmental agencies, NGOs, host nation civilians, or any other personnel/groups/ organizations who may seek medical care in a US facility. Once the policy has been determined, it should be disseminated to the lowest level possible. Refer to Appendix A.)*
- Are there any hospital resources within the theater that can operate as shared resources with hospitals from the other Services? (*To ensure that a duplication of services does not occur, the medical planner must determine if there is any state-of-the-art medical equipment [high dollar cost] which all Services could use at one location rather than equipping each Service hospital separately?)*
- Is there a hospital which is equipped to treat psychiatric casualties? *(What hospitals have psychiatric care beds? If none are deployed, what hospitals will receive psychiatric care patients? How long can psychiatric care patients be held within the theater? Is the originating medical facility required to provide a medical attendant to provide en route medical care to these patients? Will sedation and/or restraints be required prior to or in flight? How many days of medication must accompany the patient?)*

VETERINARY SERVICE

D-6. Veterinary services are provided by the Army for all Service components (except food inspection on USAF installations), and when directed, may provide veterinary support to other government agencies employing MWDs or other government-owned animals. Additionally, veterinary support includes veterinary PVNTMED activities to reduce DNBI casualties from zoonotic diseases transmissible to man.

During CBRN operations, MWD require protection from the affects of chemical warfare and biological warfare agents similar to Soldiers.

- Although the US Army is the Executive Agent for veterinary support for all Services, will the USAF conduct its own subsistence inspection on USAF installations? *(The medical planner needs to determine if the USAF will conduct its own subsistence inspections on USAF installations. How does this impact the veterinary service support plan for the operation?)*
- What types of rations are to be used by the forces in the AO*? (The type of ration used [such as meals, ready to eat versus A rations versus unitized group rations] will determine the anticipated workload for the operation. Are medical supplemental rations available?)*
- Will MWD and/or other government-owned animals be used in the operation? *(What Services/units will be employing MWD and/or government-owned animals? Where will these units/animals be located? What functions will the animals perform? Are there other government-owned animals belonging to other governmental agencies [non-DOD] which must be sustained?)*
- Does a command policy exist on unit mascots or pets? *(What is the theater policy on maintaining unit mascots or pets? Have they been screened for zoonotic diseases transferable to man? Have they been immunized?)*
- How will animals requiring evacuation be managed*? (What vehicles will be used to perform the evacuation [such as dedicated medical vehicles or general transportation assets]? Will the handler accompany the animal? If the handler cannot accompany the animal, will the animal require sedation for the evacuation?)*
- What CBRN defense actions are planned for protecting MWDs? *(Is collective protection available for MWDs? What are the chemoprophylaxis and treatment regimens available to lower the risk to MWDs and to mitigate the effects of exposure to biological warfare and chemical warfare agents and/or toxic industrial materials? Refer to FM 4-02.7 and FM 4-02.18 for additional information.)*

PREVENTIVE MEDICINE

D-7. Preventive medicine encompasses all activities aimed at reducing health threats and preventing DNBI. Field hygiene and sanitation is a command responsibility and must be a crucial pillar of the commander's information plan. All Service components will deploy PVNTMED capabilities. It is essential for the medical planner to understand what capabilities are available within the theater and what capabilities are available within the MHS that can provide reachback support.

- Do all Services have PVNTMED assets deployed in the theater? *(If no, which Service will provide PVNTMED support on an area support basis? Is augmentation required to accomplish the mission?)*
- What is the health threat in the AO? *(What are the endemic and epidemic diseases in the AO? Are disease outbreaks seasonally related? Have any of the Services previously conducted extended operations in the AO? How is medical intelligence obtained for the joint force? What are the OEH hazards faced by the joint force [to include toxic industrial materials]? Are there hazardous flora and fauna in the AO? Refer to Table 1-1 for additional information on the health threat.)*
- Have site surveys been conducted for areas to be inhabited by US forces? *(Are the individual Services responsible for providing this medical function in their individual areas? Will this medical function be performed for the joint force by one specific Service? Were any areas determined to be hazardous [such as sewage runoff, fly or other arthropod infestation, or soil contaminated by toxic industrial materials]? Can adverse environmental conditions be corrected? Is selection of another site required? Was the site previously used by other forces? Are sanitation facilities adequate? Are the methods of human waste disposal in compliance with applicable environmental laws/policies of the US and host nation [such as chemical toilets and individual waste collection bags]?)*

- Have Soldiers been properly trained and certified by support PVNTMED resources for insecticide spraying? (*Refer to DA Pamphlet 40-11 for additional information on training and certification.*)
- Is it anticipated that refugee, retained persons, and/or EPW/detainee operations will be required? (*Are sufficient PVNTMED assets deployed in theater to support these types of operations without adversely impacting the delivery of health care to US forces? Is augmentation required? Are sufficient sanitation facilities available to support the refugee, retained persons, and EPW/detainee populations? Is sanitation maintained on public food service facilities? Are water supplies adequate and potable?*)
- Do units have field hygiene and sanitation supplies and equipment on hand? *(Do all the Services have adequate field hygiene and sanitation supplies and equipment on hand? Are teams [such as the unit field sanitation team] trained to apply PVNTMED measures to counter the health threat?)*
- Do Soldiers have personal protective supplies and equipment available and/or issued? *(Are sunscreen, sunglasses, insect repellent, bed nets, or other personal protective supplies/equipment on hand or available for issue?)*
- If continuous operations are anticipated, have work/rest schedules (sleep plans) been developed and implemented when appropriate? *(Continuous operations without adequate amounts of sleep can lead to serious performance degradation [such as faulty decisionmaking or lowering resistance to diseases]. Refer to FM 6-22.5 for additional information on sleep requirements.)*
- Is a command policy established and disseminated on water discipline? *(In operations conducted in hotter climates, extreme cold weather, or in mission oriented protective posture equipment, command emphasis must be given to a water discipline program to ensure heat injuries are minimized.*

Note. Dehydration can occur in extreme cold weather operations as well as in operations conducted in hotter climates.

COMBAT AND OPERATIONAL STRESS CONTROL/BEHAVIORAL HEALTH ACTIVITIES

D-8. One of the significant health threats to deployed forces is stress. Home front issues combined with the operational environment can render Soldiers combat ineffective. Commanders and small unit leaders must recognize the signs of stress with the Soldiers and units and take immediate corrective action to mitigate the effects of combat and operational stress reactions.

- Do all the Services have BH personnel deployed to the theater? *(Do all of the Services have organic COSC/BH resources? Are there any Services which will require COSC/BH support on an area support basis?)*
- During the operation is it likely that a mass casualty situation will develop? *(What is the type of operation? What is the level of violence likely to be encountered? What is the likelihood of a mass casualty situation arising? Are assets available to provide COSC interventions during mass casualty operations?)*
- What is the likelihood of a terrorist attack? *(What is the terrorist threat? Would the likely target be a military installation and/or unit? Would the likely target be in a civilian area [such as in a subway, transportation hub, or public building]? Are COSC assets available to provide interventions for victims, caregivers, or rescue personnel?)*

MEDICAL LOGISTICS (TO INCLUDE BLOOD MANAGEMENT)

D-9. Medical logistics is essential for sustaining patient care and treatment in a deployed setting. Blood and blood products are living tissue and require special handling and distribution. The Army may be designated by the GCC as the SIMLM to provide MEDLOG support to all Service components deployed in the operation.

- Has the GCC designated a single integrated logistics manager for the operation? *(Which Service has been designated to execute the integrated MEDLOG mission? What type of equipment will be used to requisition medical supplies? What procedures and/or formats are required to requisition supplies and medical equipment?)*
- How will medical equipment maintenance and repair be accomplished? *(What units/ organizations will provide this support? Can this support be contracted?)*
- What units/organizations will provide optical fabrication support? *(Where will units providing this support be located? Within the theater? In the support base?)*
- Are there any Service-specific MEDLOG requirements? *(Do the individual Services have any special requirements for medical materiel or requirements which the Service providing the SIMLM function would normally not have/stock?)*
- How are blood management functions/activities conducted? *(The medical planner must identify the medical units which will have blood requirements, the organizations that will support these requirements, and the responsibilities of the units requesting this support. Will whole blood collection take place in the AO? What testing procedures can be conducted within the theater?)*
- How will medical waste be collected and disposed of? *(Does a command policy exist on the collection, handling, and disposition of medical waste?)*

MEDICAL LABORATORY SUPPORT

D-10. There are two types of medical laboratory support (clinical diagnostic and FHP). Medical treatment facilities (Roles 2 and 3) have a clinical diagnostic laboratory capability organic to the organization. The FHP mission is accomplished by the area medical laboratory which is capable of providing field confirmatory analysis of suspect chemical warfare and biological warfare agents.

- What medical laboratory assets will be deployed to the theater? *(Will all Services have organic medical laboratory assets to assist in the diagnosis of diseases? Will any of the Services require medical laboratory support from the other Services?)*
- What medical laboratory will provide the identification of suspect biological warfare and chemical warfare agents? *(Will an intratheater laboratory have this capability? How will specimens/samples of suspect biological warfare and chemical warfare agents be obtained? Are there any special handling requirements for suspect biological warfare and chemical warfare agent specimens/samples? How will the chain of custody be maintained for suspect biological warfare and chemical warfare agents while in transit? How will the results of the testing be disseminated?)*
- Will a near-patient testing capability be present in any of the in-theater medical units? *(Will medical units without organic laboratory support be able to do any near-patient testing [such as dipsticks]? What units will have this capability?)*
- Will any intratheater medical laboratory assets have a split-base operating capability? *(Can any of the intratheater laboratories conduct split-base operations? Can laboratory teams be deployed to collect specimens/samples of suspect biological warfare and chemical warfare agents? Can teams be deployed to investigate and/or collect samples/specimens from disease outbreaks?)*
- What procedures will be used to submit samples/specimens for analysis by CONUS-support base laboratories? *(This would include organizations such as US Army Center for Health Promotion and Preventive Medicine or the US Army Medical Research Institute of Infectious Diseases?)*
- How will samples/specimens of suspect biological warfare and chemical warfare agents be transported? *(Is there a technical escort unit deployed to the theater? If not, who will provide this service? Are procedures in place to ensure the chain of custody is not broken during transport? What procedures must be followed to ensure samples/specimens are packaged and shipped correctly? Will refrigeration or the use of dry ice be required during transport?)*

OPERATIONS IN A CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR ENVIRONMENT

D-11. Patient decontamination is the responsibility of all roles of care. Although decontamination should have been accomplished prior to arriving at the MTF, patient decontamination must be accomplished prior to admitting a patient into a treatment area of a facility using chemically biologically protected shelter, as the health care providers work without protective equipment inside of the chemically biologically protected shelter.

- Is the use of CBRN weaponry anticipated? *(Is there an imminent threat for the use of CBRN weaponry by the enemy/opposition? What is the potential threat for a terrorist incident involving the use of CBRN weapons/devices to occur during the operation? Is there a toxic industrial materials threat that can be exploited by the enemy or terrorists in the AO?)*
- What is the potential for accidental contamination*? (Is there the potential of contamination from an accidental release of radiation and/or chemicals by a commercial source [such as a nuclear power plant or chemical manufacturing facility]?)*
- What medical units have the capability to perform patient decontamination operations? *(Do all Services have an organic patient decontamination capability? If no, what units will provide this support on an area support basis? Is nonmedical augmentation required to conduct these operations [such as nonmedical personnel performing this function under the supervision* of *medical personnel]?*
- What are the reporting and notification requirements in the event of a suspect CBRN incident? *(Are report formats and required submission time factors standardized across the Services for reporting suspect CBRN incidents?)*
- Is collective protection available for MTFs? *(Do all Services have organic collective protection shelters for MTFs? If no, will certain MTFs with collective protection be designated as the units to provide patient decontamination support?)*
- Are veterinary personnel available to inspect CBRN contaminated subsistence? *(If not, who makes the decision that contaminated subsistence items can be decontaminated and determined to be safe for consumption? Are these procedures standardized in unit standing operating procedures? Refer to FM 4-02.7 for additional information.)*
- Are PVNTMED personnel available to inspect CBRN contaminated water supplies? *(If no, who determines that contaminated potable water can be treated and consumed?)*
- Are immunizations, chemoprophylaxis, antidotes, pretreatments, and barrier creams available? *(Are Soldiers immunized against the most likely biological warfare agents that might be employed? Is there any chemoprophylaxis available for the most likely biological warfare agents that might be employed? Are there any pretreatments for potential exposure to nerve agents and/or other chemical warfare agents which might be employed? Are barrier creams available?)*

SECTION II — PLANNING CONSIDERATIONS FOR MULTINATIONAL OPERATIONS

MULTINATIONAL OPERATIONS

D-12. Multinational operations present new challenges to the medical planner. In addition to ensuring the rapid, effective, and efficient delivery of health care on the battlefield for US forces, the planner must coordinate support with the health authorities of all participating nations. Thorough coordination is required to ensure that a duplication of services does not occur and that maximum use and benefit is achieved from scarce medical resources. Each nation is responsible for providing health care for its forces in multinational operations.

MULTINATIONAL OPERATIONS MEDICAL PLANNING CHECKLIST

GENERAL PLANNING CONSIDERATIONS

D-13. In multinational operations, C2 is a significant consideration among participating nations. The goal is to achieve a unity of effort and not to duplicate medical functions/services within the AO.

- What is the mission of the force and how does it affect medical operations? *(Does the mission involve combat operations? Peace operations? Foreign humanitarian assistance? How does the type of mission affect the composition of the medical force [far forward surgical capability for combat wounded or pediatric, geriatric, obstetric, and general medicine requirements for foreign humanitarian assistance]? Is this operation being conducted under the auspices of an organization such as the United Nations and how does that affect the medical infrastructure?)*
- What is the composition of the force? *(What is the composition and size of the US contingent? How many other nations are participating? What is the size of each national contingent?)*
- What are the medical capabilities of the force? *(What is the medical troop ceiling for the US forces? What medical personnel, units, and equipment do the other national contingents have? Can US forces be treated by another nation's medical personnel or in another nation's treatment facilities? Can members of other national contingents be treated in US facilities? What are the education, training, and experience role of health care professionals from participating nations?)*
- Who has been designated to provide medical support to the multinational force*? (Is each national contingent providing all aspects of medical care for their forces? Has one nation been designated to provide medical support to all nations? Does each national contingent have separate responsibilities [such as one nation providing medical evacuation support and/or another nation providing dental support]?)*
- Has a command surgeon been identified to oversee and coordinate medical activities within the multinational force? *(If yes, what nation? What are the roles and responsibilities of this position? Is there a multinational medical staff section to plan for medical operations? If no, how will medical issues be resolved among the nations? Are there medical liaison officers assigned to the participating nations' surgeons offices? What authority/technical supervision does this staff officer have over US medical operations?)*
- Are there any ISAs among the participating nations? *(Are all of the participating countries a part of NATO or the ABCA armies? If no, will nations not a party to the ISAs abide by the medical protocols, procedures, and techniques identified in the ISAs?)*

Note. Many of the ISAs deal with medical materiel standards such as the size of the NATO standard litter. It is unlikely that multinational forces would adopt/purchase a different type of litter just for the operation. However, other ISAs pertain to medical treatment protocols, report formats, notification requirements, and procedural tasks. These ISAs may be easily adapted to the current operation.

- What is the anticipated level of compliance with the provisions of the Geneva Conventions (friendly and enemy)? *(Are all participating nations signatories to these conventions? Are command policies and procedures in consonance with these conventions? How will conflicts be resolved? What is the likely disposition of the enemy to honor the protections afforded under the Geneva Conventions?)*
- Will all nations have interoperable communications and automation systems? *(If no, will one country equip the multinational force C2 elements with compatible systems? What reports are required using automated systems? Can these reports be completed by hand and submitted using a courier or messenger? How will requests for medical evacuation be received? Is using wire communications more feasible than radio transmissions? Are interpreters available at each C2 headquarters?)*

- Has a determination of eligible beneficiaries (in conjunction with the SJA) been made for care in US facilities? *(Has a policy statement been formulated and disseminated? Refer to Appendix A for additional information.)*
- If (when) members of the participating nations are treated in US facilities, what is the mechanism for returning them to their parent nation for continuing medical care? *(Do the other nations have treatment facilities established in the AO to which these patients could be transferred after receiving emergency, stabilizing care? If there are only US facilities within the AO, who will evacuate these patients to their homelands? What coordination is required to return a patient to his nation's facilities and/or evacuate him from the AO?)*
- What is the anticipated level of violence to be encountered? *(Should the primary focus of medical support be on combat trauma or DNBI [in stability operations unit/personnel ineffectiveness usually results from DNBI rather than combat-related injuries]? Is it anticipated that a change in the level of violence will be experienced during the operation? Are there sufficient medical supplies and equipment available to transition from one environment to another? Will augmentation of medical resources be required if the operation changes?)*
- What are the rules of engagement? (*How do they impact on the medical mission? What weapons will the multinational force have for self-defense and defense of patients in medical units?)*

Note. Rules of engagement are constraints on the use of force; they are not the procedures by which medical operations are executed.

- What are the mechanisms for reimbursement of services? *(How is the country providing support reimbursed for the services provided? Will repayment come directly from national contingents or through an international organization such as the United Nations? What restrictions apply to the use of funds from US forces? What services/support provided by US forces can be reimbursed [such as medical supplies and equipment used, hospitalization costs, or medical evacuation support]?)*

MEDICAL TREATMENT (AREA SUPPORT)

D-14. Medical treatment encompasses the routine health care and tactical combat casualty care provided by organic medical assets. Those units without organic medical resources are provided support on an area basis. The planner must ensure that the supported multinational force population is included in the determination of medical workload if the US is providing this support.

- Are interpreters available to translate patient complaints to the attending medical personnel*? (Has a multinational phrase book been developed for the operation? The NATO languages are included in AMedP-5. If they are not included in the AMedP-5, a local supplement should be developed. Will medical personnel have available language cards or graphic representations of medical conditions to use? Will an automated translation service be available?)*

Note. If graphic representations are used to facilitate communications, ensure that they are not offensive to the target audience and that they do not violate accepted local cultural and religious beliefs.

- What units are providing Roles 1 and 2 medical care? *(Are Roles 1 and 2 medical care being provided to non-US units/personnel on an area support basis? What units are providing this support? What are the capabilities of the units providing this support? Do Role 2 units have a holding capability? For how long? Do Role 2 units have x-ray, laboratory, BH [COSC], and PVNTMED capability?)*

DENTAL SERVICE

D-15. United States forces must be dental Class 1 or 2 prior to deployment to ensure the Soldiers will not require extensive emergency dental interventions once in theater. Multinational forces may not have the same degree of dental readiness as US forces. If the US is providing dental care for the multinational force, this fact must be considered to ensure there are sufficient dental resources (personnel, materiel, and equipment) to be able to manage the anticipated patient workload.

- What units will provide dental services for the *multinational force? (Does each national contingent have field dental assets deployed in the theater? Will one nation provide dental support to the multinational force?)*
- What is the scope of dental services to be provided within theater? (*Operational care [emergency and essential] and comprehensive care*? *What is dental health status of deployed multinational forces?*)
- Do all members of the multinational force have panorexes on file for identification purposes? *(United States forces have panorexes on file for forensic identification, if required. Will all national contingents have these x-rays taken?)*
- Will a preventive dentistry program be implemented for US forces and/or multinational forces in theater? *(What activities will comprise the preventive dentistry program in theater? Dental screenings? Mandatory training/education program? Will these activities be extended to the other national contingents in the multinational force?)*
- What dental conditions will necessitate the evacuation of patients from the theater? *(What oral conditions cannot be treated satisfactorily in theater? What coordination is required to arrange for the evacuation of dental patients? Will members of the multinational force be evacuated for dental treatment? Where will they be evacuated to? Their national contingent facilities or out of the theater?)*

MEDICAL EVACUATION

D-16. Medical evacuation and medical regulating of multinational force may present some challenges. If the US is providing medical evacuation support to multinational forces, they must have interoperable communications in order to request the medical evacuation support. For those multinational forces who cannot be returned to duty within the theater evacuation policy and must be evacuated from the theater, who arranges for this evacuation. When evacuating Soldiers out of the theater, international borders must be crossed and approval must be obtained prior to the evacuation. Depending upon any given scenario, the political situation may not permit one nation's Soldiers to cross the international borders and alternate evacuation plans are required.

- What is the theater evacuation policy*? (Is it the same for all national contingents? Are exceptions to the evacuation policy permitted [such as for special operations forces personnel]?)*
- What units are conducting medical evacuation operations? *(Can US forces be evacuated by another nation's assets? Can US forces be evacuated to another nation's MTFs? Are US forces providing medical evacuation support on an area support basis to the other national contingents?)*
- What types of evacuation assets are available? *(Air or ground? Dedicated or nonstandard evacuation platforms? Vehicle or aircraft of opportunity? Do all participating nations have organic evacuation assets?)*
- How are requests for evacuation transmitted? *(Is there a prescribed standard evacuation request format established? Are dedicated medical evacuation radio frequencies established or are land lines used? Do all units have access to communications equipment to initiate a request? If no, how will specific units submit requests?)*
- How will units requesting medical evacuation be located and identified? *(Have procedures for identifying units from the air been standardized [such as using colored smoke]? Have ground evacuation units been provided strip maps, overlays, or other navigational aids/information?)*

- Do medical evacuation vehicles/aircraft require armed escort while performing their mission? *(If yes, what units will provide this support? What is the response time? Can ground medical vehicles only move as part of convoys or are they permitted to move independently?)*
- How will patient movement items be managed? *(Will direct exchange for patient movement items be made? If equipment remains with the patient and direct exchange does not occur, how will the originating medical facility's equipment be replaced? Are patient movement items interoperable with other national contingents? Can other national contingents' medical equipment be used on-board US aircraft [airworthiness certification] and ground evacuation vehicles?)*
- Will mobile aeromedical staging facility/aeromedical staging facility/aeromedical staging squadron [or similar organizations] be established at airheads to sustain patients awaiting evacuation from the theater? *(If yes, what nation will provide these organizations or medical functions for the multinational force*? *If no, how are patients awaiting evacuation from the theater sustained?)*
- What nation will provide the medical regulating function? *(Will each nation perform the medical regulating function for their facilities? Will the US perform this function for the multinational force? Will the TPMRC [or similar organization] be activated? Will each country provide its own strategic medical evacuation function? Will the USAF provide the strategic capability for the multinational force?)*

HOSPITALIZATION

D-17. The capabilities and availability of services at the various national contingent hospitals must be determined. These capabilities and services may vary significantly from one member nation to another. Additionally, US facilities must validate credentialing and scope of practice for non-US health care providers working within US facilities.

- What hospitals are established in the AO? *(Are these US facilities? What are the capabilities of these hospitals? What is the anticipated length of stay [theater evacuation policy and hospital capability will affect the time factors for length of stay]?)*
- What ancillary services are offered by the hospitals? *(This will be affected by the anticipated duration of the operation and the theater evacuation policy. If convalescence for some injuries/illnesses is anticipated to occur within the theater, ancillary support such as physical therapy or occupational therapy may be available within the hospital. If the theater evacuation policy is short [essential care in the AO], the majority of patients would be stabilized and evacuated from the theater for definitive care in the support base.)*
- What is the surgical capability of in-theater hospitals? *(Does a far forward surgical capability exist [such as an FST]? Is there a surgical backlog? How mobile are the forward surgical capabilities of the various contingents within the multinational force? Will transportation services be required to move these assets or do they have organic transportation assets?)*
- What procedures/notifications are required when a non-US Soldier is admitted to a US facility? *(Who notifies the Soldier's national contingent? How and when is the patient transferred to his national contingent?)*
- Will non-US physicians be permitted to treat patients in a US facility? *(What will the scope of practice be? What credentialing processes must occur? Who provides technical/professional oversight?)*
- Has a formulary been established for prescription drugs? *(Does it include medications for diseases endemic to the multinational force, as well as to the AO? Does it include medications for foreign humanitarian assistance operations, if appropriate?)*
- What outpatient services will be provided? *(Will there be outpatient clinics conducted on a recurring basis? Do the hospital/clinics have an area support mission?)*
- How will patients be transferred from one hospital to another within the theater? *(Who will provide the transportation assets? What coordination is required to affect the transfer?)*
- Are the deployed hospitals capable of providing hospitalization support to the civilian populace? *(Do the hospitals have the medical equipment, medical supplies, and health care*

providers to support pediatric, geriatric, and obstetrics/gynecological patients? Is augmentation required to supplement medical specialty providers?)

- Is there a specific hospital designated for care of EPWs/detainees? *(Will multinational staffing be required for this facility?)*

VETERINARY SERVICE

D-18. The medical planner must determine if the multinational force has MWDs and/or other animals and whether the US veterinary assets will be directed to treat and sustain these animals. Additionally, the planner must determine if veterinary support will be required to inspect other nations' rations for quality assurance and safety as this will impact the anticipated medical workload.

- What types of rations are used in theater? *(This is dependent upon the anticipated duration of the operation and the availability of approved food sources within the theater.)*
- Will Class I operations be consolidated for the multinational force? *(Will each national contingent cultivate its own food sources or will all contingents receive their subsistence from the same sources?)*
- Will US forces provide veterinary inspection of subsistence for food safety and quality assurance for multinational forces? *(Will veterinarians only inspect food sources used for subsistence for US forces or for the entire multinational force?)*
- Will government-owned animals be used in the operation? *(Will MWDs or pack animals be used in the operation? Will US forces provide animal medical care to US forces animals or for the multinational force?)*
- Has a command policy been disseminated on unit mascots/pets? *(If unit mascots are permitted, who will provide care for these animals? Have they been vaccinated for zoonotic diseases transmissible to humans?)*
- How will animals be evacuated? *(If animals require evacuation will they be evacuated on dedicated medical vehicles/aircraft? On general transportation assets? Will the handlers accompany the animals? If the handlers do not accompany the animals, are special precautions [such as muzzles or sedation] required? If animals are not US-owned, where will they be evacuated to? Will each nation evacuate its own animals? How are animals evacuated and treated by US forces returned to their national contingent?)*
- Will the operation involve capacity building activities? *(Will veterinary support requirements include animal husbandry activities for the host nation populace? Are agencies [such as the US Agency for International Development] conducting veterinary activities within the AO? Do the other national contingents participating in the operation have resources which could be used in these activities?)*
- What veterinary PVNTMED activities will be implemented in-theater? *(Will zoonotic disease surveillance be conducted? Will epidemiological investigations be conducted when outbreaks of transmissible diseases occur? Who will conduct these activities? What coordination* is *required with the host nation or other national contingents?)*

PREVENTIVE MEDICINE AND THE HEALTH THREAT

D-19. Medical and OEH surveillance are two of the primary missions of PVNTMED during multinational operations. The health threat to the force must be identified early in the mission planning process. In addition to endemic diseases in the civilian population, Soldiers may also be exposed to subclinical exposures to endemic diseases in the multinational force. Further, as each nation will have different standards and policies in the conduct of field hygiene and sanitation, PVNTMED personnel must assist in site surveys and dining facilities inspections.

- What are the diseases (endemic and epidemic) in the AO and/or in the separate national contingents? *(How is medical intelligence on the proposed AO obtained [medical aspects of the intelligence preparation of the battlefield, National Center for Medical Intelligence, US Army Center for Health Promotion and Preventive Medicine, or other sources]? Have any of the participating nations conducted lengthy operations in the proposed AO and documented the*

health threat? *Are the disease outbreaks seasonally related [such as during monsoons]? Have disease surveillance missions been previously conducted in the proposed AO?)*

- Are immunizations or chemoprophylaxis available to counter the disease threat? *(Have US forces been immunized and/or provided chemoprophylaxis? Have other national contingents been immunized and/or provided chemoprophylaxis?)*
- Have site surveys been conducted in areas US forces will inhabit? *(Have bivouac areas been inspected prior to establishing the site? Will US forces be housed with members of other national contingents? Were any areas determined to be hazardous [such as sewage runoff, fly or other arthropod infestation, or soil contaminated by toxic industrial materials]? Can adverse environmental conditions be corrected? Is selection of another site required? Was the site previously used by other forces? Are sanitation facilities adequate? Are the methods of human waste disposal being used in compliance with environmental laws/policies of the host nation [such as using chemical toilets or individual waste collection bags]?)*
- What PVNTMED support will US forces provide other national contingents? *(Are pest management programs implemented in all unit areas or only in US forces AOs? Will US PVNTMED personnel inspect water supplies for all nations or just US forces? Will US PVNTMED personnel conduct dining facility inspections for all nations or just US forces? Will medical and OEH surveillance operations be conducted for all nations or for US forces only?)*
- What is the role of training in field hygiene and sanitation for US forces and other national contingents? *(Is an active PVNTMED education program required for US forces? For other national contingents? If so, who will provide the training? Are field hygiene and sanitation standards being enforced?)*
- Is it anticipated that refugee, retained or detained persons, and/or EPW operations will be required? *(Which nation will be responsible for field hygiene and sanitation if refugee and/or EPW/detainee camps/facilities must be established? Are sufficient PVNTMED assets available within country to provide this support? Is augmentation required? What would be the impact on the provision of PVNTMED to US forces if augmentation was not available?)*
- Do units have required field hygiene and sanitation supplies and equipment on hand? *(Do US forces? Do other national contingents? If the national contingents do not have adequate supplies and equipment available, will supplies/equipment be provided by the US forces? Is training required for use of this equipment?)*
- Do Soldiers have personal protective supplies and equipment available and/or issued? *(Are sunscreen, sunglasses, insect repellent, bed nets, or other personal protective supplies/equipment on hand or available for issue? Do the national contingents have these items? If they do not, will they be provided by US forces?)*

COMBAT AND OPERATIONAL STRESS CONTROL/BEHAVIORAL HEALTH ACTIVITIES

D-20. In a multinational setting, BH counseling may present unique challenges due to differences in language and culture. In disaster relief operations, the plan for these services must also include rescuers and caregivers.

- Is each national contingent responsible for its BH programs and treatment? *(Who will provide BH services to each national contingent? If one nation is providing these services to the multinational force, what accommodations will differences in language and culture require?)*
- How will NP and/or COSC patients be evacuated? *(On dedicated medical vehicles? On general transportation assets? Will NP patients require an escort, sedation, or restraints for evacuation by aircraft?)*
- What preventive programs will be implemented in theater? *(Are preventive programs implemented for US forces? For the multinational forces?)*
- Will a traumatic event management program be established? *(Is each national contingent responsible for its COSC activities? Will all Soldiers [regardless of nationality] affected by the traumatic/catastrophic event be debriefed at the same time? Who provides follow-up care, if required?)*

MEDICAL LOGISTICS (TO INCLUDE BLOOD MANAGEMENT)

D-21. A continuous flow of Class VIII supplies and blood is essential in providing medical treatment to a deployed force. Blood and blood products require special handling as they are living tissue. The health care provider must ensure that blood and blood products used are from an acceptable source and have had the requisite testing. When operating in a multinational force environment, safeguards must be in place to ensure the quality and efficacy of pharmaceuticals meet US standards. Medical logistics also includes medical equipment and medical equipment maintenance and repair. If medical equipment is not interoperable across the force, medical equipment maintenance and repair may become an issue.

- What is the Class VIII stockage level? *(Has theater policy been established and disseminated concerning the days of supply required for Class VIII in US medical units?)*
- What is the impact of multinational operations on blood management? *(Are there any cultural, religious, or social prohibitions on the use of blood and blood products for any of the national contingents? May US forces receive blood from other nations? If yes, how will the blood be tested before use? Can blood testing and collection be accomplished in the theater? Can blood requirements be fulfilled by collecting blood from members of the participating nations? What is the capability to store and maintain blood and blood products in the theater? Will the US provide blood support to the other national contingents? What reporting system will be established to track patients who have been transfused? What reports are required on a daily or weekly basis [such as the blood reports discussed in JP 4-02, FM 4-02.1, FM 8-55, or TM 8-227-12]?)*
- Is the US tasked to provide MEDLOG support to the *multinational force? (Has the US Army been designated as the SIMLM for US forces? For the multinational force?)*
- Are there donated medical supplies and equipment for use in accomplishing the mission? *(Are donated medical supplies and equipment available for use in foreign humanitarian assistance or disaster relief operations? Who is responsible for receiving, repackaging, storing, and distributing these items? What type of security is required to safeguard these supplies and equipment? Who will provide required security?)*
- How will resupply be affected? *(Are units using line item requisitioning or are combat configured loads being used? Will supply point distribution be used? Will medical vehicles/aircraft provide backhaul for medical supplies, equipment, and blood?)*
- What reports are required to be submitted to the supporting MEDLOG facility? *(Are these reports automated? Are automated systems interoperable? What are the report formats and suspense times/dates?)*
- Can medical supplies and equipment from non-US sources be used for US forces? *(Do foreign pharmaceuticals meet Food and Drug Administration guidelines? Can foreign made medical equipment be maintained and repaired by US forces? Has foreign medical equipment received air worthiness certification for use in US Army helicopters or USAF fixed-wing aircraft?)*
- If operations are conducted under the auspices of an international organization (such as the United Nations) how do their supply/resupply procedures and requirements impact on US Class VIII operations? *(Will US forces be constrained to only using designated sources? Do these sources meet appropriate guidelines?)*
- How will medical waste be collected and disposed of? *(Command policy must be established to ensure the proper collection and disposal of medical waste generated by MTFs or other medical operations.)*

MEDICAL LABORATORY SERVICES

D-22. Laboratory assets of the multinational force may be limited or may require that one national contingent provide support to the entire force.

- What laboratory capability exists within the national contingents? *(Do the field medical units have a laboratory capability? What is the scope of diagnostic laboratory services available in the hospitals? Are there any independent military laboratory units within the multinational force?)*

- How are suspect biological warfare and chemical warfare specimens and samples collected, handled, stored, and transferred? *(Who collects suspect biological warfare/chemical warfare agent specimens and samples? How is the chain of custody maintained on suspect biological warfare/chemical warfare agent specimens and samples? What special handling requirements exist for storing and transporting suspect biological warfare/chemical warfare agent specimens and samples? Is there a medical laboratory within the theater which can analyze suspect biological warfare/chemical warfare agent specimens and samples? What coordination is required to transfer suspect biological warfare/chemical warfare agent specimens and samples out of the theater to an appropriate testing facility?)*

OPERATIONS IN A CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR ENVIRONMENT

D-23. In multinational force operations the medical planner must know what protections are available for the entire force and what medical CBRN defense materials are available (chemoprophylaxis, immunization, pretreatments, antidotes, and barrier creams). The medical planner must also know what medical units have and can establish medical treatment areas in collective protection.

- What is the potential threat for use of CBRN weaponry during the operation? *(Is there an imminent threat for the use of CBRN weaponry by the enemy/opposition? What is the potential threat that a terrorist incident involving the use of CBRN weapons/devices may occur during the operation?)*
- What is the level of protection for each national contingent? *(Do all national contingents have mission-oriented protective posture equipment? If yes, what level of protection is afforded? If no, will one nation supply the needed equipment to the participating nations without the equipment?)*
- Is collective protection available to the MTFs? *(Are collective protection shelter systems available to all participating nations? If no, will one nation supply the needed shelters to the participating nations without shelters?)*
- Have patient decontamination teams been identified from supported units? *(Have designated personnel been notified? Do all nations have the organic ability to conduct patient decontamination? Is augmentation required [nonmedical Soldiers performing the function under the supervision of medical personnel]?)*
- What are the reporting and notification requirements in the event of a suspect CBRN incident? *(Are there standard formats for reporting any suspected incidents? How will the entire force be alerted to the possibility of a CBRN attack? Will the US CBRN warning system be used or will another system be established for the operation?)*
- Are veterinary personnel available to inspect CBRN contaminated subsistence*? (If not, who makes the decision that contaminated subsistence items can be decontaminated and determined to be safe for consumption? Are these procedures standardized in the multinational force [such as in unit standing operating procedures]?)*
- Are PVNTMED personnel available to inspect CBRN contaminated water supplies? *(If no, who determines that contaminated potable water can be treated and consumed?)*
- Are treatment protocols established for the treatment of CBRN casualties? *(Are all the participating nations in agreement on the treatment protocols to be used? Do all participating nations have the necessary medications and medical equipment to treat these casualties?)*
- Are immunizations, chemoprophylaxis, antidotes, pretreatments, and barrier creams available? *(Are Soldiers immunized against the most likely biological warfare agents that might be employed? Is there any chemoprophylaxis available for the most likely biological warfare agents that might be employed? Are there any pretreatments for potential exposure to nerve agents and/or other chemical warfare agents which might be employed? Are barrier creams available?)*

Glossary

SECTION I — ACRONYMS AND ABBREVIATIONS

ABCA	American, British, Canadian, Australian, and New Zealand
AHS	Army Health System
AIS	automated information system
AMEDD	Army Medical Department
AO	area of operations
AOC	area of concentration
AR	Army regulation
ASCC	Army service component command
BCT	brigade combat team
BH	behavioral health
C2	command and control
CA	civil affairs
CBRN	chemical, biological, radiological, and nuclear
CE	communications-electronics
CMO	civil-military operations
COMSEC	communications security
CONUS	continental United States
COSC	combat and operational stress control
CPT	captain
CSE	campaign support element
CSH	combat support hospital
CSM	command sergeant major
CWO	chief warrant officer
DA	Department of the Army
DCSPER	deputy chief of staff, personnel
DCSSPO	deputy chief of staff, security/plans/operations
DNBI	disease and nonbattle injury
DOD	Department of Defense
DODD	Department of Defense directive
DODI	Department of Defense instructions
EAB	echelons above brigade
EEE	early entry element
EPW	enemy prisoner of war
FHP	force health protection
1SG	first sergeant
FM	field manual
FMI	field manual interim
FST	forward surgical team
G-2	assistant chief of staff, intelligence
G-3	assistant chief of staff, operations
G-9	assistant chief of staff, civil affairs
GCC	geographic combatant commander
HHC	headquarters and headquarters company
HR	human resources
HSS	health service support
IP	internet protocol
ISA	international standardization agreement
JP	joint publication

LTC	lieutenant colonel
MAJ	major
MCP	main command post
MEDBDE	medical brigade (support)
MEDCOM (DS)	medical command (deployment support)
MEDLOG	medical logistics
METT-TC	mission, enemy, terrain and weather, troops and support available, time available, and civil considerations
MHS	Military Health System
MMB	medical battalion (multifunctional)
MOS	military occupational specialty
MSG	master sergeant
MTF	medical treatment facility
MWD	military working dog
MWR	morale, welfare, and recreation
NATO	North Atlantic Treaty Organization
NCO	noncommissioned officer
NGO	nongovernmental organization
NP	neuropsychiatry
OCP	operational command post
OEH	occupational and environmental health
OPLAN	operation plan
OPORD	operation order
PAO	public affairs office
PFC	private first class
POC	point of contact
PVNTMED	preventive medicine
S-1	personnel staff officer
S-2	intelligence staff officer
S-3	operations staff officer
S-4	logistics staff officer
S-6	signal staff officer
S-9	civil affairs staff officer
SFC	sergeant first class
SGM	sergeant major
SGT	sergeant
SIMLM	single integrated medical logistics manager
SJA	staff judge advocate
SPC	specialist
SSG	staff sergeant
STANAG	standardization agreement
TOE	table of organization and equipment
TPMC	theater patient movement center
TPMRC	theater patient movement requirements center
TSOP	tactical standing operating procedure
US	United States
USAF	United States Air Force
USAMEDDC&S	United States Army Medical Department Center and School
WO	warrant officer

SECTION II — TERMS AND DEFINITIONS

Army Health System

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

Force Health Protection

(1) Measures to promote, improve, or conserve the mental and physical well-being of service members. These measures enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards (JP 1-02). (2) Force health protection encompasses measures to promote, improve, conserve or restore the mental or physical well-being of Soldiers. These measures enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards. These measures also include the prevention aspects of a number of Army Medical Department functions (preventive medicine, including medical surveillance and occupational and environmental health surveillance; veterinary services, including the food inspection and animal care missions, and the prevention of zoonotic disease transmissible to man; combat and operational stress control; dental services (preventive dentistry); and laboratory services [area medical laboratory support]) (FM 4-02).

Health Service Support

(1) All services performed, provided, or arranged to promote, improve, conserve, or restore the mental or physical well-being of personnel. These services include, but are not limited to the management of health services resources, such as manpower, monies, and facilities; preventive and curative health measures; evacuation of the wounded, injured, or sick; selection of the medically fit and disposition of the medically unfit; blood management; medical supply, equipment, and maintenance thereof; combat and operational stress control and medical, dental, veterinary, laboratory, optometry, nutrition therapy, and medical intelligence services (JP 1-02). (2) Health service support encompasses all support and services performed, provided, and arranged by the Army Medical Department to promote, improve, conserve, or restore the mental and physical well-being of personnel in the Army. Additionally, as directed, provide support in other Services, agencies, and organizations. This includes casualty care (encompassing a number of Army Medical Department functions—organic and area medical support, hospitalization, the treatment aspects of dental care and behavioral/neuropsychiatric treatment, clinical laboratory services, and treatment of chemical, biological, radiological, and nuclear patients), medical evacuation, and medical logistics (FM 4-02).

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