

## Chapter 12

# ROLE OF THE BATTALION AND SQUADRON PHYSICIAN ASSISTANT

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## Introduction

Being a battalion (BN) or squadron (SQN) physician assistant (PA) is arguably the most significant assignment PAs hold in the Army. These are the first and most forward levels of care during deployments. Working at this level, the PA must be prepared to provide a wide variety of medical services to soldiers under potentially adverse conditions. The PA's primary function is to maintain the health, readiness, and welfare of the service members in their unit. This includes more than just providing direct health care to individual soldiers; PAs must also ensure the soldiers of their unit are medically ready for worldwide deployment to austere environments. Non-deployable service members must receive dispositions promptly through the appropriate systems. Fighting and winning the nation's wars is why the US Army exists, and unit PAs must direct their efforts toward that end. The PA must prepare to provide care in austere and constrained environments with limited logistical resources. Additionally, in the conditions of current operations, the unit PA must prepare to provide medical care to host country nationals and other coalition force service members.

## Requirements

To serve in this position, a PA must:

- graduate from an accredited PA program, pass the Physician Assistant National Certifying Examination, and maintain certification with the Physician Assistant National Recertifying Exam through the National Commission on Certification of Physician Assistants;
- hold the rank of first lieutenant or captain;
- graduate from the Basic Officer Leader Course;
- pass the Army fitness test and comply with height/weight standards of Army Regulation (AR) 600-9, *The Army Body Composition Program*<sup>1</sup>;
- meet the readiness requirements listed in the 65D (PA) individual critical task list<sup>2</sup>;
- be credentialed at the local military medical treatment facility (MTF); and
- be knowledgeable about AR 40-501, *Standards of Medical Fitness*<sup>3</sup>; AR 40-502, *Medical Readiness*<sup>4</sup>; and Department of the Army (DA) Pamphlet (PAM) 40-502, *Medical Readiness Procedures*.<sup>5</sup>

## Desired Skills and Attributes

BN/SQN PAs should:

- be able to operate in clinical, deployed, and field settings;
- be able to communicate effectively with command teams at the company/battery/troop (C/B/T) and BN/SQN levels, fellow health care providers and specialists, NCOs, soldiers, and patients;
- have deployment experience or the ability to deploy in support of worldwide operations in accordance with AR 40-501<sup>3</sup>;
- be able to operate independently even when not collocated with direct physician supervision (unit PAs are often separated from their supervising physician, making communication and direct oversight a challenge during deployments or field training exercises);
- be a lifelong learner and have an interest in keeping up to date on the latest research and best practices in clinical and prehospital medicine;
- have solid written and oral communication skills;
- have or develop a high level of knowledge and expertise in Tactical Combat Casualty Care (TCCC)<sup>6</sup>;

- have the knowledge and ability to train and supervise combat medics (military occupational specialty [MOS] 68W), combat lifesavers, and other allied and ancillary health specialists in Tactical Combat Casualty Care (TCCC)<sup>6,7</sup>; and
- complete unit-specific schools such as airborne and air assault.

## **Job Duties and Responsibilities**

The primary role of the Army PA at the BN/SQN level is to provide world-class health care to soldiers. The unit PA is responsible for organization and supervision of medical care at the Role 1 MTF, at the unit aid station, during field training, and in deployed environments, including prehospital resuscitation, stabilization, and evacuation. In the garrison environment, the PA operates as the primary care manager for the soldiers assigned to their unit. Daily responsibilities include:

- acute care during sick call operations;
- managing routine and chronic conditions in a clinical setting;
- ordering and interpreting laboratory and imaging studies;
- providing treatment and medication to patients;
- coordinating specialty care needs;
- consulting with the supervising physician; and
- communicating matters of medical health and readiness with the BN/SQN executive officer or commander.<sup>8</sup>

As the principal advisor to the commander and their staff, the PA is responsible for:

- maintaining unit medical readiness for deployment by overseeing preventive health measures such as:
  - routine and special-purpose immunizations,
  - periodic health assessments,
  - audiometry,
  - dental exams,
  - up-to-date laboratory test screening, and
  - management of chronic conditions<sup>3</sup>;
- when appropriate (as soldiers reach the medical retention decision point), initiating permanent profiles in coordination with the physician approving authority, and referring soldiers to MOS

administrative retention review (MAR2) or enrolling them in the Integrated Disability Evaluation System (IDES);

- planning, supervising, and overseeing the medical training and employment of 68W combat medics within the medical platoon or section (Figure 12-1); and
- overall supervision of the unit's combat lifesaver (CLS) program.<sup>9</sup>

## **Professionalism**

The BN/SQN PA is responsible for cultivating a sense of professionalism and unit confidence in the BN/SQN medical team, whether in garrison or deployed. The team's functionality and appearance, competence, and innate ability to accommodate any requirement are set by the PA. The PA should serve as a mentor to increase the technical and professional capabilities of all team members. The PA guides soldiers interested in becoming a PA and provides opportunities for shadowing (following the PA in performing their daily activities). BN/SQN PAs are also mentees, seeking guidance from the brigade (BDE) or unit surgeon and senior BDE combat team PA.

Collaboration is essential throughout the BDE to ensure its units are successful in their individual missions. This includes collaboration and camaraderie within the PA community for clinical success and professional development. PAs should participate in clinical and officer professional development opportunities within both the unit and the MTF. The local MTF usually has grand rounds or continuing medical education sessions already established for credentialed providers. These events provide networking opportunities and are vital to building relationships within the unit and MTF. The unit PA must demonstrate their leadership role by being visible to unit and MTF leaders. A presence at command and staff meetings, face-to-face counseling, and unit or MTF social events is essential to building relationships with the chain of command, staff peers, other providers, and specialists (such as physical therapy, behavioral health, and dental). It is also crucial the PA get to know non-medical personnel such as the chaplain, sexual assault response coordinator, and victim advocates.



**Figure 12-1.** Captain Tetevi Torsoo (back end of table), 2nd Battalion, 87th Infantry Regiment, 2nd Brigade, 10th Mountain Division (Light), teaches suturing techniques to medics in Camp Dwyer, Afghanistan, April 13, 2019. Photograph courtesy of Staff Sergeant Andres Rodriguez.

## Systems Access Requirements

Numerous software applications have been adopted by the Army and military MTFs for reviewing, documenting, and updating patient care and soldier readiness information. Ensuring proper systems access and being well versed in their use is an important aspect of the PA's duties. A security clearance and current Health Insurance Portability and Accountability Act (HIPAA) training certificate are required to gain access to the secure systems used by the PA. These systems are used to manage and organize vast amounts of information; as with any software application, they are subject to frequent updates and changes that the PA must keep up with. The systems listed below are intended as an outline and are not all that may be required by a PA.

- **Electronic health records (EHRs)**, including the Military Health System's Genesis program and its predecessor, the Armed Forces Health Longitudinal Technology Application (AHLTA), which is being phased out, are integral to the daily routine of military PAs.<sup>10</sup> EHRs are used by medical professionals to order medications, request laboratory tests, and document progress notes for the 9.4 million Department of Defense beneficiaries.<sup>10</sup> The EHR system provides for continuity of care and sharing of information across the global military health care network and the Department of Veterans Affairs.<sup>10</sup> The BN/SQN PA must understand appropriate documentation and coding procedures utilizing the current EHR system employed by their MTF and clinic.
- The **Medical Operational Data System (MODS)** is an integrated system of applications used by the Army Medical Department to track medical readiness, education, manpower, and logistics.<sup>11</sup> Data may be exchanged among MODS applications and with Army personnel systems to expand visibility of unit readiness status.<sup>11</sup> The four systems below are applications within MODS, but each requires separate permission for access.
  - The **Medical Protection System (MEDPROS)** is a website that displays a comprehensive review of the medical readiness data for all medical and dental readiness requirements in accordance with AR-600-8-101, *Personnel Processing*.<sup>12</sup> MEDPROS (<https://medpros.mods.army.mil/MEDPROSNew/>) allows viewing and analysis of readiness information for individuals,

units, and custom task forces. Unit medical personnel usually use MEDPROS, while commanders use the Medical Readiness Portal's Commander Portal.

- The **Medical Readiness Portal** provides a more up-to-date version of MEDPROS with varying functionality dependent on a user's access. Within the Medical Readiness Portal, users can request access to the Healthcare Portal, Commander Portal, Senior Commander Portal, and Admin Portal.<sup>13</sup>
  - The **Healthcare Portal** serves as a single location for integration of medical readiness.<sup>5,14</sup> It provides an updated electronic profile (e-Profile) system to manage soldiers' temporary and permanent medical conditions with specific duty limitations.<sup>15</sup> Medical readiness information such as the Individual Medical Readiness report, PULHES data (discussed below), and immunizations are also viewable here.
  - The **Commander Portal** is a website that assists unit commanders by providing a single interface to view the medical readiness of their organization. It eliminates the need for commanders to log into multiple systems. Through this portal, commanders can view readiness deficiencies and deployment-limiting (DL) profiles, and make deployability determinations that automatically feed into the unit status report. Unit providers can access the Commander Portal and Senior Commander Portal by requesting the "BN Staff" role via MODS. Although PAs may not frequently use the Commander Portal, it is important for their situational awareness and to understand what commanders can view.<sup>16,17</sup>
  - The **Admin Portal** provides "reports that will pull data from all of the readiness systems."<sup>5</sup> Access to this portal is generally limited to users at echelons above BDE. PAs should request access to allow for ease of profile tracking.<sup>18</sup>
- **MEDPROS Web Data Entry (MWDE)** is the module in which the PA can update individual soldiers' medical readiness data for MEDPROS.<sup>19</sup>
- The **Medical Health Assessment (MHA)** is a module used to update periodic health assessments as well as predeployment and postdeployment health assessments. The completion of these requirements is automatically uploaded into MEDPROS.<sup>20</sup>

- The **Transportation Command Regulating and Command & Control Evacuation System** (TRAC<sup>2</sup>ES) is a significant part of a deployed medical professional's toolkit, used to coordinate and monitor patient movement between MTFs during peacetime, contingency, and wartime operations.<sup>21</sup>

## Administrative Duties

The PA must be proficient in various administrative functions. Unit leadership will often seek information from the PA about the availability, limitations, expectations, and courses of recovery for soldiers within the unit. Proficiency in the functions listed below promote a clear understanding between medical and command teams, as well as cultivating a sense of trust within the organization.

### Profiles

Physical profiling of a soldier is a medical recommendation intended to inform unit commanders of any limiting condition, provide clear guidance on the functions an individual can and cannot perform, and outline recovery expectations. PAs utilize the Physical Profile, DA Form 3349, on the Healthcare Portal to specify duty and functional limitations. When a medical condition causes a soldier to be non-deployable, the Medical Readiness Portal assigns them one of seven deployment-limiting (DL) codes in MEDPROS. It is vital to educate commanders that they must use the Commander Portal to review each physically limiting profile no more than 14 days after creation (30 days for reservists).<sup>5</sup> During their review, commanders can improve their units deployability by designating soldiers with DL codes 1 and 2 as deployable. Clear and concise communication on a soldier's physical limitations is imperative to allow for a correct deployability determination. Section 5 of DA Form 3349, Medical Instructions to Unit Commander, affords providers an avenue for such communication. It is helpful to organize profiles into the categories below to formulate accurate unit medical readiness data. The Unit Medical Readiness (UMR) report within MEDPROS provides PAs an easy way to view and sort soldiers with temporary and permanent profiles.<sup>22</sup>

- **Temporary and non-deployable:** the soldier has a temporary limitation and is NOT capable of deploying. This classification is



defined by those on profiles greater than 30 days (DL 1), those who are dental readiness class 3 (DL 2), and pregnant soldiers (DL 3). PAs must communicate clearly and knowledgeably with the chain of command about the status of these soldiers. Information commanders need to know includes the total number of days on profile, the soldier's duty limitations, the required steps to recovery, and the amount of time needed to return the soldier to duty (or qualify for entry into IDES).

- **Permanent and non-deployable:** the soldier has a permanent condition and is undergoing a MAR2 (DL 4), medical evaluation board (MEB) or physical evaluation board (PEB) (DL 5), or non-duty PEB (DL 6) for not meeting the standards in AR 40-501, chapter 3. This category also includes soldiers awaiting denotation of physical category codes F, V, X, or Y (DL 7) on DA Form 3349.<sup>3</sup> Once listed, soldiers with code F or V remain non-deployable, while those with X or Y are deployable. Code meanings are as follows:
  - F. No assignment or deployment to areas outside the continental United States (where definitive medical care for the soldier's medical condition is not available).
  - V. Identifies a soldier with restrictions on deployment to certain areas.
  - X. Continuation on active duty or active reserve. Denotes soldiers with a disease, injury, or medical defect that is below medical retention standards, but they are granted a waiver to continue on active status.
  - Y. Fit for duty. Soldiers determined to be fit for duty after a review of a physical disability.<sup>4</sup>
  - Once DL codes 3 through 7 are written on DA Form 3349, commanders are unable to override them and the soldier will remain on permanent profile until their board is complete.<sup>4</sup> Table 12-1 provides an example of non-deployable soldier tracking.
- **Temporary and deployable:** the soldier has a temporary limitation but is available to deploy to an austere environment. For example, a soldier with routine knee pain with a "run at own pace and distance" profile with no limitations in section 4 (Functional Activities) of the DA Form 3349. This group includes those with DL code 1 or 2 who the commander designates as deployable in the Commander Portal.
- **Permanent and deployable:** the soldier has a permanent condition without a non-deployable code (F or V) on their DA Form 3349

**Table 12-1. Tracking non-deployable soldiers.**

Name	Rank/MOS	Days on Profile	Illness/Injury	Way Ahead
Doe, John	SPC/11B	60	Leg fracture/ surgery 9/03/20	Anticipate RTD 11/10/20
Doe, Jane	PFC/42A	98	Pregnancy, EDD: 2/15/2021	Anticipate RTD 5/15/21

EDD: estimated delivery date; MOS: military occupational specialty; PFC: private first class; RTD: return to duty; SPC: specialist

and can perform duties of their MOS. Examples include a soldier with a permanent shaving profile (facial hair allowed due to pseudofolliculitis barbae), or a 92Y (supply specialist) who meets all physical requirements of their MOS, but has a permanent L2 (lower extremity, minimal limitation) profile and performs an alternative Army fitness test event.

The Army has standardized its profile templates to facilitate physical training, recovery, and performance optimization. To assist the master fitness trainer of a unit, PAs should use the reconditioning physical readiness training (PRT) profiling program in Field Manual (FM) 7-22, *Army Physical Readiness Training*,<sup>23</sup> and the associated Medical Readiness Portal PRT standard templates. Commanders are familiar with references such as FM 7-22, and the PA must be able to provide profiling recommendations to commanders based on these references. To appropriately manage profiles, the PA must also understand what the Army expects of soldiers based on their MOS. The Smartbook version of DA PAM 611-21, *Military Occupational Classification and Structure*, lists physical expectations by MOS.<sup>24</sup> AR 40-501, chapters 3 and 7, contain information on the numerical identification of permanent profiles (1, 2, 3, 4) and the anatomical determination of performance abilities according to the acronym “PULHES”: P (physical), U (upper), L (lower), H (hearing), E (eyes), S (psychiatric).<sup>3</sup>

Of note, BN/SQN PAs are unable to extend profiles beyond 180 days without a physician’s review, except in cases of profiling pregnant soldiers. They are also limited to writing profiles for 90 days in duration at one time. Once an initial profile is written, it may be extended thereafter. For all profiles, the unit PA must specify when a soldier is eligible for a record physical fitness test. This date may be twice

the length of the profile but cannot exceed 90 days. Additionally, all permanent profiles require co-signature from a physician.

### ***Integrated Disability Evaluation System***

The IDES is commonly referred to as an MEB by command teams, but it is actually a multistage process that includes the MEB—an evaluation to determine if a medical condition renders a soldier non-retainable in the military—as well as the PEB, which determines the degree of compensation, if warranted. The BDE senior PA, clinical nurse case manager, MEB Physician, and the installation Disability Evaluations Chief are typically IDES subject matter experts and can provide guidance. PAs must be familiar with their local IDES process as it varies among installations (see Chapter 30 in this handbook for a detailed overview of the IDES).

### ***Military Occupational Specialty Administrative Retention Review***

The MAR2's purpose is to retain quality service members who can no longer meet the physical requirements of their MOS in accordance with DA PAM 611-21.<sup>24,25</sup> Ideally, the process is completed in less than 6 weeks, and the soldier is assigned a new MOS within the limits of the permanent profile. The MAR2 is a tool to keep good soldiers in service and should not be used to move substandard performers to another MOS or unit. The BDE or division career counselor is responsible for maintaining the MAR2 program. The PA is responsible for working with command teams to identify potential candidates and, with the unit career counselor, ensure their profiles meet MAR2 criteria. Once a MAR2 is submitted, soldiers must speak to their career counselor to determine which MOS they qualify for. The career counselor will then submit the required MAR2 documents to Human Resource Command for review.<sup>24</sup> To ensure timely completion of the MAR2 it is good practice for the PA to notify the retention NCO when a MAR2 profile is written and signed.

### ***High-Risk Tracking***

The PA is often required to track soldiers in the unit considered “high risk” (Figure 12-2). Soldiers are regarded as high risk due to various concerns, including legal, marital, occupational, behavioral

Race: WHITE Gender: MALE Age: 20 Position: Infantryman Time in Service: 21 months Time in Unit: 18 months # of Deployments: 0 # of Dependents: 0 Marital Status: single Flag/Bar: NONE Battle Buddy: SPC Brown Roommate: SPC Green Supervisor: SGT Grey Risk to self/others: YES		<b>PFC Doe, John (Company, Battalion, Brigade)</b>							
		5 DOMAINS OF FUNCTIONING		RISK FACTORS				RESOURCES	
		[Score 1-5, 1 is healthy, 5 is unhealthy]		Alcohol/Drug Abuse	<input checked="" type="radio"/> Y	<input type="radio"/> N	Mentor / Battle Buddy	<input checked="" type="checkbox"/> BH (Group)	<input type="checkbox"/> I
		Physical	4	Suicide Ideation	<input type="radio"/> Y	<input checked="" type="radio"/> N	Chaplain	<input checked="" type="checkbox"/> BH (HRCM)	<input type="checkbox"/> I
		Emotional/Behavioral	5	BH Treatment	<input checked="" type="radio"/> Y	<input type="radio"/> N	FAP (ACS)	<input checked="" type="checkbox"/> ASAP	<input type="checkbox"/> A
		Occupational	2	Work Issues	<input checked="" type="radio"/> Y	<input type="radio"/> N	Financial (ACS)	<input checked="" type="checkbox"/> SWS	<input type="checkbox"/> N/A
		Social/Interpersonal	3	Relational Issues	<input checked="" type="radio"/> Y	<input type="radio"/> N	Legal Services	<input checked="" type="checkbox"/> MFLC	<input type="checkbox"/> N/A
		Financial	2	Financial Issues	<input type="radio"/> Y	<input checked="" type="radio"/> N	BH (Individual)	<input checked="" type="checkbox"/> Community Involvement	<input type="checkbox"/> N/A
		Legal/Disciplinary	5	Legal Issues	<input type="radio"/> Y	<input checked="" type="radio"/> N	Informed, no action	<input checked="" type="checkbox"/> Scheduled	<input type="checkbox"/> Attending
		TOTAL SCORE: 21		CDR Risk Assessment: MODERATE RISK		Reason on HR Tracker: Alcohol Abuse/DV		Months on HR Tracker: 3	
PROFESSIONAL INPUT:					EVENTS/INCIDENTS OF SIGNIFICANCE:				
BCT SURGEON:									
BH PROVIDERS:					CURRENT UPDATE:				
BCT JAG:									
COMMANDER ASSESSMENT:					UNIT PLAN OF ACTION:				
UNCLASSIFIED					v 1 May 2020				

Figure 12-2. Example of a tracking card for high-risk soldiers.

health, polypharmacy, and physical issues.<sup>26</sup> The US Army Soldier Leader Risk Reduction Tool assists commanders in identifying these soldiers and is a useful reference for what behaviors or circumstances constitute “high risk.”<sup>26</sup> The PA should be aware of soldiers involved with polypharmacy medications, controlled substances, and substance abuse, as well as the impact that soldiers’ physical illness or injury can have on their ability to function. The PA must routinely assess their soldiers for these high-risk behaviors. For example, there is often a correlation between recent legal troubles and increased use of sick call. Establishing a two-way dialogue with the command teams and the BDE behavioral health officer is the fastest way to identify and maintain visibility of these soldiers. It does not matter who identifies the soldier (command, behavioral health officer, or PA); what matters is that all three are in agreement regarding the soldier’s status, monitoring, treatment, and projected disposition. Appropriate awareness may allow the PA to identify and address underlying issues on behalf of the soldier. These stressors should be identified and discussed between the PA, behavioral health officer, and leadership. The sole provider medication program is available to PAs wishing to restrict medication access to high-risk soldiers. This program prevents soldiers from receiving specific medications from providers other than those the PA designates. It is useful for soldiers on controlled medications

or those with a high likelihood or past history of abuse. PAs should speak to their MTF's clinical pharmacist for the program specifics and enrollment paperwork.

### ***Enlisted Separation for Certain Physical or Mental Conditions***

AR 635-200, *Active Duty Enlisted Administrative Separations*,<sup>27</sup> describes ways in which enlisted soldiers can be separated (discharged) from the Army. PAs must clearly understand AR 635-200's paragraph 5-17, which states that a commander may separate a soldier "on the basis of other physical or mental conditions not amounting to disability . . . that potentially interfere with assignment to or performance of duty."<sup>27</sup> The type of separation described in this paragraph is almost exclusively utilized for behavioral health conditions, and it contains numerous guidelines and exclusionary terms. In particular, the section is a tool to determine if soldiers may not be fit for military service due to the inability to cope with stressors. However, this form of separation should not be used instead of an MEB for known medical conditions that make a soldier unfit for service, per AR 40-501, chapter 3.<sup>3</sup> The BDE behavioral health officer should be consulted for any consideration of a paragraph 5-17 separation.

## **Operating an Aid Station**

Established for 24-hour operations, the aid station often serves as the point of entry into the medical system during field training exercises and deployments. It typically exists as a multifunctional center that can serve as a medical command post, treatment facility, classroom, counseling area, living quarters, or mass casualty (MASCAL) anchor, based on various mission requirements. It can provide "tailgate" medicine (giving care based on what is readily available in a vehicle) until care can be provided at a more established site, such as a tent or other facility in the area of operation. The unit PA is responsible for establishing the aid station based on mission requirements.

The aid station has capabilities to perform sick call, advanced trauma management, basic laboratory procedures, patient administration, and medication supply management, and it must be able to move or relocate at a moment's notice. The aid station is assigned evacuation resources such as field litter ambulances and nonstandard vehicles such as utility vehicles, but the availability of the nonstandard vehicles is based on

local resources, space, and local standard operating procedures (SOPs) and MASCAL procedures. When establishing the aid station, the BN/SQN PA must also designate an easily accessible landing zone to facilitate rapid aeromedical evacuation.<sup>28</sup>

In a deployed environment, requests for medical care are often made by individuals who are not authorized to receive it from military assets. The task force commander decides on the medical rules of engagement, which determine when and to whom military health care providers are allowed to provide medical care (eg, to save life, limb, or eyesight, or stabilize and evacuate patients to a local national medical facility). The needs of the mission, available resources, and capability of the host nation's medical system will significantly affect these decisions. Planning for these situations is imperative. Before the start of the operation, all medical personnel must understand the commander's expectations.

The aid station provides the organizational structure that comprises the medical support system for the unit and its area of responsibility. A thorough understanding of aid station operations is found in Army Techniques Publication (ATP) 4-02.3, *Army Health Systems Support to Maneuver Forces*.<sup>29</sup> Situational training exercises are an opportunity for the medical team to set up its aid station, establish protocols and procedures, and integrate the aid station with unit operations.

## Mass Casualty Operations

A MASCAL event is defined as a situation in which “the number of casualties exceeds the available medical capability to rapidly treat and evacuate them.”<sup>30</sup> Various options exist for managing a MASCAL event. A holistic or flexible approach can allow for individuals to move among multiple roles as the operation develops and needs are identified; however, a predetermined plan consisting of specific assignments for each individual team member can provide clear understanding within the entire unit. The critical success factor in handling a MASCAL situation is the preparation and tone set by the BN/SQN PA. This section will focus on the BDE medical team in a deployed MASCAL setting. Appendix A of ATP 4-02.3 is an excellent resource and strongly recommended for review before developing a MASCAL plan.<sup>29</sup> Chapter 4 of ATP 4-25.13, *Casualty Evacuation*,<sup>30</sup> also provides valuable information when developing a MASCAL evacuation plan.

## ***Planning***

It is critical for the PA to have input in the development and implementation of a MASCAL plan at the earliest opportunity in both the deployed and field settings. The PA must coordinate with the medical operations officer to determine and implement a feasible MASCAL plan. MASCAL plans should be as simple as possible; personnel should not need to make complicated decisions during a MASCAL situation. Personnel responding to a MASCAL situation may be new to the organization, unfamiliar with traumatic events, or simply overwhelmed by the current conditions. A simple plan will be remembered under stress and is often the most successful plan.

Plans should be based on the unit's capabilities; for example, a combat arms (infantry, armor, or field artillery) NCO can serve as a traffic control officer or organize litter teams. The plan must account for ongoing combat operations and limited personnel and resources. Litter bearers who are not medical personnel must be identified so that medical assets are reserved for providing medical care. In MASCAL situations, medical care may be competing with other priorities; for example, a firefight may be ongoing or evacuation assets may be unavailable due to operational requirements or weather constraints. The PA must utilize NCO leadership (medical and non-medical) in both planning and execution. These leaders are the backbone of any operation and will give it structure throughout the process.

The plan must include knowing "the way out": how the unit will get the casualties to where they need to go. The PA is responsible for planning care for all patients in the unit's geographic area of responsibility, which entails the preparation of mobile trauma sets, designation of alternative treatment locations, evaluation of remote locations for storing medical supplies, and plans for moving casualties to and from remote locations. Questions to ask include the following: What is the next level of care? What assets are available at that facility? What modes of transportation are available to move patients? What capabilities does the aid station have to provide care en-route? This line of decision-making prior to an incident will instill confidence that the plan has a legitimate solution in place. In a deployed setting, the medical regulating officer (MRO) can help answer these questions.<sup>31</sup> MROs work in every Role 3 hospital and medical mission command headquarters.<sup>32</sup> They are responsible for regulating and supporting patient movement

and in-transit visibility requirements under the guidance of the division surgeon or subordinate MTF.<sup>29</sup>

Once a MASCAL plan has been formalized and approved, it must be rehearsed until done correctly and repeated periodically to maintain readiness; the PA should strive to create “muscle memory” within the organization. Moreover, rehearsals do not have to be a formal exercise. The PA should quiz personnel on MASCAL procedures at various opportunities (eg, waiting in line at a dining facility or following a routine sick call encounter). It is likely the unit already has a MASCAL plan which is formalized in their Tactical SOP. Upon arriving to a new unit PAs should speak to their BN’s operations officer and obtain a copy for review. The PA can then discuss MASCAL procedures with medical personnel and the BN’s leadership to determine where a need for improvement or revision exists.

### ***Triage and Evacuation***

Triage is the assignment of degrees of urgency to illnesses or wounds in order to decide the priority of treatment for a large number of casualties. It is based on medical supplies and assets available, regardless of the number of patients or casualties.<sup>29</sup> The best way to triage is to use the “DIME” acronym (delayed, immediate, minimal, and expectant) to categorize the severity of casualties’ injuries. Triage categories prioritize the casualties for treatment, and evacuation categories (urgent, priority, and routine) prioritize them for evacuation. Patients must be periodically reevaluated to check whether their status has changed. Changes in the patient’s condition should immediately prompt a change in the assigned triage or evacuation category. A nine-line medevac (medical evacuation) request is used when calling for evacuation of patients from designated units by ground or air. Information on the request includes the patient’s evacuation category, if the patient is litter or ambulatory, and any special equipment (eg, ventilator or hoist) needed.<sup>31</sup>

### ***Accountability***

During the MASCAL event, there must be accountability of assigned weapons and equipment as well as controlled medications. A unit’s S-4 officer (logistician) typically manages supply and property accountability. Controlled medications must be accounted for inside and outside the aid station. There are several options for accounting



for medications outside the aid station, and procedures should be matched with mission requirements. One option is to store a portion of the aid station narcotics in “ready-bags,” such as a plastic sandwich bag with two autoinjectors of morphine and one vial of intravenous diazepam; an RSI (rapid sequence intubation) ready-bag; or the small Pelican 1030 (Pelican Products Inc) medication cases (national stock number: 8145-01-573-2533) included in medical sets (these are a more expensive option). The PA should be familiar with and adhere to the process for signing out and storing narcotics in accordance with AR 190-51, *Security of Unclassified Army Resources (Sensitive and Nonsensitive)*, chapter 4.<sup>33</sup>

### Patient Tracking

Patient tracking and documentation are often the most overlooked aspects of casualty operations. Commanders are entitled to know the location and status of their soldiers, and the PA is responsible for having a plan in place for recording medical encounters. Medics must

<p style="text-align: center;"><b>TACTICAL COMBAT CASUALTY CARE (TCCC) CARD</b></p> <p style="text-align: center;"><b>BATTLE ROSTER #:</b> _____</p> <p style="text-align: center;">EVAC: <input type="checkbox"/> Urgent <input type="checkbox"/> Priority <input type="checkbox"/> Routine</p> <p>NAME (Last, First): _____ LAST 4: _____</p> <p>GENDER: <input type="checkbox"/> M <input type="checkbox"/> F DATE (DD-MMM-YY): _____ TIME: _____</p> <p>SERVICE: _____ UNIT: _____ ALLERGIES: _____</p> <p><b>Mechanism of Injury:</b> (X all that apply)</p> <p><input type="checkbox"/> Artillery <input type="checkbox"/> Blunt <input type="checkbox"/> Burn <input type="checkbox"/> Fall <input type="checkbox"/> Grenade <input type="checkbox"/> GSW <input type="checkbox"/> IED  <input type="checkbox"/> Landmine <input type="checkbox"/> MVC <input type="checkbox"/> RPG <input type="checkbox"/> Other: _____</p> <p><b>Injury:</b> (Mark injuries with an X)</p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>TQ: R Arm</p> <p>TYPE: _____</p> <p>TIME: _____</p> </div> <div style="text-align: center;"> <p>TQ: L Arm</p> <p>TYPE: _____</p> <p>TIME: _____</p> </div> </div> <div style="text-align: center; font-size: 2em; font-weight: bold; letter-spacing: 0.5em;">S A M P L E</div> <div style="display: flex; justify-content: space-around; margin-top: 20px;"> <div style="text-align: center;"> <p>TQ: R Leg</p> <p>TYPE: _____</p> <p>TIME: _____</p> </div> <div style="text-align: center;"> <p>TQ: L Leg</p> <p>TYPE: _____</p> <p>TIME: _____</p> </div> </div> <p><b>Signs &amp; Symptoms:</b> (Fill in the blank)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Time</th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>Pulse (Rate &amp; Location)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Blood Pressure</td> <td>/</td> <td>/</td> <td>/</td> <td>/</td> </tr> <tr> <td>Respiratory Rate</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Pulse Ox % O2 Sat</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>AVPU</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Pain Scale (0-10)</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p style="font-size: 0.8em;">DD Form 1380, JUN 2014 <span style="float: right;">TCCC CARD</span></p>	Time					Pulse (Rate & Location)					Blood Pressure	/	/	/	/	Respiratory Rate					Pulse Ox % O2 Sat					AVPU					Pain Scale (0-10)					<p style="text-align: center;"><b>BATTLE ROSTER #:</b> _____</p> <p style="text-align: center;">EVAC: <input type="checkbox"/> Urgent <input type="checkbox"/> Priority <input type="checkbox"/> Routine</p> <p><b>Treatments:</b> (X all that apply, and fill in the blank) <span style="float: right;">Type</span></p> <p>C: TQ- <input type="checkbox"/> Extremity <input type="checkbox"/> Junctional <input type="checkbox"/> Truncal _____</p> <p style="padding-left: 20px;">Dressing- <input type="checkbox"/> Hemostatic <input type="checkbox"/> Pressure <input type="checkbox"/> Other _____</p> <p>A: <input type="checkbox"/> Intact <input type="checkbox"/> NPA <input type="checkbox"/> CRIC <input type="checkbox"/> ET-Tube <input type="checkbox"/> SGA _____</p> <p>B: <input type="checkbox"/> O2 <input type="checkbox"/> Needle-D <input type="checkbox"/> Chest-Tube <input type="checkbox"/> Chest-Seal _____</p> <p><b>C:</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Name</th> <th>Volume</th> <th>Route</th> <th>Time</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">Fluid</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">Blood Product</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p><b>MEDS:</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Name</th> <th>Dose</th> <th>Route</th> <th>Time</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">Analgesic (e.g., Oxycodone, Fentanyl, Morphine)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">Antibiotic (e.g., Moxifloxacin, Ertapenem)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">Other (e.g., TXA)</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>OTHER: <input type="checkbox"/> Combat-Pill-Pack <input type="checkbox"/> Eye-Shield (<input type="checkbox"/> R <input type="checkbox"/> L) <input type="checkbox"/> Splint  <input type="checkbox"/> Hypothermia-Prevention Type: _____</p> <p><b>NOTES:</b></p> <hr/> <p>FIRST RESPONDER  NAME (Last, First): _____ LAST 4: _____</p> <p style="font-size: 0.8em;">DD Form 1380, JUN 2014 (Back) <span style="float: right;">TCCC CARD</span></p>		Name	Volume	Route	Time	Fluid					Blood Product						Name	Dose	Route	Time	Analgesic (e.g., Oxycodone, Fentanyl, Morphine)					Antibiotic (e.g., Moxifloxacin, Ertapenem)					Other (e.g., TXA)				
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Figure 12-3. DD Form 1380 (Tactical Combat Casualty Care Card) example.

recognize the importance of maintaining accountability for those treated, including their name, injury, and location if evacuated. Necessary medical information is rapidly captured on DD Form 1380, the TCCC card (Figure 12-3). A simple white board in the aid station should also be used to provide redundancy and prevent information loss. When time allows, conversion of analog documentation into EHRs must occur. The Medical Communications for Combat Casualty Care (MC4) computer is used to accomplish this task.

It is imperative that every casualty is accurately accounted for throughout the process. Patient tracking starts with the S-1 (officer in charge of personnel accountability), who uses the TCCC cards attached to the patients as they are evacuated to ensure pertinent information is captured. The BN/SQN PA should contact the unit liaison (either intra- or inter-theater, depending on unit preference) for the commander to gather timely patient tracking status. PAs should provide patient location and disposition to commanders every 24 hours. The Joint Operation Planning and Execution System (JOPES)<sup>34</sup> and TRAC<sup>2</sup>ES<sup>21</sup> can also be used for real-time casualty tracking. The mortuary affairs NCO, typically assigned to the staff of the BDE support BN, assists in the disposition of deceased soldiers.<sup>35</sup>

## **Sick Call Operations**

Sick call is an assembly of sick and injured soldiers held each day at a designated time and place, usually at the Soldier-Centered Medical Home (SCMH) or unit aid station, for the purpose of providing routine medical examination and treatment. After examination by the senior medical officer (usually the unit PA or surgeon), soldiers who are medically unfit are either referred to the hospital or provided quarters (returned to unit or home for medically directed self-treatment) for up to 72 hours. All others are returned to either full duty or duty with specific limitations. Some clinics are moving away from sick call and going to an “appointment only” system.

The establishment of specific sick call procedures is at the PA’s discretion; however, hours and procedures should be coordinated with the unit command sergeant major. For example, if the PA determines that specific sick call hours must be set to account for limited medical personnel, create appropriate sleep/work cycles, or simply consolidate resources, input should be sought from the command team. The PA

should recognize that sick call is designed to enhance the unit's mission readiness, not hinder it.

It is the responsibility of the BN/SQN PA to provide care to unit personnel whether in the aid station or the garrison environment. While in the field, the PA or their medics should conduct sick call rounds (ie, taking an aid bag full of sick call supplies and checking on soldiers) for individuals who have competing requirements and cannot leave their posts. Examples include tactical operations center personnel, who may be working 12- or 14-hour shifts, and command teams, who may be unable to dedicate time to sick call.

### ***Triage During Sick Call***

Triage during sick call is managed according to the algorithm-directed troop medical care (ADTMC) system described in Medical Command (MEDCOM) Pamphlet 40-7-21.<sup>36</sup> This system is designed to allow providers to quickly evaluate the urgency of a soldier's acute conditions and, if possible, effectively treat the soldier for return to duty. ADTMC provides a medical complaint-based algorithm for the medical screener, usually a senior medic, to follow to determine the level of care each soldier requires.<sup>36</sup> Once the soldier is triaged using ADTMC, based on the complexity of the medical problems, the screener can either (a) treat the acute condition, (b) educate the patient on medications and treatment options they may use at home, (c) refer the patient to a physician or PA for immediate evaluation, or (d) set up an appointment with the physician or PA, who may then refer the patient for specialty care if needed.

### ***"Sick Call Slip"***

DD Form 689, known as a "sick call slip," is a communication tool between unit leadership and the medical team for accountability and visibility of duty status.<sup>37</sup> Before reporting to sick call, soldiers should have a sick call slip signed by their unit leadership (usually a platoon sergeant or above). The sick call slip can be found at the unit orderly room or wherever the local SOP dictates. After the soldier is examined by the medical officer, the soldier's disposition is indicated on the sick call slip, which is returned to the unit commander or other leader. The sick call slip should provide duty status recommendations, such as return to duty or quarters (with both duration and expiration date), and time

released from sick call (physical limitations should be entered on DA Form 3349, not DD Form 689). The DD Form 689 may also be used by the commander to request medical evaluations, such as fitness for duty evaluations, by the unit medical provider.<sup>23,37</sup>

## **Training Medics During Sick Call**

The PA is responsible for developing and implementing programs that encourage and teach medics to conduct patient assessments, perform physical exams, and develop proper treatment plans. Sick call is an ideal opportunity to conduct training and teach medics to evaluate patients, especially to prepare for situations when the medic is the only provider available (eg, during a MASCAL at a location distant from the aid station, in which the line medic is the only medical personnel in the immediate area). Medics respond best to hands-on training with actual patients. A focus on identifying “red flags” (conditions that require immediate attention by, or evacuation to, a medical provider) is a good starting point for training new medics. A medic assigned only to take vitals (blood pressure, temperature, pulse, and pain level) and write the subjective portion of a report (what the patient tells the medic) at sick call will not learn to function when separated from medical providers. In addition, cultivating the responsibilities of a medic in the presence of unit soldiers will instill a sense of confidence throughout the unit in their medical personnel.

## **Clinical Operations**

BN/SQN PAs will be in a clinical setting during much of their time at the BDE Combat Team level. The PA is the primary leader in establishing the efficient performance of clinical duties. The medics and SCM staff will seek guidance from the PA on how to manage schedules, perform procedures, handle medication refills, and conduct unit physicals (ie, the processes for completing each part of the various types of examinations for schools, retirements, chapter separations, periodic health assessments, etc).

In the past, nearly all aspects of primary patient care were completely under the PA’s control because most units operated nearly all medical operations out of an aid station. However, over the last few years, the Army has transitioned to the SCM model and has required PAs to see

patients in troop medical clinics operated by MEDCOM.<sup>38</sup> Therefore, PAs must know which aspects of health care delivery are determined by MEDCOM and which they can influence at the BN/SQN level to ensure the needs of the unit are met. Establishing a good working relationship with MEDCOM soldiers, civilians, and contractors helps in coordinating unity of effort.

To start practicing medicine at a given duty station, the PA must receive appropriate credentials from the local MTF. This process can be lengthy and unique for each MTF, so it should be initiated as soon as the next duty station is known. The BDE PA, BDE surgeon, or MTF staff can provide information about the credentialing process and how to expedite the process. The PA should be very familiar with the expectations and limitations of their role as a provider. Further guidance and expectations for PA performance are available in AR 40-501<sup>3</sup> and AR 40-68, *Clinical Quality Management*.<sup>8</sup>

Although clinical operations are largely affected by the policies set forth by MEDCOM, PAs must remember they answer to the BN/SQN commander and their primary mission is to meet the operational needs of the unit. The PA must also be proactive in communicating clinic schedules and policies to the units within the BN or SQN. For example, units must know sick call times and procedures, the process and schedule for completing periodic health assessments, physical examinations, and audiology and vision screenings. The medical operations officer or platoon sergeant can assist with this. A one-page “smart card” outlining the times, locations, and procedures for these tasks is also an efficient way to ensure all units have the information. The smart card serves as a quick reference and is easily posted in unit areas as a reminder for soldiers. Helpful information includes topics such as separation physical procedures, annual periodic health assessment requirements, or the necessity to complete Department of Veterans Affairs separation history and physical examination forms on the Medical Readiness Portal prior to disability appointments.<sup>39</sup>

## **Logistical Operations and Property Accountability**

### ***Property and Accountability***

As the primary provider for the unit, responsible for the health care of its soldiers, the PA should quickly assess the Class VIII (medical) supply level of readiness upon arrival at a new duty station. The PA must know

which medical assets the section has and which it lacks. If the unit has a Medical Service Corps officer, he or she should be the primary hand receipt holder for the section and sub-hand receipt various items to the primary user. However, many units have no assigned Medical Service Corps officer, and in these units the medical platoon sergeant may also manage the hand receipt and supply. Here are some things to consider upon arrival at a duty station:

- When was the last 100% inventory completed?
- Have sub-hand receipt holders been assigned to primary users of all equipment?
- What are the deficiencies of durable, non-durable, and expendable items? Has action been taken to fill the shortages? Shortages should be reflected on a shortage annex (DA Form 2062) and funding verified to requisition replacement supplies.
- When was the last time medical equipment sets (MESs) were inventoried? MESs should be inventoried after every field training exercise or every 6 months, whichever comes first.<sup>40,41</sup> No more than 3% of excess durable and nonexpendable Class VIII items should be maintained.<sup>41</sup> See “Sets, Kits, and Outfits and Medical Equipment Sets” below for more information on how to determine what should be in an MES.
- Has an inventory been completed since the last field training exercise? Inventories should be part of recovery operations and should be documented.<sup>41</sup>
- If not done already, a binder should be made that accounts for all hand receipt items and the national stock number (NSN), authorized quantity, quantity on hand, and an accompanying picture for each item. This will greatly facilitate change of command, cyclic, or expendable Class VIII inventories.

PAs should also ensure a method is in place to track expiration dates of medical supplies with limited shelf lives, typically referred to as “Ps & Ds” (potency and dated items). Medical equipment is unique in that items expire relatively quickly and must be reordered on a regular basis. Two key mechanisms to manage medical supplies are the Medical Materiel Mobilization Planning Tool (M3PT) and the Defense Medical Logistics Standard Support (DMLSS) Customer Assistance Module (DCAM).

M3PT is the approved system for management of MES inventory.<sup>41</sup> Although it requires an investment in time up front to enter all the section's Class VIII items into M3PT, the system can be used to keep track of when items expire; send a notification 30 days before expiration (to allow reordering before items expire); quantify percent fill in accordance with AR 220-1, *Army Unit Status Reporting and Force Registration—Consolidated Policies*; and generate a list of shortages that need to be reordered.<sup>42</sup> If used correctly, M3PT can support the medical platoon's equipment readiness and rapid deployability. Another benefit is M3PT's ability to quantify (in both amount and cost) a unit's Class VIII shortages. For example, a commander may choose to assume risk by underfunding Class VIII replenishment to fund other requirements. The PA should be prepared to provide the commander visibility of the costs (in dollars, capability, and readiness) of this decision. Using reports from M3PT, this data can be rapidly queried to provide such information to the command.

DCAM is a medical logistics ordering tool that enables operational units to order Class VIII and replenish levels when required. It automates the medical materiel supply requisition process at lower levels of care and allows non-logisticians to electronically view and order from their supplier's catalog.<sup>43</sup> DCAM can interface with other Department of Defense medical logistics systems, including the Joint Medical Asset Repository (JMAR), the Theater Army Medical Management Information System (TAMMIS), and the Theater Enterprise-Wide Logistics System (TEWLS). Each section should have two soldiers with access to and training on DCAM.<sup>43</sup>

### ***Sets, Kits, and Outfits and Medical Equipment Sets***

One of the most important concepts the PA needs to know is how the Army assigns and accounts for medical equipment in their unit. First, the PA should work with the medical platoon leadership (the platoon leader and platoon sergeant) to identify the numbers and types of equipment authorized on the medical section's modified table of organization and equipment (MTOE). Next, it is important to establish the correct version of components or contents for that equipment.

All equipment is issued from the commander's property book to a sub-hand receipt holder. Most equipment sets are known as sets, kits, and outfits (SKOs); MESs are medical-specific SKOs. The medical

section is authorized and issued multiple MESs based on its required medical capability. The MES's line item number (LIN) identifies a specific medical capability that the unit must be able to accomplish (eg, sick call, tactical combat medical care, ground ambulance).

The number and type of authorized MESs for each unit can be found on the unit's MTOE. The Force Management System website, or FMSWeb (<https://fmsweb.army.mil>)<sup>44</sup> is the repository for every Army unit's MTOE (Attachment 1). After requesting access from the homepage, the PA can search the website by the unit identification code (UIC, a six-digit alphanumeric code assigned to each Army unit) or unit type (infantry, armor, etc). It is important to note that the MTOE only shows what the unit is authorized. The medical section's actual equipment on hand is on the section's sub-hand receipt from the unit commander. Variation from authorizations may exist.

While every item of equipment on the MTOE (rifle, truck, computer, etc) has an LIN, the specific item assigned to the unit to meet that LIN's required capability is represented by a unique NSN (eg, LIN C06935 is a requirement for an individual weapon, and a Carbine 5.56 mm M4A1 has a different NSN than a Rifle, 5.56 mm M16A4). The specific NSN assigned to each MES LIN represents a "version" of that MES. For example, the addition of new equipment or medication (eg, junctional tourniquets and ketamine) results in a new version of the contents list, and thus a new NSN. This new content list and NSN is associated with a unit assemblage code (UAC).

To determine which version of the MES is issued to the medical section, identify the associated NSN on the medical section's sub-hand receipt and cross reference that NSN to the US Army Medical Materiel Agency (USAMMA) Medical Materiel Information Portal (MMIP) assemblage lists (<https://a01.usamma.amedd.army.mil/mmip/>).<sup>45</sup> The MESs can be searched under the "Unit Assemblage Search" tab. The USAMMA assemblage list for each UAC also provides a hyperlinked listing of additional information for every item on the list, which includes the subcomponents of each item (eg, the durable and expendable items needed for a blood warmer or a ventilator). It is important to note that if the PA does not correctly identify which UAC (by NSN) the unit is issued, then it is impossible to know exactly what supplies (by item, quantity, and sub-component) are supposed to be maintained within the MESs.



## ***Packing Lists***

Packing lists are essential to ensuring appropriate readiness within the section. They can and should be applied to aid bags, ambulances, aid stations, individual chests within the MES, and load plans. The PA should be very involved in managing packing lists to ensure medics and the entire section are properly prepared to treat casualties and that aid stations are set up in an efficient and organized manner. The PA should explicitly state how each item should be packed. A soldier or NCO should then develop a standardized packing list and load plan (Attachment 2) with pictures to incorporate into the section SOP.

Although opinions differ about how and what medics should carry in their aid bag, a minimum packing list should be established (Attachment 3) to provide a certain level of accountability for readiness, while allowing some personal preferences. Whatever the approach, a clear standard should be established and incorporated into the section SOP, and medics' aid bags should be inspected regularly by leadership.

## ***Narcotics Management***

Narcotics are a useful and potentially necessary part of patient care in and out of the aid station. However, they can also become a liability to the unit when not managed appropriately. Narcotics are sensitive items and should be treated as such. Each unit or MTF will have its own SOP for safeguarding, storing, managing, drawing from storage, and disposing of narcotics. PAs must become familiar with how to access these medications and the process of turning them back in. In deployment situations, while operating under predefined protocols, junior personnel (eg, line medics) can administer these medications in the absence of direct supervision. It is the PA's responsibility to ensure that the acquisition, storage, inventory, and use of narcotics are in accordance with current regulations, TCCC guidelines, SOPs, and organizational requirements.<sup>33</sup> It is also the unit PA's responsibility to know which narcotics are used forward of the aid station. Furthermore, the BN/SQN PA, in coordination with the supervising physician, must approve the medications their combat medics are authorized to carry and ensure the medics are trained in their proper use. The unit PA, and any medic carrying opioids, should

also carry and know how to use naloxone hydrochloride to counter the effects of an opioid overdose.

In a deployed setting, units may be required to adhere to theater-specific policies in addition to Army regulations. It is critical for the PA to verify current standards with higher levels of command. PAs should become familiar with narcotic SOPs as early as possible to ensure they can quickly support the unit's operational needs. Training should also be started early, before deployment (eg, during field training exercises and Combat Training Center rotations) on how the medical platoon and treatment teams will manage narcotics (Figure 12-4). The BDE surgeon cell, BDE medical supply officer, and Role 3 (eg, combat support hospital) pharmacy are excellent sources of information concerning these policies and procedures in a deployed environment. For further guidance refer to the unit SOP and ARs 40-3, *Medical, Dental, and Veterinary Care*<sup>46</sup>; 40-61, *Medical Logistics Policies* (chapter 3)<sup>40</sup>; 190-51, *Security of Unclassified Army Property* (chapter 4)<sup>33</sup>; and AR 735-5, *Property Accountability Policies*, chapter 2-8.<sup>47</sup> The following list describes a few key components of appropriate narcotic management.



**Figure 12-4.** Medical platoon, 1st Battalion, 501st Infantry Regiment, 4th Brigade, 25th Infantry Division (Airborne), conducts narcotics refresher training while deployed to Jalalabad, Afghanistan, February 10, 2018. Photograph courtesy of Major Devon Greer.

- To request controlled medications, a physician or PA must sign a DA Form 1687 (Delegation of Authority/Signature Card).
- A disinterested officer (E-7 or higher) must be appointed by the commander to perform monthly inventories.
- Narcotics must be tracked on a DA Form 3949 (Controlled Substances Record). Any change in the quantity on hand (medication given, destroyed, turned in, or lost) must be documented immediately. Lost medication should trigger an immediate investigation.
- The PA must perform weekly inventories at the hand receipt holder level and document supplies accordingly on DA Form 3949.
- The PA must ensure proper securing of narcotics per unit SOP. AR 190-51 requires a double lock and key.<sup>33</sup> One way to prevent problems is to let the PA have one key and the noncommissioned officer in charge (NCOIC) have the other, so no one can access narcotics by themselves.
- Narcotics issued to a medic must be on the medic's person at all times and under their constant supervision when not locked in an approved narcotics storage container.<sup>33,41,46</sup>
- The PA or NCOIC should provide written counseling to all personnel who will be handling narcotics to clearly communicate their expectations and the consequences of failing to meet those expectations.

### ***Deployment***

Prior to deploying, the unit PA should inquire about the Class VIII resupply process to find out how long supplies take to be delivered, what type of storage is available, what the turn-in process is for equipment and narcotics, and how regulated medical waste is disposed of. They must also know what theater-provided equipment is available (there will likely be some if the theater is well-established and other units deploy there on a rotating basis). If the deployment is to an austere environment (eg, the first units into Afghanistan or Iraq), then what the unit brings is what it will have until the supply system is established.

In addition to day-to-day management of supplies, BN/SQN PAs must be aware of the operational tempo and timelines within their unit and other supported elements. They must know when the unit will be executing missions and what type of medical support each might require. Unit PAs must resource the medics and soldiers with appropriate Class VIII supplies and knowledge of medical assets on hand. For example,

units or medics may request a medical “speedball”—a standardized package of Class VIII supplies that is prepackaged, staged, and rapidly dispersible to units in the field when needed. These supplies can be packed per unit SOP (based on the anticipated mission needs) and strategically placed (eg, with a quick reaction force or air medevac team) to facilitate rapid resupply to units in the field.

## Combat Medic Training

Combat medic specialists (68W) have several requirements they must meet to maintain their MOS qualification.<sup>48</sup> Most non-medical units are unfamiliar with the requirements and amount of time necessary to complete this training; therefore, the PA must ensure that command teams are aware of these requirements and allow appropriate time in the training schedule to accomplish them.<sup>49</sup>

Tracking all the required medical training can be a laborious process. Proof of all the training conducted must be maintained in a competency assessment file (CAF) and should be given to the medic upon leaving the unit. “Documents that reflect the individual’s employment history, education, and assessment of competence will be maintained in the CAF for a minimum of 3 years and may be purged according to local policy.”<sup>8</sup> The CAF is best maintained in a brown, six-sided folder (its assembly is outlined in Appendix C of AR 40-68<sup>8</sup>). Below are medic requirements for MOS recertification and validation:

- biennial Emergency Medical Technician (EMT) recertification by the National Registry of Emergency Medical Technicians in accordance with AR 40-68<sup>8,49</sup>;
- Basic Life Support certification at the health care provider level;
- 24 hours of continuing education equivalency refresher training;
- 48 hours of additional continuing education;
- verification of skills validation (Table VIII training), an annually required hands-on skills test (refer to Figure 1.1 of TC 8-800, *Medical Education and Demonstration of Individual Competence*<sup>49</sup>); and
- role-based TCCC training every 3 years and within 12 months before deployment.<sup>6,7</sup>

Refer to TC 8-800 for more detailed information on MOS requirements for combat medics (Figure 12-5).<sup>49</sup>



**Figure 12-5.** Captain Bryan Jow, Regimental Engineer Squadron, 2nd Cavalry Regiment, trains medics on orthopedic physical exams using a simulated patient (First Lieutenant Connor Fink), October 4, 2019. Photograph courtesy of Staff Sergeant William Maldonado.

When training medics, it is important to remember that requirements for 68W certification may differ from requirements for preparation to provide medical care in combat according to TCCC guidelines.<sup>6</sup> TCCC guidelines have been proven to reduce both morbidity and mortality in combat and are the most effective way to reduce the 25% of battlefield deaths that are potentially preventable.<sup>50</sup> The Committee on TCCC, made up of leading experts in the field of combat and tactical medicine, constantly updates TCCC guidelines as new information and equipment become available.<sup>6</sup> In the past, some medical providers have determined that a skill or medication recommended by the committee was too complex or dangerous for medics to use<sup>50</sup>; however, soldiers on the battlefield deserve the best evidence-based care that the TCCC guidelines provide. If the TCCC guidelines recommend anything medics are not regularly trained in, the PA must develop a training program to fill that knowledge or skill gap. PAs are the subject matter experts in the application of TCCC for their unit, and it is up to them to ensure the following<sup>50</sup>:

- TCCC is the standard of care for prehospital medical care in their unit.
- Commanders and unit leaders are aware of the TCCC guidelines so they can be integrated into training exercises at all levels. Initial casualty response (from point of injury to the casualty collection point) is both a tactical and medical problem. Therefore, it is a maneuver unit, not a medical, responsibility, and must be trained until its practice is automatic.
- Unit medics are trained and resourced to provide care in accordance with the most current TCCC guidelines.

## **Modified Table of Organization and Equipment Assigned Personnel**

With the transition to the Defense Health Agency, the Army eliminated the Professional Filler System (PROFIS). PROFIS providers held assignments in an MTF and deployed in support of Forces Command (FORSCOM) units, filling critical deployment shortages when needed.<sup>51</sup> To replace PROFIS and increase readiness, the MTOE Assigned Personnel (MAP) system was created. With MAP, providers are assigned to FORSCOM units and perform their clinical duty in MTFs. This reorganization makes MAP providers accountable to the unit they are assigned to, instead of the MTF they work in. With MAP, the unit can train and deploy with their organic providers, thus decreasing the likelihood of provider changeover and anonymity.

The unit PA should understand this system because MAP providers are an integral part of the unit's medical team. A MAP provider is likely to be the PA's supervising physician, but they are not always collocated at the same duty station or MTF. Requests for MAP providers stationed elsewhere to attend training must be submitted at least 90 days before the training begins.<sup>51</sup> Because the training (ie, medical specialty) and military experience of MAP personnel will vary, the PA should be prepared to assist with their orientation and integration into the unit. The PA should contact a new MAP provider as early as possible after they are identified and ensure they have needed information (packing lists, points of contact, timelines, etc) to make a smooth transition into the unit.

## **Combat Lifesaver Training**

The unit PA is also ultimately responsible for the success of the unit's CLS program.<sup>9</sup> NCOs in the medical section will likely have experience conducting CLS training, but the unit PA is charged with ensuring the training is relevant, realistic, and applicable to the combat environment. The PA should have an active role in the training while still providing ample opportunity for medics to take charge. CLS competency is an ongoing process, not just a certificate, and the PA should create opportunities for soldiers to revisit CLS principles and procedures during training.

### ***Initial Certification***

The 40-hour CLS certification course includes both didactic and practical training, in addition to a 40-question test and a hands-on test. After successful completion of the course, soldiers are considered CLS qualified for 1 year. Unit independence in conducting this training will facilitate flexibility in adjusting to the unit's training calendar.<sup>52</sup>

### ***Recertification***

Recertification of combat lifesavers via an 8-hour class must occur annually. Hands-on skills and a written test are required for recertification. Validation and recording of recertification is maintained at the unit level. It is important to monitor the recertification and training needs of the unit combat lifesavers; it is much easier to recertify combat lifesavers in smaller numbers over time than it is to wait until the unit requires a large number to be trained just before deployment, a Combat Training Center rotation, or a command inspection. Training in smaller numbers also makes it easier for the unit medical team to fit this requirement into the unit's training schedule.<sup>52</sup>

## **“Battle Rhythm”**

The following section lists some of the regular day-to-day aspects of being a BN/SQN PA.

### ***Daily***

- Sick call: see “Sick Call Operations” earlier in this chapter.
- Clinic: PAs must work a minimum of a 0.5 full-time equivalent day (dependent on MTF and unit leadership guidance).
- Administrative duties: as required, including completing paperwork for physical exams and medical clearances for training.

### ***Weekly***

- Command and staff: PAs should be prepared to answer command questions about the unit’s medical readiness and training requirements.
- Non-deployable profile reviews: meetings with command teams to review and discuss soldiers in non-deployable status and outline the way forward for these soldiers. These meetings provide an opportunity to educate leaders on medical trends that are adversely affecting their units and answer questions about medical concerns. BN/SQN, BDE, and senior mission commanders must review profiles that exceed 120, 180, and 240 days, respectively.<sup>17</sup>
- Medical platoon huddle: this meeting ensures that unit PAs who work primarily in SCMHs stay in touch with the needs of the platoon and their BN/SQN.
- Medic training meetings: unit PAs must be sure to spend adequate time with their medics. Treatment administered by medics to unit personnel is ultimately the responsibility of the PA. Clinic and leader responsibilities must not prevent PAs from keeping medics trained on both clinical and emergency medical care skills.
- Other regular meetings.

## **Reserve Component and National Guard**

### ***Unit Medical Readiness and Soldier Tracking***

In most states, reserve and National Guard unit medical readiness (immunizations, periodic health assessments, etc) is maintained at the state level during annual soldier readiness processing events, in which the entire unit designates one drill period for getting all soldiers ready to deploy. Unit PAs should still know the medical readiness status of



their unit, identify deficiencies and trends, and be able to brief the commander on how the unit can get and stay healthy. This may require coordination and communication with state medical assets.

PAs in the reserve component (RC) face different challenges in tracking non-deployable soldiers in their unit and providing a way forward to command teams. Because many RC units do not have an organic PA, and most RC soldiers are not treated within the military system, staying up to date on their injuries and treatment progress can be difficult. In addition, the PA must rely on each soldier to provide their most recent medical records from non-military medical providers. As stated in AR 40-501:

- It is the responsibility of RC soldiers to maintain their medical and dental fitness. This includes correcting remedial defects, avoiding harmful habits, and controlling weight. RC soldiers are responsible for seeking medical advice and treatment quickly when they believe their physical well-being is in question. RC soldiers must report any change in their health status that impacts their readiness status to their unit commander.
- All RC soldiers are responsible for providing the unit commander all medical documentation, including civilian health records, and for completing the annual physical health assessment. Civilian health records documenting a change which may impact their readiness status will be placed in the soldier's military health record.<sup>3</sup>

RC soldiers get their health care from civilian medical providers, who cannot write profiles. It is possible that the only military medical providers writing soldier profiles are consolidated at the state level and have no interface with command teams. To overcome this communication gap, command teams must pay close attention to their Commander Portal account to keep track of soldiers' medical conditions. The provider writing the profile also has the responsibility to clearly state the recommended next step in the patient's care, which will allow the commander to conduct proper follow-up.

However, given the time constraints on RC units, this close tracking often does not occur. Additionally, RC soldiers may have ongoing, untreated medical conditions because they might not participate in the daily physical training or activities performed by active duty soldiers. Untreated conditions may only become an issue when it is

time to perform the Army fitness test, attend a field training exercise, or deploy. There may be soldiers who are not ready to deploy, yet lack a profile. As a result, command teams may have a false sense of security regarding the readiness of their unit. Thus it is important that RC providers be familiar with AR 40-501 and the requirements for being medically fit.<sup>3</sup>

As soon as a medical condition is identified, a profile must be written. It can be helpful to outline a treatment plan on the profile as permitted by HIPAA. Command teams must track these soldiers closely because there is often no follow-up with a military medical provider once the soldier's profile expires. Soldiers and leaders must remember that RC soldiers have the same maximum 12 months to rectify an ailment as do active duty soldiers. Beyond the 12 months, or as soon as the medical retention decision point has been met, a permanent profile should be completed if the soldier can perform basic soldier functions and the duties of their MOS per DA PAM 611-21.<sup>3,24</sup> If not, the RC soldier should be referred to a MAR2 or IDES as appropriate.

### ***Line of Duty***

The line of duty (LD, or LOD, as it is often referred to) determination is a tool commanders can use to determine if an injury, illness, disease, or death occurred while a service member was in an authorized duty status. This determination is used to decide if the Department of Defense is responsible for covering the resulting costs and associated entitlements. AR 600-8-4, *Line of Duty Policy, Procedures, and Investigations*, chapter 2, states, "The Army LOD Program is a commander's program which essentially protects the interest of both the Soldier and the U.S. Government where service is interrupted by injury, disease or death."<sup>53(p6)</sup> The frequency of required LD determinations is higher in the RC because its soldiers are not on duty continuously.<sup>54</sup> LD determinations can have significant financial and professional impacts on soldiers and their families. Although initiating an LD determination is a command responsibility, both active duty and RC PAs should be familiar with the process, and advise command when its use is appropriate. It is especially important when an RC soldier is medically evacuated from theater because a determination that an injury or other condition was incurred in the line of duty is required for admission into a warrior transition unit or BN/SQN.<sup>54</sup>

Deciding whether an injury, illness, or death occurred on duty may or may not require an investigation. If warranted, investigations “are conducted essentially to arrive at a determination of whether misconduct or negligence was involved in the disease, injury, or death and, if so, to what degree. Depending on the circumstances of the case, an LOD investigation may or may not be required to make this determination.”<sup>53(p6)</sup> AR 600-8-4, section 2-2 lists the conditions when an LD investigation must be performed. Investigations are initiated on DA Form 2173 and can be performed informally or formally by the chain of command.<sup>53</sup>

LD determinations for the National Guard must be input into the Electronic Medical Management Processing System (eMMPS). Without a completed LD investigation in eMMPS, the service member will not be authorized for any benefits associated with the incident. PAs should check their unit SOP to determine who is responsible for entering this information into eMMPS.

### ***Incapacitation of Reserve Component Soldiers***

When an RC soldier sustains an injury or aggravates a preexisting injury, illness, or disease while on active duty, or on inactive duty training orders, that either restricts performance of military duties or causes a loss of income from a civilian job, the soldier can submit an incapacitation pay claim to help supplement lost financial income.<sup>55,56</sup> AR 135-381, *Incapacitation of Reserve Component Soldiers*,<sup>55</sup> and DA PAM 135-381, *Incapacitation of Reserve Component Soldiers Processing Procedures*,<sup>56</sup> provide further details regarding incapacitation of RC soldiers.

## **Being a Good Steward of the Army Profession**

The term “stewardship” expresses the Army’s responsibility to strengthen the soldier’s profession. “It includes caring for the people and resources entrusted to [us] by the American people, ensuring Army forces are ready, now and in the future, to accomplish the Army’s missions.”<sup>57</sup> Officers and leaders have a duty to teach, coach, and mentor their subordinates to groom the next generation of Army leaders. Good stewardship is about investing in people and the organization before oneself. PAs should always strive to leave their BN, SQN, medical platoon, or unit better than they found it. Ways to do this include:

- improving SOPs and continuity books to establish best practices for future PAs and MAP providers<sup>58</sup>;
- teaching medics and encouraging those who have the desire and aptitude to become PAs;
- mentoring soldiers and NCOs to assist them in performing their assigned duties or preparing for positions of increased responsibility;
- focusing on long-term sustainability over short-term success by establishing systems to accomplish routine tasks that are sustainable in the future; and
- ensuring the medical platoon honors traditions such as military customs and courtesies, the “hail and farewell,” and recognition of good performance (awards, certificates of achievement, coins, etc) (Figure 12-6).



**Figure 12-6.** Medical platoon, 2nd Battalion, 377 Parachute Field Artillery Regiment, 4th Brigade, 25th Infantry Division (Airborne), poses for a group photo after completing a month-long rotation at the Joint Forces Training Center, Camp Shelby, Mississippi, October 15, 2019. Photograph courtesy of Captain Isaias Lopez.

## Lessons Learned

The most fundamental responsibility of the BN/SQN PA is understanding their role in the unit. The unit PA is the commander's medical advisor, responsible for providing informed decisions regarding the health, welfare, and readiness of the unit. As such, their primary duty is working to meet the commander's readiness goals. To effectively do this, they must work in conjunction with the unit's physical therapist, behavioral health officer, nurse case managers, and the specialty clinics, both on post and in the surrounding area. The role and responsibilities of the PA are detailed in ATP 4-02.3, *Army Health System Support to Maneuver Forces*.<sup>29</sup> A thorough understanding of this publication is integral to the PAs success in the BN/SQN.

When arriving at the unit, the PA must become familiar with the base hospital, its clinics, its referral guidelines, and the civilian trauma centers soldiers are likely to be transferred to. The unit's mission and upcoming training events should be discussed with the BN/SQN executive officer, BDE PA, and BDE surgeon. Each person should be seen as a mentor and resource to evaluate performance. Relationships should be built with the other providers in the clinic. It is likely the PA will need their help while assigned to the BDE. The PA should cultivate a good working relationship with the medical platoon sergeant, clinic staff, and medical operations officer (if allocated in the MTOE). The more the PA is integrated into the team, the better they are able to support the unit (Figure 12-7). The PA should take part in organization days, unit/formation runs, hail and farewells, unit balls, family readiness group meetings, and other events. Be a part of the unit!

The BN/SQN PA must also take time to improve their medical practice through continuing their medical and military education, training the unit's medics, and mentoring the medical operations officer, platoon sergeant, and junior medics. The better trained these individuals are, the more the PA is able to focus on providing excellent medical care to the unit's soldiers. Patients should be educated on medical diagnoses, the clinic's procedures, and SOPs to increase understanding and decrease clinic return rates. If soldiers are transferred to civilian emergency rooms or admitted to off-post hospitals, the PA should take the opportunity to visit them during



**Figure 12-7.** First Lieutenant Danielle Hicks, a battalion physician assistant with the 2-43 Air Defense Artillery Battalion from Fort Bliss, Texas, treats a patient as combat medic Private First Class Jenna Andrada assists during a deployment in Al Asad Air Base, Iraq, in February 2020. Photograph courtesy of First Lieutenant Danielle Hicks.

their recovery. Without violating HIPAA, the PA should be available to speak with spouses, relatives, or other family members about a soldier's disposition. It must be understood that evaluating patients in clinic may come second to soldier readiness processing, PHAs, or immunization rodeos specified by the commander to increase deployability. Readiness is the first priority!

## **Conclusion**

The PA is the linchpin in the Army Medical Department's mission to conserve the fighting strength. PAs proactively shape their unit's medical readiness by providing mentorship and direction to medical personnel, conducting expert patient care, advising unit commanders, and planning for an array of real-world operations. The unit PA is intimately involved in the aid station, the most forward location providing an MTF. They also serve as liaison between soldiers and their leaders in matters of

health protection, combat health readiness, and preventive care. The discussions outlined in this chapter are an effort to ensure that future BN/SQN PAs are educated and trained in the management of their duties and responsibilities in this critical role.

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LIN Characteristics										
Equipment Characteristics										
LIN	Desc	Corp	Proc	Labl	Stk	Inst	Inst	Inst	Stk	Sub
1450499	200	4	30 30	30 30	30 30	30 30	30 30	30 30	30 30	30 30
<b>LIN Properties</b>										
<input checked="" type="checkbox"/>	Documentable on MTOE	YES								
<input checked="" type="checkbox"/>	Documentable on TDA	YES								
<input checked="" type="checkbox"/>	4000 Current Request	3								
<input checked="" type="checkbox"/>	4000 LHM Cycle Request Command (LDMC)	Not Applicable, Supply Class not BCE MAMP								
<input checked="" type="checkbox"/>	4000 Tact Vehicle	Not Applicable								
<input checked="" type="checkbox"/>	4000 Non Tact Vehicle	Not Applicable								
<input checked="" type="checkbox"/>	CSEA Comm. Svc. Logistics Activity	Not Controlled								
<input checked="" type="checkbox"/>	300 (To accompany troops)	Not Qualified								
<input checked="" type="checkbox"/>	300	SAB000								
<input checked="" type="checkbox"/>	30 700-20 Sub LHM	No Substitutes Found								
<input checked="" type="checkbox"/>	30 700-20 Convaid/TCC	No Conversions or TCC Found								
<b>NSN Managed LIN Information</b>										
Agency (NSN Number)										
MTOE Cat (as reported by cDAP/SLARMS)										
Synchronization Staff Officer (SSO) Name										
Current Health Information										
Part	NSN	Inst	Inst	Inst	Inst	Inst	Inst	Inst	Inst	Term
1450499	MES TACTICAL COMBAT MEDICAL CARE (TMC)	SAB000	SAB000	M23400	90					
<b>National Stock Number (NSN) Information</b>										
NSN	UAC	QTR	Qty	Inst	Inst	Inst	Inst	Inst	Inst	Term
14545 01 228 3887	B	2	84	2						
14545 01 499 2238	B	2	84	2						
14545 01 074 8120	S	2	84	2						
14545 01 905 3927	B	2	84	2						
14545 01 605 1778	B	2	84	2						
14545 01 847 5040	A	2	84	2						
<b>Is Label 30-700-20 (Chap. 2/4/1)</b>										
Yes										
<b>Part</b>										
Combat Service Support Subelement										

On this MTOE, there are different national stock numbers (NSNs) issued to meet line item number (LIN) authorizations. In this example, six different NSNs are issued for the LIN M30499. The MESs have NSNs that correlate to a specific UAC, which can be located on the USAMMA website via the MMIP, as identified in the previous example.

The screenshot displays the 'Unit Assemblage Search' interface. At the top, there are search filters for 'UAC Code', 'NSN Number', and 'LIN'. Below the filters is a table of results. The table has columns for 'UAC', 'Image', 'NSN', 'Description', 'DC Code', and 'LIN'. There are six rows of data, each representing a different version of the list of equipment contained within the TCMC MES. Red boxes highlight the UAC, NSN, and LIN columns. The UAC column contains values: 300, 200, 300, 200, 200, 200. The NSN column contains values: 999-01-999-200, 999-01-999-200, 999-01-999-175, 999-01-999-200, 999-01-999-200, 999-01-220-200. The LIN column contains values: 30499, 30499, 30499, 30499, 30499, 30499. The table is titled 'Records: 1 of 6' and 'Current Page: 1'. At the bottom, there are navigation links: Home, Contact, Privacy and Security, External Link Disclaimer, Position of Honorary AAFPCW, and Accessibility.

UAC	Image	NSN	Description	DC Code	LIN
300		999-01-999-200	MEDICAL EQUIPMENT SET TACTICAL COMBAT MEDICAL CARE	304	30499
200		999-01-999-200	MEDICAL EQUIPMENT SET TACTICAL COMBAT MEDICAL CARE	300	30499
300		999-01-999-175	MEDICAL EQUIPMENT SET TACTICAL COMBAT MEDICAL CARE	307	30499
200		999-01-999-200	MEDICAL EQUIPMENT SET TACTICAL COMBAT MEDICAL CARE	300	30499
200		999-01-999-200	MEDICAL EQUIPMENT SET TACTICAL COMBAT MEDICAL CARE	300	30499
200		999-01-220-200	MEDICAL EQUIPMENT SET TACTICAL COMBAT MEDICAL CARE	300	30499

In this example of a USAMMA MMIP search for LIN 30499 (MES Tactical Combat Medical Care [TCMC]), six UACs and the associated NSNs are shown, each representing a different version of the list of equipment contained within the TCMC MES. Additionally, the hyperlinked UAC will provide the assemblage list, and each item on the list is hyperlinked to additional information including the subcomponents of each item on the list, both durable and expendable.



## ATTACHMENT 2: EXAMPLE OF BATTALION AID STATION LOAD PLANS

VEHICLE LOAD CARD						
(TB 55-46- 1 & 2) and (FORSCOM Reg 55-1)						
UNIT UIC	VEH LIN NO	NOMEN / MODEL NO	SEC / PLT	SHIPMENT UNIT NO	DATE COMPILED	
WAJRT0	HQ-10	M1078	MED/TMT		21-May-10	
LENGTH OF VEH		WIDTH OF VEH		HEIGHT OF VEH		VEH EMPTY WT
OPERATIONAL	REDUCED	OPERATIONAL	REDUCED	OPERATIONAL	REDUCED	
CARGO AREA			CARGO AREA CUBIC FEET			
LENGTH	WIDTH	HEIGHT	OPERATIONAL	REDUCED		
NOT COMPUTED FOR HS TO MS			TEST LOAD VERIFIED BY			DATE
CB/CG IS		INCHED FROM				

  

CARGO LOC NO	CARGO DESCRIPTION & TYPE PACK	NO OF ITEMS	PC CUBIC FEET	TOTAL CUBIC FEET	TOTAL WT
1	*MES CHEM PATIENT DECONTAMINATION	4.5			
2	*MES CHEM PATIENT TREATMENT	3			
3	*MES TACTICAL COMBAT CASUALTY CARE	25			
4 / 5 / 6	LITTERS REG / RAVEN LITTERS / LITTER STANDS	10 / 2 / 4			
7	SUCTION APPARATUS	1			
8	OXYGEN TANKS	2			
9	SPINE BOARDS	2			
10	HEATER	13			
11	GENERATOR - HQ10G	1			
12	OLD MC4 COMPUTERS (GREEN CASE)	3			
13	NEW MC4 PRINTER (BLACK CASE)	1			
14	HYPOTHERMIA MANAGEMENT KITS (HPMK)				
15	MED DRAWER CHEST	1			
16 / 17	PLASTIC ROLLS (CHEM DECON) / DECON BUCKETS	1			
18 / 19	CAMO NET / POLES	1 / 1 SET			
20	PERSONAL BAGS (1 RUCK / 1 DUFFEL EA)	6			

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VEHICLE LOAD CARD							
(TB 55-46- 1 & 2) and (FORSCOM Reg 55-1)							
UNIT UIC		VEH LIN NO		NOMEN / MODEL NO		SEC 7/PLY	SHIPMENT UNIT NO
WAJRTD		HQ-85		M998		MED/TMT	20-May-10
LENGTH OF VEH		WIDTH OF VEH		HEIGHT OF VEH		VEH EMPTY WT	
OPERATIONAL	REDUCED	OPERATIONAL	REDUCED	OPERATIONAL	REDUCED		
CARGO AREA				CARGO AREA CUBIC FEET			
LENGTH		WIDTH		HEIGHT		OPERATIONAL	
						REDUCED	
NOT COMPUTED FOR HS TO MS				TEST LOAD VERIFIED BY			DATE
CB/CG IS		INCHED FROM					
CARGO LOC NO	CARGO DESCRIPTION & TYPE PACK			NO OF ITEMS	PC CUBIC FEET	TOTAL CUBIC FEET	TOTAL WT
1	LZ MARKING KIT			1			
2	OE-254			1			
3	PERSONAL BAGS (1 RUCK / 1 DUFFEL EA)			4			
4	TRAINING FILES/SOPs/FMs			1			
5	CLASS II SUPPLIES			1			
6	MREs			2			
7	MC4 LAPTOP			2			
8	NIPR LAPTOP			2			
9	CAMO NET W/ POLES			1 EA			
10	MC4 PRINTER			1			
11	FUEL CAN			2			

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## ATTACHMENT 3. M9 AID BAG PACKING LIST

### OUTSIDE (THREADED THROUGH OR BANDED TO MOLLE WEBBING WITH HEAVY DUTY

#### RUBBER BANDS)

- 1 PR. - SCISSORS W/ RETRACTABLE LANYARD
- 1 EA. - STRAP CUTTER W/ RETRACTABLE LANYARD
- 2 EA. - SHARPIE MARKER
- 1 EA. - CARABINER
- 1 EA. - BACKROLLED GORILLA TAPE ON PVC TUBING

#### LOWER COMPARTMENT

- 1 EA. IV SET CONSISTING OF THE FOLLOWING:
  - 1 GALLON ZIP LOCK BAG
  - 1 PENROSE DRAIN (WRAPPED AROUND THE ZIP LOCK BAG)
  - 1 EA. - 500ML BAG OF HEXTEND
  - 3 EA. - 18 GA 1.25" ANGIOCATHETERS
  - 2 EA. - SALINE LOCKS
  - 4 EA. - ALCOHOL PREPS
  - 2 EA. - TAGEDERM/TRANSPARENT DRESSINGS
  - 2 EA. - 18 GA. 1.5" NEEDLES
  - 2 EA. - 10ML PRE-FILLED SYRINGES (NORMAL SALINE FLUSH)
  - 4 EA. - 4X4 GAUZE
  - 1 PR. - EXAM GLOVES
- 1 EA. - FAST IO KIT CONSISTING OF THE FOLLOWING:
  - 1 EA. - QUART ZIP LOCK BAG
  - 1 EA. - FAST IO DEVICE AND ACCOMPANYING EQUIPMENT
  - 1 EA. - SALINE LOCK

- 2 EA. - ALCOHOL PREPS
- 1 EA. - 10 ML PRE-FILLED SYRINGES (NORMAL SALINE FLUSH)
- 1 EA. - 500 ML BAG HEXTEND
- 1 EA. - 100 ML BAG 0.9% NAACL (for TXA/ABX)
- 1 EA. - PRESSURE INFUSER
- 1 EA. - SHARPS SHUTTLE

**MAIN COMPARTMENT**

- 1 EA. - CRIC SET
- 1 EA. - BVM
- 1 EA.- NONIN PULSE OXIMETER
- 1 EA.- BLIZZARD BLANKET
- 1 EA.- ABDOMINAL DRESSING (W/ SMALL TRASH BAG AND DONUT)
- 1 EA.- PETZL TIKKA TACTICAL PLUS HEADLAMP
- 1 EA. - SIGNAL PACK CONSISTING OF THE FOLLOWING:
  - 1 EA. - SILK SIGNAL PANEL (for example MPIL Mk 1 by BattleSystems,LLC)
  - 3 EA.- BLUE MINI-CHEMLIGHTS
  - 1 EA. - SIGNAL MIRROR
  - 5 EA. - AAA BATTERIES
- 1-2 EA. - BATTLE PACKS IN 1 GALLON ZIP LOCK BAGS CONSISTING OF THE FOLLOWING:
  - 1 EA. - TRAUMA DRESSING
  - 1 EA. - 6" ACE WRAP
  - 2 EA. - COMPRESSED GAUZE
  - 2 EA. - CRAVATS
  - 2 EA. - - OCCLUSIVE DRESSINGS (at least 1 vented)

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- 2 EA. – 14 GA. 3.25" ANGIOCATHETERS (NCD)
- 1 EA. – NASAL TRUMPET (NPA)
- 2 EA. – TOURNIQUETS
- 1 EA. – 3" SILK TAPE
- 1 EA. – SHARPIE MARKER
- 1 PR. – EXAM GLOVES
- 1 EA. – RED MINI-CHEMLIGHT
- 1 EA. – GREEN MINI-CHEMLIGHT
- 1 EA. – TCCC CARD (DD FORM 1380)

### **BOTTOM OF BAG (BENEATH NETTING)**

- 1 EA. – READY-HEAT BLANKET
- 1 EA. – SAM SPLINT
- 1 EA. – PRESSURE BOARD
- 1 EA. – POLELESS LITTER

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