

## Chapter 7

**Sustaining the Soldier****Contents**

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**SOLDIER SUPPLY SUPPORT**

The companies in the multifunctional battalions and the AMCO of the DISCOM provide supply support to the LID. The supply companies provide Class I through VII. The medical companies provide Class VIII. The maintenance companies provide Class IX. This chapter addresses Class I, II, and VI and water. Chapter 8 discusses Class IV and V as part of arming the force. Chapter 9 discusses Class III as part of fueling the force. Chapter 10 discusses Class VII and IX supply as part of fixing the force.

**CONCEPTS**

Due to mobility requirements and austere storage and transportation assets, the DISCOM has on hand only a limited quantity and variety of supplies at any given time. As a result, the DISCOM puts several supply principles to work to cut down on the response time between initial request and later issue of an item. Many of these supply support concepts also apply to arming and fueling the force.

**Push System**

A push system is the initial go-to-war supply system in an undeveloped theater. Supply elements send pre-planned packages of selected supplies forward to replenish expended supplies in anticipation of requirements of supported units. They base initial quantities on strength data and historical demand. When the theater stabilizes, the supply system in some cases becomes a pull system based on actual demand. However, as discussed in Chapter 1, supporters anticipate requirements whenever possible, rather than react to requests. This is especially true for heavily engaged units during high-intensity operations. Such units may not ask for supplies because of gaps in the chain of command or intensive jamming on the battlefield. In such cases, the appropriate DISCOM commander coordinates with the DMMC to generate requisitions to support units with standard

packages. He adjusts these packages for changes in personnel and equipment and the tactical situation. Supply elements also push supplies to support a deep operation.

**Throughput**

Throughput distribution is the main distribution method used in the LID. Throughput distribution is a method of shipment that bypasses one or more echelons in the supply system to lessen handling and speed delivery forward. Supplies are primarily throughput to the FSBs from the corps. Whenever possible, Class IV barrier materials and some Class VII major end items go directly to the user in the brigade area. When most of the load is for a specific unit and the situation allows, the transporter delivers other classes of supply directly to the requesting unit.

**Supply Point and Unit Distribution**

To tailor supply distribution, the DISCOM uses a combination of supply point and unit distribution to support the division. With supply point distribution, unit representatives come to the supply points in the DSA and the BSA to pick up their supplies. To provide a quick turnaround for the using units, the supply points stagger the unit pickup times. They also set up to provide a smooth traffic flow through the supply areas. With unit distribution, organic or corps assets deliver supplies to the using units. Personnel use unit distribution to deliver fuel and water to light infantry battalions in the brigade area. Corps personnel also use unit distribution to deliver Class IV barrier materials as discussed in the paragraph on throughput. They deliver other classes of supply using unit distribution when the tactical situation permits and transportation assets are available. They accomplish emergency resupply using unit distribution via motor or air transport.

**Reconfigured Unit Loads**

The PUL concept provides streamlined supply support to the LID with its austere logistics structure. A PUL

is a predetermined quantity of selected supplies configured for a specific number of troops for a specific period, such as chemical protective clothing. It is also configured for a specific purpose, such as 100 meters of barrier material. Supply personnel pack it in a disposable container or on a standard pallet with defined cube limits to ease transfer from aircraft to vehicles and PLS. It is airlift and airdrop capable. Supply personnel assemble and store it at CONUS depots with limited stockage at the corps. Units request it by single-line requisition through normal supply channels. Each PUL configuration has its own NSN which simplifies requests at the unit level. It is throughput as far forward as possible to limit the burden on division units.

There are now three types of PULs. The Class IV barrier PUL consists of all the supplies necessary to employ 100 meters of hasty barrier material. The administrative PUL consists of all the administrative and housekeeping supplies designed to support a battalion-sized element for 15 days. The chemical defense equipment PUL contains MOPP gear and selected chemical-related Class IX items for 25 soldiers.

### Unit Configured Loads

Another method of resupply is the UCL. The UCL concept is a refinement of the throughput process. COSCOM supply personnel configure the UCL. It consists of an assortment of supply items and, unlike the PUL, units request it using multiple NSNs. Supply personnel assemble it for a specific unit and throughput it to the requester by air or ground delivery. Commanders determine UCL contents in coordination with the S4 in advance whenever possible.

## SUPPLY OPERATIONS

### Class I

The DISCOM provides subsistence through the HSCs in the DSA and the BSAs. Figure 7-1 shows the flow of supplies. The Army field feeding concept calls for three quality meals per day. This includes individual MREs and group rations (T, B, and A). Introduction of any rations other than MREs, unitized B Rations, and T Rations requires augmentation of the Class I distribution system. The augmentation consists of a perishable subsistence team from the corps perishable subsistence platoon.

The DMMC manages Class I supplies. Personnel provide Class I supplies based on personnel strength reports from units. The supply is preplanned. This eliminates the requirement for complicated ration requests from

units. Initially, units subsist on the MREs in their basic load, and Class I supplies are pushed into the theater. Supply units replenish their basic load as soon as supply lines are established. As soon as possible, the theater commander directs the introduction of first group meal. The division Class I points issue sufficient rations to feed three quality meals to a given unit based on the prescribed menu. If there is a change in the type of rations for a certain period, the unit receiving the rations indicates the type of ration needed. For example, an infantry brigade wants individual meals on certain days because a tactical maneuver prohibits the preparation of a group meal. To get the individual meal, the brigade S4 notifies the FSB HSC. If possible, the brigade S4 forwards the change in the type of rations at least 24 to 48 hours in advance of the required delivery date. This facilitates the change in corps throughput deliveries. If 24-hour notice is not possible, corps deliveries may have to go to the HSC in the DSA. In such cases, personnel issue the required rations from division reserve stocks.

The Class I manager, located in the DMMC, is responsible for —

- Coordinating issue/delivery frequency and turn-in procedures. He also publishes the delivery schedule by message.
- Determining the type rations the division is issued. He bases this on commander's input through the G4, strength reports, authorized reserves, ration change requests, and special requirements.
- Submitting a consolidated division ration request to the CMMC 24 to 72 hours before required delivery. (The length of time depends on the tactical situation and the COSCOM SOP.) As a minimum, the request shows the type and quantity of rations for each of the four Class I points (one operated in each BSA and one in the DSA).
- Submitting a subsistence status report to the CMMC to help in planning. This shows the type and quantities of subsistence on hand in the division. The DMMC determines stock requirements based on several factors. These factors include the tactical situation, mobility requirements, availability of storage assets, lengths of LOCs, and dependability of resupply channels.
- Directing issue from the division reserve or placing special demands on the CMMC in emergencies.

The division receives rations from the COSCOM. Personnel at the Class I points in the DSA and BSA unload

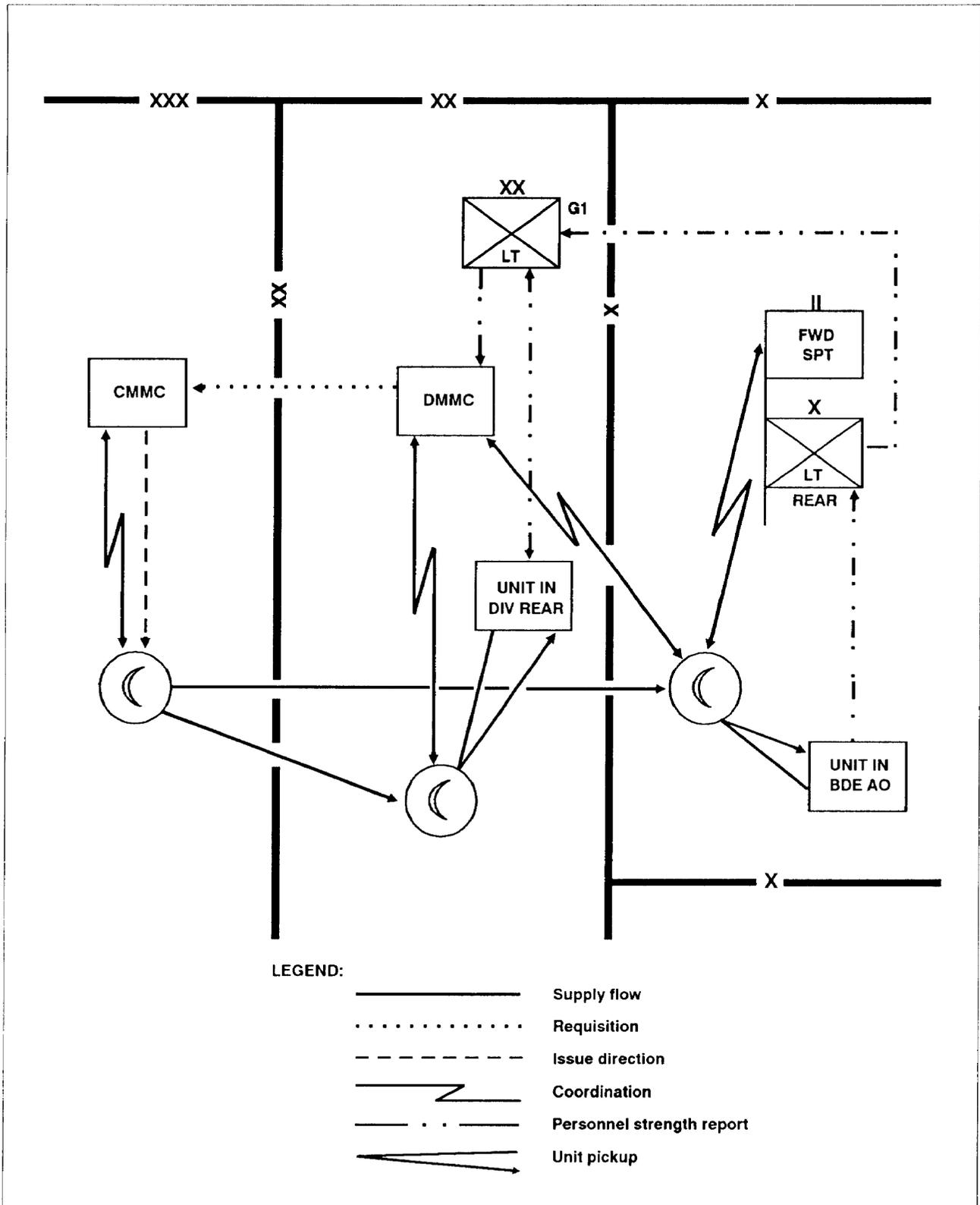


Figure 7-1. Class I flow (initial push system).

the shipment. They inspect it for type, number, and condition before signing for it. They break down the rations into unit or item piles depending on the type of ration and time and equipment available. Supported units pick up Class I supplies at the division main or forward Class I points using organic transportation. DISCOM accountability ends when the user completes the receipt at the Class I point. FM 10-23 discusses the receipt, storage, and issue of rations. As soon as the tactical situation permits and logistics capabilities exist, the LID uses the pull system as prescribed in AR 30-21.

### **Class II**

Supply doctrine limits Class II stockage in the LID to essential items only since clothing and individual equipment are bulky and impede mobility. Units request items on a line-item basis, as required. Supply personnel provide selected items, such as NBC overgarments, as PULs.

The HSCs maintain a limited amount of Class II items on hand for issue to supported units. This small ASL consists of mission-essential, expendable items required to support combat operations such as protective masks. Supply personnel determine levels of stockage within the division according to AR 710-2. Supply points stock durable Class II items such as tools only on an exception basis when authorized to support a specific operation.

Units in the forward areas submit requests to the appropriate HSC in the BSA. Units in the division rear submit them to the HSC in the DSA. The property book teams process requests for nonexpendable items.

If the item is on hand in the DSA or BSA, supply personnel issue it. If the item is not on hand in the division, the Class II manager in the DMMC sends a requisition to the CMMC. If the item is available in the corps, the CMMC sends an MRO to a GS supply company. The GS supply company arranges for corps transportation of the item to the appropriate HSC. The requesting unit picks the item up there. If required, and the situation permits, a high-priority item is throughput by division or corps transport to the requesting unit. Figure 7-2 shows the flow of Class II items.

Intense combat and sustained operations in an NBC environment increase the demand for Class II items. As soon as they know tactical intentions, supply personnel make arrangements for scheduled resupply of required protective overgarments and other Class II NBC-related items and equipment.

The HSCs or, if appropriate, the gaining unit's supply element, reequip soldiers returning to duty from MTFs

in the division area. If the gaining unit has support elements operating in the vicinity of the MTF (for example, a field train in the BSA with the clearing station), the SOP may require the unit bring personal equipment when it picks up personnel returning to duty. If the gaining unit does not have elements operating near the MTF the SOP may require medical personnel to pick up clothing and essential protective gear at the supply point to provide minimum protection before the soldier returns to duty. The MTF does not issue individual weapons.

### **Class VI**

The supply system furnishes Class VI items without cost to the soldier. This occurs after units operate under combat conditions for more than 15 days without AAFES support or access to civilian markets. In early, highly mobile, or intense conflicts Class VI is limited to items required for the minimum personal hygiene, comfort, and welfare of the soldier. Items, such as essential toilet articles and confections, are issued in a sundry pack through Class I channels. The Class I manager in the DMMC coordinates the issue of these sundry packs, when available, as directed by the division G4. More information on Class VI items is FM 10-27.

### **Maps**

Forward units get unclassified maps through the HSC in the BSA based on requirements set by the brigade S2/S3. Units in the division rear get them through the Class II, III (packaged), IV and VII distribution point. The ASL management branch of the DMMC sends requests for unclassified maps to the CMMC. Units submit classified map requirements through command channels to the intelligence staff officer.

### **Water Purification and Distribution**

The DISCOM plans, directs, and supervises the division's water purification and water distribution support. The DISCOM commander gives guidance to the DMMC on handling water functions for the division. The Class I and III and water branch in the DMMC prepares detailed plans and policies on the operation of water production and distribution points. Responsibilities of the Class I and III and water branch are detailed in Chapter 2.

Division units submit water requirements, usually consolidated at battalion level, to the water section. The water section of the HSC uses standard computations to determine the total daily requirement for water and

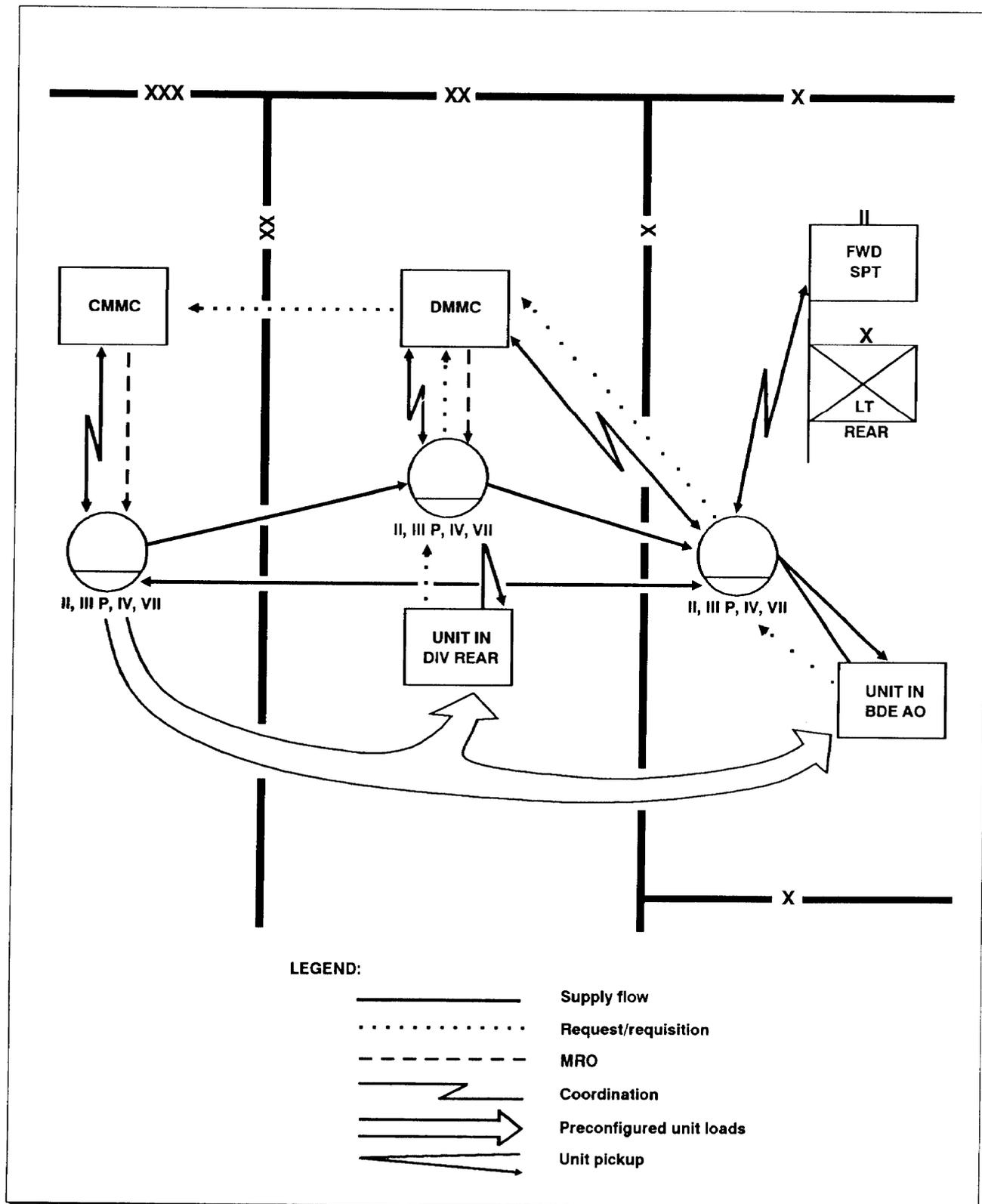


Figure 7-2. Class II, III P, IV, VII flow.

forwards the total daily requirement to the DMMC. The Class I and III and water branch checks purification and storage capabilities of each point and diverts supplies if necessary. It consolidates and submits the total daily water requirements to the CMMC.

The water section of the MSB HSC provides potable water to the division. This section is responsible for purification, storage, issue, and limited distribution. The water section operates up to three water points in the DSA or in or near each BSA. It provides water using both unit and supply point distribution. It delivers water to the infantry battalion

field trains in the BSA. It supplies all other units by supply point distribution except in cases of emergency resupply. Units operating in the division rear go to the nearest water point for water.

In arid environments, augmentation is necessary. The augmentation consists of a 120,000-gallon distribution system for the DSA, a 40,000-gallon system for each BSA, six truck drivers, and three FAWPSSs to increase distribution capabilities. More information on water purification and distribution operations is in FM 10-52.

## HEALTH SERVICE SUPPORT

HSS plays a fundamental role in developing and maintaining combat power. Supporting the health of fighting forces is a critical factor in the success of the LID.

### HSS CONCEPTS

#### Levels of Care

HSS is arranged in levels of care. Each level reflects an increase in capability, yet includes the capabilities found in lower levels. Within the LID, there are two levels of HSS: Echelons I and II, or unit and division level.

**Echelon I or Unit Level.** Unit-level HSS consists of disease prevention, patient collection and evacuation, emergency medical care, and routine sick call support to return to duty those personnel not requiring higher level care. Care and treatment are provided by individual soldiers, combat lifesavers, combat medics, and the treatment squad. Major emphasis is placed on those measures, such as maintaining an airway and preventing shock, necessary to resuscitate, stabilize, and allow for evacuation to the next level of care. Unit-level care involves the following:

- **Self-aid/buddy-aid.** Each individual soldier is trained to proficiency in a variety of specific first aid and emergency decontamination procedures. This training enables the soldier or a buddy to apply immediate care to alleviate a life-threatening situation.
- **Combat lifesaver.** This individual is a nonmedical unit member selected by the unit commander for additional training to increase medical skills beyond basic first aid procedures. This individual assists the combat medic by providing immediate

care for injuries. A minimum of one individual per squad, crew, team, or equivalent-sized unit receives training. Training is provided by HSS personnel. The training program is managed by the senior medical person designated by the commander. The performance of combat lifesaver duties does not detract from the performance of the soldier's primary duties and responsibilities.

- **Combat medic (aidman).** This person is the first individual in the HSS chain capable of making medical-substantiated decisions based on formal training. He provides EMT and medical care based on medical MOS-specific training.
- **Battalion aid stations.** Treatment squads are trained and equipped to provide ATM or trauma treatment at BASS for the battlefield casualty. They also conduct sick call. Organic medical platoons/sections operating BASS provide unit medical care to combat battalions and some CS battalions. Units without organic Level I medical capability obtain support from the nearest supporting Level I or II MTF (medical platoons or medical company organic to the DISCOM). Examples of such units include elements of the combat engineer battalion and the artillery batteries. All medical units having a treatment/medical evacuation capability also have an area support responsibility to adjacent units that do not have sufficient organic medical capability.

**Echelon II or Division Level.** The medical companies in the DSA and BSAs provide this level of support. They duplicate unit-level resources. They also provide expanded services with the addition of dental, x-ray,

medical laboratory, and patient-holding capabilities. The medical company headquarters operating in the DSA provides additional HSS in the areas of preventive medicine, mental health, optometry, and medical logistics and maintenance. HSS at this echelon is characterized by initiating resuscitative care. The largest number of patients returning to duty within the division comes from this level of support. For those soldiers not RTD within the division, the system provides care necessary to maintain life and limb while they are awaiting evacuation to corps level hospitals.

### Advanced Trauma Management

ATM is a system of managing traumatically injured patients. It is an initial emergency treatment phase where personnel apply medical skills and judgment of a higher degree in the immediate and effective management of the acutely injured or wounded (trauma) patient. Physicians, dental officers, and physician assistants receive training in ATM procedures. Personnel trained in EMT help these physicians and physician assistants, EMT characteristics are —

- Rapid and accurate assessment of the patient's condition.
- Provision for resuscitation and stabilization on a priority basis.
- Arrangement for evacuation to the appropriate MTF.
- Assurance optimum care is provided.

Treatment procedures include the use of intravenous fluids and antibiotics and the preservation of the patient's airway by mechanical or surgical insertion of a breathing tube (intubation). They also include control of bleeding and the application of more secure splints and bandages. This comprehensive care is most effective when personnel provide it within 30 minutes of wounding or injuring. Unit- and division-level treatment squads provide ATM.

The supported force needs HSS during and immediately after combat engagements. HSS has equal communications capability and equal or greater mobility than the supported unit.

During those times when the division is not in battle, HSS works to maintain combat power by treating and returning to duty soldiers suffering from minor illnesses or injuries. Also during this period, HSS efforts help commanders in applying preventive medicine measures to reduce the incidence of DNBI.

### Modular Medical Support System

All division medical units and resources are organized by function into modules. This enables the commander to task organize his medical assets to meet varied medical mission requirements. The modules are duplicated throughout the division. This eases rapid reinforcement at both the unit and division level of HSS. There are five basic modules. They are —

- **Combat medic.** This module consists of one combat medic and his medical basic load. He is part of the medical platoon/section in combat and CS battalions and is attached to platoons/companies of maneuver and support elements.
- **Treatment squad.** This squad consists of one physician, one physician's assistant, two EMT NCOs, and four medical specialists. The physician and physician's assistant are trained to provide ATM to the battlefield casualty. The squad operates out of two HMMWVs (or vehicles configured for trauma treatment). It has the ability to deploy as two treatment teams as the tactical situation requires. The physician and one EMT NCO and two medical specialists make up one team. The physician's assistant and one EMT NCO and two medical specialists make up the other team. Treatment squads are expansion elements of the division clearing station. The MSB treatment squads are the same as those in the forward support medical company and the infantry battalion's medical platoon. These squads reinforce other division medical elements. They directly support rear area task force operations, inclusive of area damage control and mass casualty operations.
- **Ambulance squad.** An ambulance squad consists of two ambulance teams. Each team consists of one aide/evacuation NCO or specialist, one medical specialist/ambulance driver, and one HMMWV ambulance. The teams evacuate patients throughout the division and provide for their continued care en route.
- **Area support squad.** This squad consists of a dentist who is ATM trained, a dental specialist, an x-ray specialist, and a medical laboratory specialist. The squad offers emergency dental service and provides x-ray and laboratory support to the treatment squads at the division level of HSS.
- **Patient-holding squad.** This squad consists of two practical nurses and two medical specialists. The squad is capable of providing minimal care for 40 patients who will return to duty within 72 hours.

When a treatment squad, an area support squad, and a patient-holding squad collocate, they form an area support section which provides HSS on an area basis. The section operates in the DSA or BSA at a division clearing station. The area support and patient-holding squads are not staffed or equipped to conduct independent operations.

### **Forward Medical Support**

Medical treatment elements locate as far forward as possible to provide HSS without interfering with combat operations or subjecting the MTF to undue risk. Early acquisition, sorting, and evaluation of patients is necessary to reduce morbidity and mortality. Personnel perform four phases of medical treatment in the brigade area. They are –

- Self- and buddy-aid. This is the lifesaving care given to an ill, injured, or wounded person by himself or by another nonmedical trained soldier. All soldiers should know the lifesaving measures in FM 21-11.
- Combat lifesaver. The combat lifesaver who is a member of a combat, CS, or CSS unit performs advanced first aid. The combat lifesaver is not a medic but has received medical training beyond basic first aid. This function is an additional duty for the soldier. It is an extension of the combat medic.
- Emergency medical treatment. This involves medically substantiated decisions based on medical MOS-specific training. The combat medic, aide/evacuation team, or EMT NCO provides EMT. It includes emergency lifesaving measures, management of the airway, control of bleeding and administration of intravenous fluids and medicinal drugs.
- Advanced trauma management. ATM requires a higher degree of medical skill and judgment. Physicians helped by physician assistants and EMT NCOs, perform it at both the unit and division level. At Echelon II MTFs, this phase includes the administration of blood (packed red blood cells) and emergency dental procedures; limited x-ray and laboratory procedures; a wide range of drugs, medical equipment, and supplies and also a patient-holding capability.

### **Patient Evacuation**

The best patient care and treatment in the combat zone depend on a dedicated evacuation system which can provide efficient and continuous movement of patients. Medical evacuation is the process of moving patients while providing en route care. Evacuation occurs

from the point of injury or illness through successive MTFs. Medical personnel provide appropriate medical treatment to enhance the patient's early return to duty or facilitate stabilization for further evacuation.

The responsibility for patient evacuation rests with the level of HSS to which the patient is to be evacuated. Ambulances from supporting units go forward to supported units, acquire patients, and bring them back to the supporting MTF. When necessary, personnel set up an ambulance shuttle system or set up AXP's between the supporting and supported medical units. This allows ambulances to move forward as others move rearward setting up a continuous evacuation flow. The system evacuates patients no further to the rear than their conditions require.

Ambulance teams of the combat or CS unit's medical platoon evacuate patients from the site of injury or collection point to the location of the platoon's treatment squad or team operating the BAS. Movement of patients to the initial patient collection point is the responsibility of the tactical commander. Ambulance squads of the forward support medical company evacuate patients from the combat or CS unit's treatment squads or teams to the division clearing station located in the BSA. Ambulance squads of the MSB medical company have the primary mission of providing evacuation support on an area basis to the division rear. They have the secondary mission of reinforcing the ambulance squads of the FSB medical company. Patients are evacuated from division clearing stations in the BSAs to the division clearing station in the DSA only on an exception basis or if they are in need of psychiatric or optometric services. Evacuation of patients in the BSA clearing station is accomplished by corps evacuation assets to corps MTFs.

Aeromedical evacuation resources are allocated to the LID from corps assets. They are essential in clearing seriously injured patients from forward areas and in providing rapid transportation of critical medical supplies, equipment, and personnel. Air ambulances operate as far forward as is tactically possible. Figure 7-3 depicts patient evacuation.

## **HSS OPERATIONS**

### **Planning**

The DMOC and the support operations sections of the MSB and FSBs plan for medical operations within the division area. The basic considerations

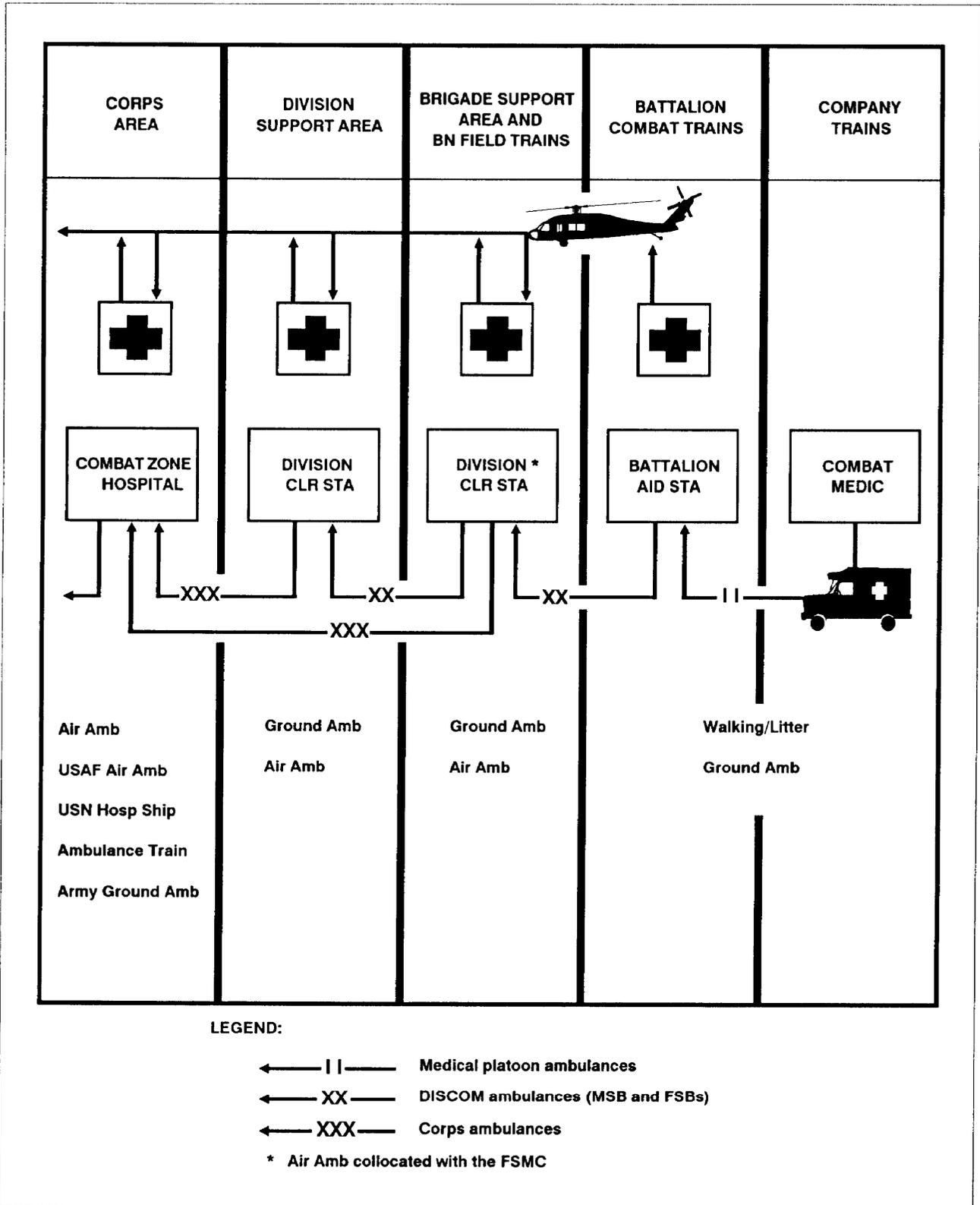


Figure 7-3. Patient evacuation flow.

which influence the employment of medical assets within the division are—

- Division commander's plan.
- Anticipated patient load.
- Expected areas of casualty density.
- Available medical treatment and evacuation resources.

On the basis of these factors, planners determine how the companies are organized for support operations. They also determine the location of each clearing station and identify the possible evacuation routes. The chief of the DMOC prepares to reinforce HSS forward and to request augmentation through the S2/S3 section. The company commanders also ensure the SOP specifies methods for handling chemical casualties, moving the clearing stations, providing Class VIII supply, and coordinating air evacuation.

Planners determine how to manage mass casualties conditions. Such situations severely tax the division HSS system. The key to handling mass casualties is the use of on-site treatment teams, effective communications, and skillful employment of air and ground ambulances. The prompt movement of patients to all available treatment facilities helps. If medical evacuation assets are overwhelmed in a mass casualty situation, nonmedical vehicles are used and medical personnel accompany the patients to provide en route medical care. If additional assets are required, the DMOC coordinates augmentation.

#### Clearing Station operations

“Division clearing station” is the generic term used in designating the division-level MTFs in both the DSA and BSA. They locate away from likely target areas but near evacuation routes and near an open area for landing air ambulances. The Geneva Conventions protect medical personnel, facilities, and vehicles from deliberate attack by the enemy. Chapter 6 discusses security and positioning considerations.

Treatment platoons operate the division clearing stations. In addition, teams from the MSB preventive medicine section behavioral science NCOS from the mental health section and the brigade UMT may operate from the clearing stations in the BSAs and the DSA. Also operating at the clearing stations in the BSAs are any elements of the forward support medical company treatment platoon not deployed forward. During static situations, ambulance teams also station themselves at the clearing stations in

the BSA. They provide routine sick call runs and emergency standby support to units operating in and around the BSA. The clearing stations maintain their integrity at all times except when locating to a new site. Figure 7-4 shows a sample clearing station layout in a field environment.

Medical personnel give necessary treatment to seriously ill or wounded patients arriving at an MTF and stabilize them for movement. They hold these patients for continued treatment or observation for up to 72 hours if the patients can RTD in that time frame. If not, personnel evacuate the patients to the appropriate MTF for further treatment, evaluation, or disposition. Other functions of the clearing station include —

- Providing consultation and limited clinical laboratory and x-ray diagnostics for unit physicians and physician assistants.
- Recording all patients seen or treated at the clearing station. It also notifies the brigade S1 or first sergeant of supported CS and CSS units.
- Monitoring patients for decontamination before treatment.

The preventive medicine teams ensure units carry out preventive medicine measures. These measures protect against food-, water-, and arthropod-borne diseases and environmental injuries such as heat and cold injuries. Specifically the team —

- Performs environmental health surveys and inspections.
- Checks water production and distribution within the division area.
- Investigates incidents of food-borne, water-borne, arthropod-borne, zoonotic, and other communicable diseases.
- Helps train unit field sanitation teams.

The teams emphasize preemptive action. In past conflicts, more soldiers were ineffective from DNBI than combat. The teams are proactive. They do not wait until problems appear to act.

The representatives from the mental health section function as the combat stress control coordinators. They advise the division surgeon and the brigade surgeons on mental health considerations. They keep abreast of the tactical situation and plan for BF/NP care when maneuver units pull back for rest and recuperation. At the clearing stations, they help inpatient triage and ensure

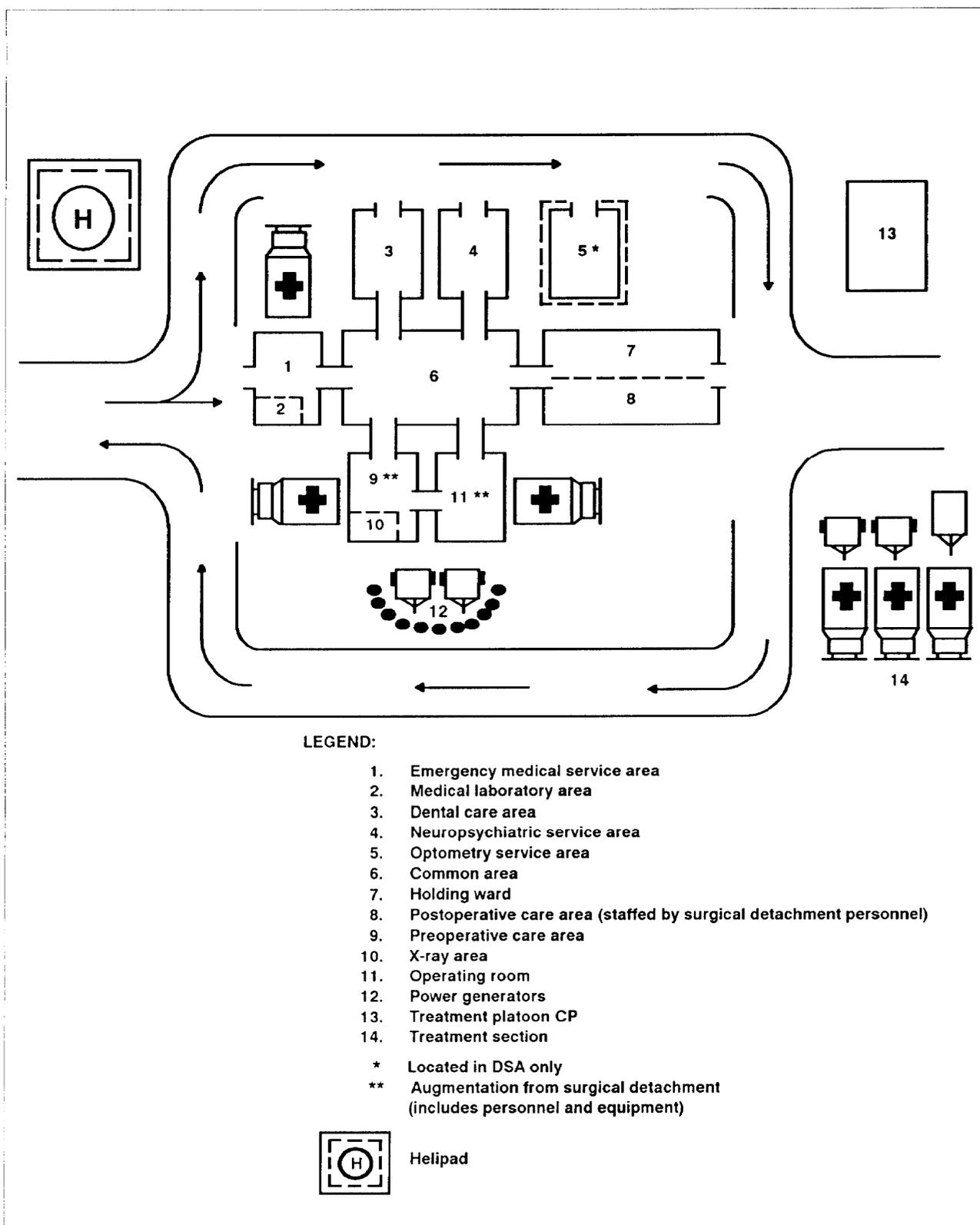


Figure 7-4. Sample clearing station.

personnel handle BF/NP patients properly. Medical personnel follow these treatment guidelines:

- They give mild cases a brief respite of one to six hours of comfort and reassurance, Then they return them to their units.
- They send moderate cases to a CSS unit for one or two days for rest and recuperation. They continue to watch the individuals, and the medical unit feeds and clothes them. The CSS unit gives them tasks to perform. Medical personnel also hold moderate cases at the medical holding facility if space is available and no suitable nonmedical CSS quartering facility is available.
- They hold severe cases in the clearing station holding facility for up to 48 hours if behavior is not too disruptive. Treatment consists of sleep, hydration, quality food, hygiene, general health measures, and restoration of confidence. It also includes soldierly work details and individual counseling. The attending physician prescribes medication only to aid briefly in sleep or to control disruptive behavior.
- At the BSA clearing stations, they arrange evacuation of severe cases to the DSA clearing station as conditions permit. The physician decides to evacuate the patient directly to a corps facility if diagnosis indicates the patient requires treatment at that level.

### **Evacuation Operations**

The forward support medical company ambulance platoon and a forward air ambulance team of the supporting corps air ambulance company provide evacuation from the BASS if the tactical situation permits. These assets also support other units in the brigade area on an area basis. Typically, one team from the forward support medical company ambulance platoon field sites at each BAS. The other ambulances of the platoon locate at the AXP, shuttle points, designated patient-collecting points, or at the clearing station.

Air and ground ambulance elements of the corps medical evacuation battalion have a field site in the DSA and BSA. The leaders of these elements establish liaison with the DMOC and plan the employment of corps assets. The DMOC helps the reporting air ambulance liaison officer/flight leader in getting the required air space management information. The DISCOM S2/S3 section also helps the ground evacuation liaison officer in getting information on MSRs and in getting road clearances.

Corps air and ground ambulances evacuate patients from clearing stations in the BSA and DSA directly to hospitals in the corps rear. Air ambulances evacuate patients from BASS to division clearing stations as the tactical situation permits and from the clearing stations to corps hospitals. Corps medical regulating officers regulate patients evacuated out of the division. The DMOC regulates patients evacuated within the division from BASS to clearing stations and from clearing stations to clearing stations. It also informally tracks patients evacuated to the mobile army surgical hospital located in the division rear.

When division medical evacuation assets become overwhelmed, the DMOC requests reinforcements from the corps through command channels. Another alternative to lessen intradivision evacuation backlogs is to use division nonmedical air and transportation assets. Commanders set up these procedures in command logistics SOPS and carry them out when required.

When necessary, to ensure timely ground ambulance support to maneuver battalions BASS, the forward support medical company sets up AXP or shuttle points between clearing stations and maneuver battalions, terrain permitting. AXP are loading points where ambulances are stationed to receive patients. They facilitate transfer of patients between division ground ambulances, division and corps ground ambulances, or between division ground ambulances and air ambulances. AXP allow ambulances to return to their supporting positions more rapidly, This is desirable since aide/evacuation teams are more familiar with the roads and tactical situation near their base of operations.

Another evacuation system tool involves an ambulance shuttle system. The shuttle system uses relay points. Ambulances station themselves at relay points to replace ambulances leaving loading points to evacuate patients. This requires control points at crossroads or junctions to direct empty ambulances from relay points to loading points. After delivering patients to the MTF, the empty ambulances return to the relay point to await further employment.

### **Class VIII Supply Operations**

Personnel obtain medical supplies, equipment, and repair parts through medical channels. Unit- and division-level medical elements carry a five-day stockage of medical supplies with an additional day of expendable. During combat operations, the forward support

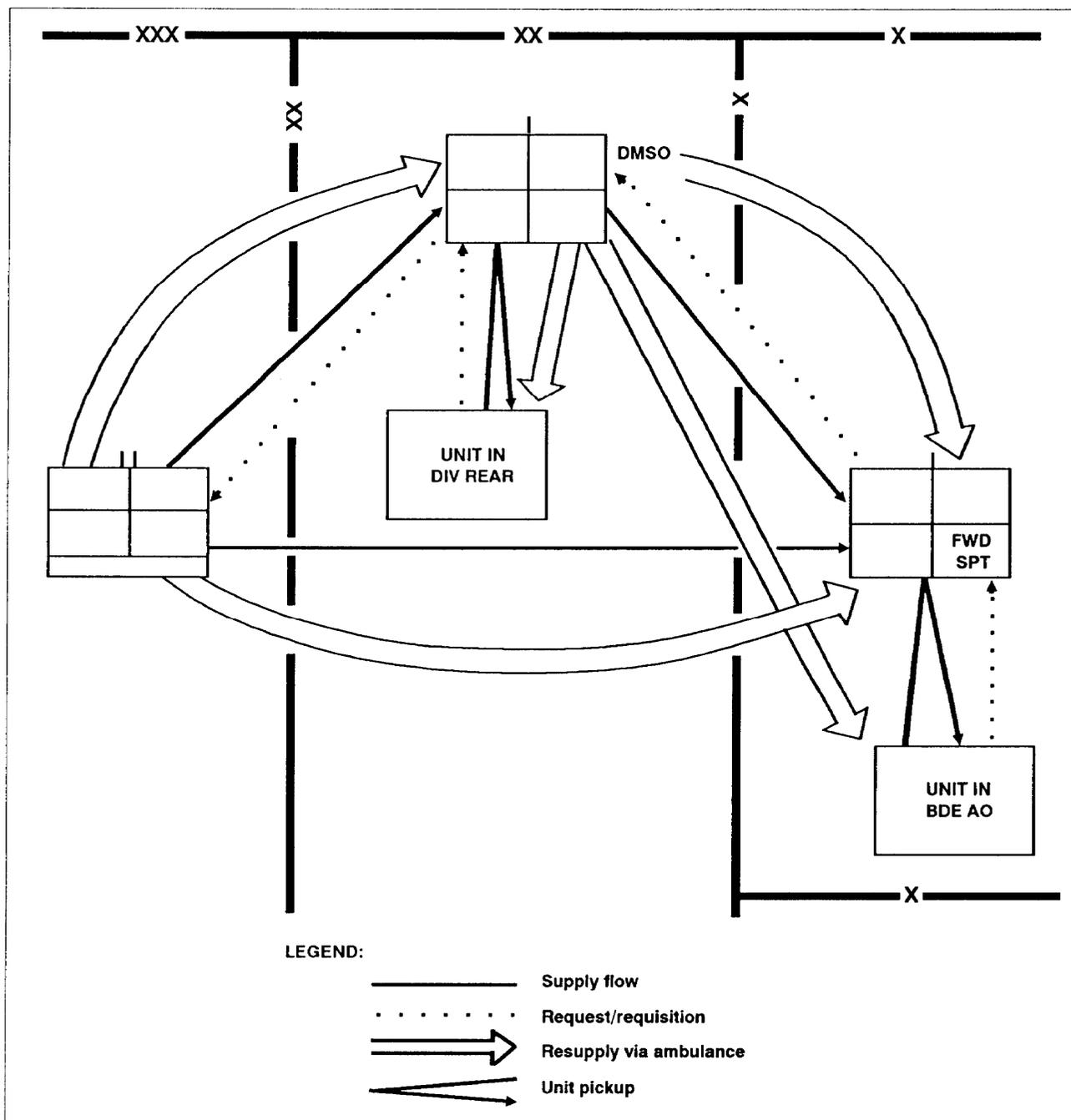


Figure 7-5. Class VIII flow.

medical company receives preconfigured medical supply packages from the DMSO. As medical units consume their initial issue, they request resupply from the next higher level of HSS. The DMSO provides routine medical resupply of division units. The forward support medical company receives its supplies from the

DMSO in the DSA or throughput from MEDLOG forward. The DMSO coordinates shipment through the MCO. Ambulances transport medical supplies using the backhaul method. However, in emergencies medical elements request and receive medical supplies as quickly as possible. Figure 7-5 depicts the flow of Class VIII supplies.

## FIELD SERVICES SUPPORT

Field services include CEB, mortuary affairs, salvage, laundry, textile renovation, and airdrop. When personnel are not available in the division or in an augmentation to the division to perform these services, a COSCOM service element provides the services. Salvage operations are addressed in Chapter 10. Chapter 11 discusses airdrop.

Field services support requires close coordination with the DISCOM S2/S3, DMMC, the S2/S3 and support operations section of the MSB battalion, the FSB commanders, and the commanders/leaders of the augmentation units involved. Commanders of augmentation units assume the operating responsibilities and help the MSB S2/S3 in planning field services support.

### CLOTHING EXCHANGE AND BATH

Before arrival of CEB augmentation, soldiers use available water or indigenous facilities for bathing and washing clothes. Personnel use supply actions to replace unserviceable clothing.

Augmentation in the form of a CEB platoon attached to the HSC of the MSB provides CEB services. The platoon consists of eight teams. Upon arrival they set up a maximum of eight CEB points in the DSA and BSAs. In the future, CEB augmentation elements will be replaced by the corps field services company (DS).

The teams provide support on an area basis with a capability to provide one clothing exchange and bath per soldier every seven days. If the commander reduces the seven-day period, the teams may require additional augmentation or they may reduce individual bathing time. Laundry support to the CEB platoon is provided by COSCOM elements. The supported unit provides labor details to help set up the bath unit, safeguard valuables, and receive and issue clothing. FM 10-280 covers general operations of CEB teams.

In an NBC environment, CEB teams help in decontaminating personnel contaminated with radioactive dust or biological agents. (Showers are not considered essential in decontaminating personnel contaminated by chemical agents.) The teams check water used during bath operations to ensure it is not contaminated. During bath operations, they check all personnel to detect contamination. They segregate contaminated personnel from noncontaminated personnel. Contaminated personnel decontaminate themselves and receive bath service first.

### MORTUARY AFFAIRS

A well-organized mortuary affairs system in the division helps to ensure —

- Prompt recovery of all remains from the division area of responsibility.
- Prompt and accurate identification of remains.
- Prompt recovery, inventory, and security of the personal effects found on the remains.
- Prompt evacuation of remains with their personal effects out of the division area to the COSCOM collection points/cemetery or mortuary.
- Prompt, accurate, and complete administrative recording and reporting.
- Prompt and adequate care for deceased allied and threat personnel according to the current United Nations agreements.
- Reverent handling of the remains and adequate ceremonies and services for deceased persons performed according to current doctrine.
- Emergency burial, when required.

Company commanders are responsible for the search, recovery, tentative identification, and evacuation of deceased personnel from their areas of responsibility. Deceased personnel include members of the company, other Services, and other remains found in the area. Company personnel serve on mortuary affairs teams to clear operational areas and perform search and recovery and to make the initial identification of the remains before evacuation to a collection point. Company commanders are also responsible for the evacuation of these remains to a collection point.

Team members perform necessary emergency burials when higher headquarters grants permission and the tactical situation prevents the evacuation of the remains and their personal effects. The commander permits burial of remains during NBC warfare or when the number of remains recovered and decontaminated is greater than the capacity of the resources to evacuate the remains. This is done only when it is authorized according to the conditions in ARs 638-30, 600-8-1, and FM 10-63. Mortuary affairs teams also complete records and reports of these emergency burials and forward them through mortuary affairs channels to the theater joint mortuary affairs office.

The LID has one mortuary affairs NCO in the support operations section of the MSB battalion and one in each FSB. These NCOs are a planning, coordinating, and training base for the unit's mortuary affairs functions. They plan for and coordinate augmentation for the division. They train division personnel to serve on mortuary affairs teams until the augmentations arrive. They provide staff supervision over mortuary affairs operations and serve as chiefs of the collection points staffed by unit personnel until the teams arrive.

Organic augmentation provides services on or after deployment. This augmentation consists of a GRREG platoon assigned to the HSC of the MSB. Support is limited to minimum essential capabilities required to collect, initially identify, and evacuate or hastily bury remains. If the division needs more support, the DISCOM S2/S3 requests it from the COSCOM services branch. Handling of contaminated remains requires additional augmentation from EAD. In the future, augmentation elements will be replaced by a corps mortuary affairs company.

When the GRREG platoon arrives, they setup four collection points (one in the DSA and one in each BSA). Collection points locate a short distance from the MSR. It is the commander's responsibility to select the sites of these points.

Collection and evacuation teams set up collection points in the BSAs to receive deceased personnel from supported units. They tentatively identify the remains and arrange for evacuation to the division collection

point. They provide technical advice and training to unit personnel in their areas of responsibility. They tentatively identify deceased personnel as early, as completely, and as accurately as possible. Units evacuate deceased personnel with their effects from forward areas to the DSA collection point as a backhaul mission. They use vehicles which brought supplies (except Class I and VIII) to the BSA.

Personnel perform emergency burials (isolated burials, sea burials and mass burials) in other than established cemeteries for the sake of expediency. They resort to these burials only in extreme emergencies and when authorized by the theater commander and in accordance with AR 638-30 and FM 10-63. They document these burials fully and report them promptly through mortuary affairs channels to the theater joint mortuary affairs office. If they lose contact with higher headquarters, the senior officer in the stricken area is responsible for determining burial procedures.

#### **LAUNDRY AND RENOVATION**

Corps field services companies provide division troops laundry and renovation in coordination with CEB efforts. This support requires close coordination between the S2/S3 section of the DISCOM, the FSB commanders, the supported unit, the support operations section of the MSB, and the corps field services companies involved. FMs 10-280 and 29-114 describe day-to-day laundry and renovation operations.