

***ATP 4-02.43**

ARMY HEALTH SYSTEM SUPPORT TO ARMY SPECIAL OPERATIONS FORCES

December 2015

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*This publication supersedes FM 4-02.43, Force Health Protection Support for Army Special Operations Forces, dated 27 November 2006.

Headquarters, Department of the Army

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Preface

The purpose of Army Techniques Publication (ATP) 4-02.43 is to provide the authoritative doctrine for the Army Medical Department's (AMEDD's) Army Health System (AHS) support of Army special operations forces (ARSOF) as part of the protection and sustainment warfighting functions support to unified land operations. Army special operations forces are those Active Army and Reserve Component forces designated by the Secretary of Defense that are specifically organized, trained, and equipped to conduct and support special operations. The acronym ARSOF represents special forces (SF), special mission units, Rangers, civil affairs (CA), military information support operations (MISO), and Army special operations aviation forces assigned to the United States Army Special Operations Command (USASOC), which are all supported by the sustainment brigade (special operations) (airborne) (SB[SO][A]). This publication also discusses joint special operations and provides a limited discussion of other Services capabilities.

The principal audience for this publication includes—commanders at all levels to provide a universal understanding of how AHS must function to support ARSOF; ARSOF and medical unit commanders and their staffs; doctrinal proponents to institutionalize the integration of AHS support into all Active Army, joint force, and multinational missions that contain ARSOF.

Commanders, staffs, and subordinates ensure their decisions and actions comply with the applicable United States (U.S.), international, and, in some cases, host-nation laws and regulations. Commanders at all levels ensure their Soldiers operate in accordance with the law of war and the rules of engagement. Refer to Field Manual (FM) 27-10.

Army Techniques Publication 4-02.43 implements or is in consonance with the following North Atlantic Treaty Organization (NATO) Standardization Agreements (STANAGs) and American, British, Canadian, Australian, and New Zealand (Armies) (ABCA) Publication:

Title	NATO STANAGs	ABCA Publication
Information Relative to Medical Evacuation, Treatment and Cause of Death of ABCA Casualties		363
Medical Employment of Air Transport in the Forward Area	2087	
Documentation Relative to Initial Medical Treatment and Evacuation (Allied Medical Publication-8.1	2132	

Army Techniques Publication 4-02.43 uses joint terms where applicable. Selected joint and Army terms and definitions appear in both the glossary and the text. For definitions shown in the text, the term is italicized and the number of the proponent publication follows the definition. This publication is not the proponent for any Army terms.

This publication applies to the Active Army, Army National Guard/Army National Guard of the United States, and the United States Army Reserve, unless otherwise stated.

The proponent and preparing agency of ATP 4-02.43 is the Commander, United States Army Medical Department Center and School, United States Army Health Readiness Center of Excellence. Send comments and recommendations on a DA Form 2028 (Recommended Changes to Publications and Blank Forms) to **Commander, United States Army Medical Department Center and School, United States Army Health Readiness Center of Excellence, ATTN: MCCS-FDL (ATP 4-02.43), 2377 Greeley Road, Building 4011, Suite D, JBSA Fort Sam Houston, Texas 78234-7731**; by e-mail to usarmy.jbsa.medcom-ameddcs.mbx.ameddcs-medical-doctrine@mail.mil; or submit an electronic DA Form 2028. All recommended changes should be keyed to the specific page, paragraph, and line number. A rationale for each proposed change is required to aid in the evaluation and adjudication of each comment.

Introduction

Army Techniques Publication 4-02.43 remains generally consistent with FM 4-02.43 on key topics while adopting updated terminology and concepts, as necessary. Army Health System support to ARSOF is challenging in that ARSOF are lightly equipped with limited organic support assets. Therefore, they must be self-sustaining in all areas of medical care throughout the range of military operations. Since they routinely operate in undeveloped joint operational areas without established support systems, ARSOF medical personnel must assume both AHS missions of health service support (HSS) and force health protection (FHP) responsibilities.

Army Techniques Publication 4-02.43 contains the following six chapters and three appendixes:

Chapter 1 provides an overview of AHS support and its mission to provide health care to Soldiers across the range of military operations. It identifies and discusses the purpose of the AHS, reviews the roles of medical care and the AHS principles.

Chapter 2 discusses the missions and activities of ARSOF. It also examines ARSOF medical capabilities and the range of medical personnel and their responsibilities serving in ARSOF.

Chapter 3 lists the AMEDD medical functions and their relationship to ARSOF. In addition, there is a comparison of AHS support between conventional forces and ARSOF.

Chapter 4 discusses planning for AHS support to ARSOF. It focuses upon planning requirements for a number of core activities.

Chapter 5 focuses upon AHS support to ARSOF in joint operations and the various considerations involved in joint task force (JTF) planning.

Chapter 6 examines medical logistics (MEDLOG) support to ARSOF and its unique requirements.

Appendix A provides an explanation of the law of war, which includes the Geneva Conventions, and the protections afforded to conventional medical personnel, medical aircraft, and medical materiel.

Appendix B discusses medical evacuation planning in the support of ARSOF missions and units.

Appendix C discusses the relationship between special operations (SO) mission command in the joint environment.

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Chapter 1

Overview of Army Health System Support

The AHS is designed to provide health care to our Soldiers across the entire range of military operations from austere environments to well-staffed and -equipped medical treatment facilities (MTFs). It is responsible for the operational management of the HSS and FHP missions for training, predeployment, deployment, and postdeployment operations. Although many features of ARSOF are common to conventional forces, some unique differences in tactical employment are necessary for ARSOF. The differences arise primarily in how medical assets are employed and the operational, tactical, and geographical constraints that routinely confront ARSOF medical capabilities. Medical planners should review recent lessons learned from operations such as Operation Iraqi Freedom, Operation New Dawn, and Operation Enduring Freedom, and be prepared to integrate ARSOF support operations into their planning process. For a more detailed overview of the AHS, refer to FM 4-02.

PURPOSE

1-1. The purpose of the AHS is to conserve the fighting strength. This includes both the deployed force and the sustaining base. Consistent with operational requirements, AHS operates in a range across strategic, operational, and tactical levels. In an Army with a joint and expeditionary focus, the AHS support must be seamless, deployable, versatile, sustainable, and survivable. This will ensure the supported forces are rapidly deployable, lethal, adaptable, and possess the capability to sustain operations over a prolonged operational time frame. The AHS must be operationally agile and responsive in light of ARSOF extended lines of communication and broad range of worldwide requirements.

ROLES OF MEDICAL CARE

1-2. The AHS is organized to provide four roles of medical care. Each role of medical care reflects an increase in medical capabilities while retaining the capabilities found in the lower role of care. Role 1 and limited Role 2 capabilities are found in ARSOF.

1-3. The first medical care a Soldier receives is provided at Role 1 and it includes the following:

- Immediate lifesaving measures.
- Disease and nonbattle injury (DNBI) prevention.
- Combat and operational stress control (COSC) preventive measures.
- Patient and casualty collection.
- Medical evacuation from supported units to supporting medical treatment elements, as appropriate.

1-4. Role 1 medical treatment in conventional forces is provided by combat medics, health care specialists, and the physician assistant (PA) or physician in the battalion aid station/Role 1 MTF. In ARSOF, Role 1 medical treatment is provided by special operations combat medics (SOCMs) (military occupational specialty [MOS] 68WW1); special forces medical sergeants (SFMSs) (MOS 18D); and physicians or PAs at forward operating bases, SF operations bases, or in joint SO task force area of operations (AO).

Note. Special operations forces (SOFs) must often maintain patients for longer periods of time at Role 1 than do conventional forces because evacuation resources may not be available in a hostile or a denied AO.

1-5. First aid can be administered by nonmedical personnel in the form of self-aid/buddy aid and enhanced first aid by the combat lifesaver. Such measures assist the combat medic in his duties. In addition, Ranger units also have maneuver element tactical combat casualty care (TC3) capability (Ranger Regiment). First responder care capability is known as tactical combat casualty care and is the military counterpart to prehospital trauma life support. All first responders will carry and use DD Form 1380 (Tactical Combat Casualty Care (TCCC) Card) to document pre-MTF care at the point of injury. This card was formerly known as the U.S. Field Medical Card. The Ranger first responder is a nonmedical MOS Ranger currently registered as an emergency medical technician-basic, within each maneuver element. This individual serves as a bridge between the administering of self-aid/ buddy aid and the Ranger SOCMs in tactical and administrative care.

1-6. The combat lifesaver is a Soldier with a nonmedical MOS selected by the unit commander for training beyond basic first aid procedures. A minimum of one individual per squad, crew, team, or equivalent-sized unit should be trained. The primary duty of this Soldier remains in his nonmedical MOS. The additional duty of the combat lifesaver is to provide enhanced first aid for injuries based on his training before the combat medic arrives. All members of SF operational detachment A receive enhanced first aid training above the combat lifesaver level. The standard for all ARSOF first responders is the TC3 committee standards.

1-7. The ARSOF has limited Role 2 medical care. The SB(SO)(A) provides limited AHS, MEDLOG, and physical therapist support.

1-8. For more information on Role 3 and Role 4 medical care, refer to FM 4-02.

PRINCIPLES OF THE ARMY HEALTH SYSTEM

1-9. The medical planner must be agile, forward thinking, and work closely with both supported and supporting elements across all the affected Services, different agencies, and other potentially involved organizations, as required. For optimum AHS support, the medical planner must be involved as early as possible in the planning process and in the development of the operation plan. With AHS planning considerations, it is incumbent upon the planner to produce a plan that is straightforward, workable and lacking unnecessary complication. The principles of AHS include—

- *Conformity* with the operation plan is the most fundamental element for effectively providing AHS support. The medical planner must incorporate ARSOF considerations into the AHS plan to ensure that AHS support will be available when and where required. Army Health System planners ensure AHS support operations are in consonance with the combatant commander and meet ARSOF requirements.
- *Continuity* is vital since an interruption of treatment could cause a deterioration of the patient's condition and result in possible death. No patient is evacuated from the point of injury any farther than his physical condition or the operational situation allows. To ensure continuity of care for ARSOF personnel, the AHS plan must provide for a seamless transition from care provided by ARSOF's limited organic medical assets through acquisition by the conventional AHS support capabilities. This requires direct coordination with supporting joint medical elements within the evacuation and treatment chain from the point of injury to MTFs in the continental U.S. The need for continuity has been demonstrated in prior and current ARSOF operations, to include overseas contingency operations.
- *Control* is required to ensure that scarce AHS resources are efficiently employed and support the operational and strategic plan. It also ensures that medical treatment meets professional standards and relevant policies and laws. Technical supervision of AHS assets must remain with the appropriate medical commander/command surgeon due to his professional training, knowledge, and experience. Medical planners must be proactive and keep their commanders and surgeons informed as to the impact of future operations on AHS resources and capabilities.

Army Health System support must be responsive to a rapidly changing operational environment and must support the operation plan. As ARSOF possesses limited medical units, the ARSOF commander retains ultimate control of internal AHS assets with the technical guidance of the ARSOF surgeon. Casualty management is operationally controlled by the ARSOF commander with the technical supervision of the ARSOF surgeon and the support of the AHS planner.

- *Proximity* to supported forces and the location of AHS assets in support of operations is dictated by the operational situation (mission, enemy, terrain and weather, troops and support available, time available, and civil considerations [mission variables]). The unique challenges of time and distance of evacuation legs, availability of limited mobility platforms for delivery into the AO, and accessibility of evacuation resources from the operation requires planning and coordination to ensure prompt evacuation. The speed at which medical treatment is initiated is extremely important in reducing morbidity and mortality. As ARSOF operations are often conducted in hostile or denied areas, conventional AHS support must be planned so that it does not compromise the security of the operation. However, AHS support must be rapidly and readily accessible once casualties are evacuated from hostile or denied territory.
- *Flexibility* is the principle that allows AHS resources to be shifted to meet changing requirements. Changes in plans or operations make flexibility in AHS planning and execution essential. When supporting ARSOF, medical planners and commanders must ensure they remain receptive to innovative and nontraditional methods of providing AHS support.
- *Mobility* is measured by the extent to which a unit can move its personnel and equipment with organic transportation and the ability of its platforms to be sustained and survive in the operational environment. Since contact with supported units must be maintained, AHS elements must have mobility comparable to the units being supported. The only means available to increase the mobility of AHS units is to evacuate all patients they are holding.

ARMY HEALTH SYSTEM MEDICAL FUNCTIONS

1-10. Army Health System support is provided through ten medical functions by units specifically organized to provide these functions: mission command; medical evacuation (to include medical regulating); medical treatment (organic and area support); hospitalization; MEDLOG; preventive medicine (PVNTMED) services, veterinary services; dental services; COSC; and medical laboratory services. For further information on the AHS medical functions, refer to FM 4-02. In SF operations conducted in hostile or denied areas, SF uses the infiltration and exfiltration platforms to perform casualty evacuation (CASEVAC) as conventional forces do not have platforms that can operate in hostile or denied territory.

1-11. Army special operations forces must employ some unique aspects of AHS medical functions. For example, ARSOF may require specialized medical evacuation platforms, exceptions to the theater evacuation policy, extended time-distance factors, and extensive use of CASEVAC assets. Preventive medicine services are extremely important in the AO in that they support ARSOF Soldiers, indigenous personnel, and local populations. When deployed, veterinary services for ARSOF increase in importance in the areas of food protection, support to military working dogs and other government-owned animals, and the prevention and control of zoonotic diseases.

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Chapter 2

Special Operations Forces Missions and Activities

Special operations missions are inherently joint and may include interagency and multinational efforts. Their operations are conducted throughout the full range of military operations from peace to war, either independently or integrated with conventional operations. They are targeted on strategic and operational goals. Military information support operations and CA operations are the exceptions; they normally operate at all echelons simultaneously in support of the joint force commander's (JFC's) campaign plan in war or the combatant command plan. They are also able to support each U.S. ambassador's country plan in peacetime, as required. Both political and military considerations frequently shape operations, requiring clandestine, covert, or low visibility techniques at the national level. Special operations differ from conventional operations in their methods of employment, operational techniques, independence from friendly support, and dependence on detailed operational intelligence and indigenous assets. The AHS planner and health care provider must apply the fundamentals of providing AHS support to the full range of military operations. Given their unique operational requirements, it is imperative to maintain an appropriate role of AHS support for ARSOF. Refer to ADRP 3-05 and JP 3-05.

CORE ACTIVITIES OF ARMY SPECIAL OPERATIONS FORCES

2-1. The ARSOF possess unique capabilities to support USASOC roles, missions, and functions as directed by Congress in Title 10, United States Code, Chapter 6 (Combatant Commands), Sections 164 and 167 (10 USC Chapter 6 (Combatant Commands), Sections 164 and 167). During the development of joint doctrine for SO, certain legislated SO activities were refined into the SO core activities. The goal of the health care provider is to sustain ARSOF activities with seamless high quality medical care, within the parameters of the ARSOF mission envelope. Special operations forces may conduct several different core activities simultaneously in a single operation.

SPECIAL OPERATIONS CORE ACTIVITIES

2-2. Special operations core activities are the military missions for which SOF have unique modes of employment, tactics, techniques, equipment, and training to orchestrate effects, often in concert with conventional forces. These core activities are as follows:

- Unconventional warfare (UW).
- Foreign internal defense (FID).
- Security force assistance.
- Counterinsurgency.
- Direct action.
- Special reconnaissance (SR).
- Counterterrorism (CT).
- Preparation of the environment.
- Military information support operations (MISO).
- Civil affairs operations.

- Counterproliferation of weapons of mass destruction.
- Humanitarian assistance/disaster relief.

2-3. For further information on SO core activities, refer to FM 3-05.

MISSION TASKING AUTHORITY

2-4. Special operations forces support the combatant command, JFC, U.S. ambassadors, and other agencies of the U.S. Government to perform missions for which they are the best suited among available forces and also in situations as the only force available. When assigned an operation by controlling headquarters, that operation becomes the focus of the assigned unit. The SOF provides the tasking commander with a candid assessment of their capabilities, limitations, and the risks associated with the operation.

ARMY SPECIAL OPERATIONS FORCE ORGANIZATIONS

2-5. The mission of the 75th Ranger Regiment (Airborne) is to plan and conduct SO and special light infantry operations in any operational environment across the AO. The primary SO mission of the Ranger Regiment is direct action. Ranger directs action operations may support or be supported by other SOF. They may also be conducted independently or in conjunction with conventional military operations. Rangers can also operate as special light infantry when conventional airborne or light infantry units are unsuited for or unable to perform a specific mission. Ranger units can deploy by land, sea, and air and may operate in a force-size as small as company-level teams or regimental task forces.

2-6. Army special operations aviation regiment (airborne) (SOAR[A]) specialized assets covertly penetrate hostile and denied airspace to conduct and support SO. These assets operate with great precision for extended ranges under adverse weather conditions and during periods of limited visibility. Army SOAR(A) assets may insert, resupply, and extract U.S. SOF and other designated personnel. They provide forward air control for both U.S. and multinational close air support and indirect fire for SOF. The SOAR(A) can provide terminal guidance for precision munitions in support of SOF. The SOAR(A) conducts electronic and visual reconnaissance in support of SO. The SOAR(A) performs CASEVAC, armed attacks, mine dispersing, and air messenger service in support of SO. The SOAR(A) can support and facilitate mission command of SO. Army SOAR(A) units can provide general aviation support to SOF when the use of other Army aviation assets is unavailable or unfeasible. However, the use of ARSOF aviation assets for these missions detracts from their primary mission of covert penetration into denied areas.

2-7. The special forces group (airborne) (SFG[A]) plans, conducts, and supports SO in any operational environment and across the operational continuum. All SF MOSs are managed as a combat arms career management field. Their primary skills and special expertise are operations and intelligence, light and heavy weapons, engineer, communications, and medical. Special forces groups also maintain within their support base specific specialties that enhance their mission capabilities such as logistics, signal, and limited AHS professionals. Special operations forces medical personnel include flight surgeons, aviation medicine PAs, dental officers, physical therapists, environmental science and engineer officers (ESEOs) and Medical Corps PVNTMED officers, veterinary officers, and MEDLOG personnel. Special operations forces have the capability to combine, at the lowest operational level, the functions performed by several conventional branches of the Army. Special operations forces commanders integrate and synchronize their organic capabilities with those of other SOF and operational assets.

2-8. Civil Affairs personnel and units support both conventional forces and SOF conducting unified land operations in all environments, across the range of military operations. They may conduct unilateral operations or work with other Army conventional forces, SOF, interagency, host-nation military and civilian authorities, as well as coordinate efforts with nongovernmental organizations (NGOs). The medical assets within CA are not assigned clinical duties. They advise, evaluate, and coordinate public health resources and activities for advancing the medical support system available to the general public.

2-9. The Active Army MISO groups conduct regionally focused influence using MISO and other information-related and influence capabilities in support of ARSOF. They provide limited contingency

response capabilities supporting conventional forces until Reserve Component MISO groups can be mobilized. Army special operations forces MISO conduct three primary missions: support to DOD; interagency and intergovernmental support; and information support activities to civil authorities during domestic disasters. They have limited organic medical staffing and rely on the units they support for all medical requirements. They are trained to provide first aid, buddy aid, and combat lifesaver skills.

2-10. The SB(SO)A is responsible for providing USASOC medical support at the operational level of sustainment, utilizing a distribution management center and technical supervision on all logistics functions. The SB(SO)A maintains a medical detachment which provides two sections capable of providing patient holding for up to ten patients each. Each patient hold section provides four intensive/critical care (ventilator capable) cots for postsurgical and seriously injured patients. The medical detachment also provides enhanced laboratory services and digital x-ray to each ten-cot section. Neither the SB(SO)A nor the SFG(A) medical sections have any organic surgical capability.

MEDICAL CAPABILITIES OF ARMY SPECIAL OPERATIONS FORCES

2-11. The SFG(A) has the most robust AHS support structure of any ARSOF unit. Special forces groups and battalions are usually assigned physicians, PAs, and medical noncommissioned officers (NCOs). There are two SFMSs authorized per SF operational detachment A. However, it is similar to other light units in that it is dependent upon theater AHS assets for timely evacuation and Role 2 support on an area basis.

2-12. The AHS structure in the Ranger Regiment is similar to that of an airborne infantry brigade, although somewhat more austere. The primary difference between these two types of organizations is the lack of a brigade support medical company (brigade support battalion) in the regiment. In addition, the Ranger units have organic SOCMs. The Ranger Regiment and its battalions are dependent upon theater assets for Role 2 and above medical care on an area support basis. The Ranger Regiment requires that every infantry squad maintain an MOS 11B (infantryman) trained and certified as an emergency medical technician-basic. All Rangers are qualified as Ranger first responders in their selection training or within six months of being assigned to a unit. Ranger first responders must complete yearly recertification. Ranger units modify the battalion aid station concept into platoon, company, and battalion-level patient (casualty) collection points. Although designated as patient (casualty) collection points, these collection points are locations where emergency medical treatment certified squad personnel, SOCMs, PAs, physical therapists, and/or physicians render care before patients are evacuated. Ranger Regiment patient (casualty) collection points are often established as joint casualty collection points due to multiple Service elements that are often employed during Ranger operations. The joint casualty collection point manning is mission-dependent and typically requires augmentation. The Ranger Regiment does not have organic medical evacuation assets and normally uses mission aircraft such as logistical platforms to backhaul patients to support bases. The Ranger Regiment does not have an organic brigade support battalion and depends heavily on augmentation and area support when placed in a conventional fight. The Ranger Regiment has an organic regimental support battalion that offers a support company to each maneuver battalion.

2-13. The SOAR(A) is assigned flight surgeons, aviation medicine PAs, a clinical psychologist, and several SOCMs who are qualified as flight medics. However, like other light units, it is dependent upon the theater AHS assets for the Role 2 and above support on an area support basis.

2-14. The SB(SO)(A) is designed to provide operational logistical and signal planning for deployed ARSOF. For ARSOF, the sustainment brigade has two Active Army and one Reserve Component medical detachments; each is capable of providing Role 2 when combined with the medical elements in the group support battalion. Role 2 ARSOF medical detachments similarly provide TC3, including beginning resuscitation, and, if necessary, additional emergency measures are instituted. To perform their AHS planning function, the SB(SO)(A) has a medical planning cell composed of a command surgeon, two medical operations officers, a MEDLOG officer, a field veterinary service officer, a medical operations NCO, a PVNTMED NCO, and a medical supply NCO. The ARSOF must rely on theater area or JTF support assets for large or sustained operations, and the SB(SO)(A) provides the connectivity. The Role 2 MTF has the capability to provide packed red blood cell; limited x-ray, medical laboratory, and dental

support. Class VIII materiel is managed at the wholesale level in the SB(SO)(A) by the medical operations branch. The medical operations branch provides MEDLOG commodity management of Class VIII and the medical maintenance within the SB(SO)(A) and ARSOF, as applicable.

2-15. The SO signal battalion possesses limited organic AHS assets. Soldiers are trained as first responders and combat lifesavers during their training cycle. Every small team that deploys has individuals that can provide immediate lifesaving measures. However, the battalion relies upon the supported unit for almost all aspects of AHS support.

2-16. Army CA units have medical personnel assigned with the duties of providing advice, evaluation, and coordination of medical infrastructure, support, and systems issues in foreign countries. Particular emphasis is placed on PVNTMED (sanitation and disease prevention), veterinary medicine, and prevention of zoonotic diseases. Therefore, CA units are dependent on the theater assets for most aspects of AHS support. Assigned SFMSs or SOCMs can provide limited AHS to members of the unit in some mission profiles.

2-17. Army MISO units possess no organic AHS assets. They are entirely dependent on the force they are supporting for all operational and tactical AHS support.

MEDICAL PERSONNEL IN ARMY SPECIAL OPERATIONS FORCES

2-18. Army SOF units have medically trained personnel who provide Role 1 medical care to deployed forces. In addition, ARSOF medical personnel provide advice and training to the indigenous personnel and paramilitary organizations they are supporting. The roles and responsibilities of these medical personnel and the organizations to which they are assigned are discussed in the following paragraphs. Special operations forces have reduced organic patient holding capabilities when unit assets are combined with SB(SO)(A). Special operations forces are reliant upon the regional or combatant command theater infrastructure for AHS support above unit organic capabilities on an area support basis for complete Role 2 and above care.

2-19. The ARSOF surgeon, at all levels of command, is responsible for planning, coordinating, and synchronizing AHS functions and missions. This includes the necessary coordination to ensure that AHS is obtained from the theaterwide AHS when requirements exceed the organic capabilities of deployed ARSOF. The ARSOF surgeon is responsible for determining requirements and providing medical control for the following:

- Requisition, procurement, storage, maintenance, distribution management, and documentation of MEDLOG.
- Army SOF medical personnel.
- Financial management of resources allocated and expended for mission accomplishment.
- Planning and coordinating transportation and/or medical evacuation requirements in excess of organic capability.
- Planning and coordinating with the AHS commanders, task force commanders, or other elements, units, agencies for continuous AHS.
- Submitting to higher headquarters those recommendations on professional medical problems that require research and development. (In developing nations, this responsibility takes on added significance as unfamiliar diseases are encountered.)
- Recommending uses of captured (or abandoned) Class VIII or locally available medical supplies in support of indigenous forces or other recipients.

2-20. The ARSOF surgeon also advises the combatant command on—

- Health of the command and indigenous forces supported.
- Army Health System resources available within the AO.
- Medical effects of the environment and of chemical, biological, radiological, and nuclear (CBRN), as well as directed-energy weapons systems and devices on personnel, Class VIII materiel, rations, and water.
- Medical intelligence requirements.

- Local population assessment.
- Planning and coordinating (both internally and externally) the following AHS operations:
 - Medical evacuation by U.S. Air Force or U.S. Navy resources or resources from the civilian community, host nation, and multinational resources.
 - Medical treatment, to include hospitalization in Role 3 MTFs established by other Services, multinational forces, or host nation. This also includes MTFs afloat.
 - Dental services.
 - Veterinary food safety and security inspection, animal care, veterinary PVNTMED activities of the command, and civic assistance programs within the local community.
 - Preventive medicine services.
 - Medical laboratory services.
 - Foreign humanitarian assistance programs.
 - Behavioral health and COSC programs.
 - Army Health System assessments, estimates, and plans.

2-21. The SFMS (MOS 18D) forms the backbone of medical care within the SFG(A). The two SFMSs assigned to each SF operational detachment A provide emergency and routine medical care for detachment members, associated multinational forces, or indigenous personnel. They also provide emergency dental care and veterinary care. They train, advise, and direct detachment members, multinational forces, or indigenous personnel in routine, emergency, and preventive medical, dental, and veterinary care. They establish field MTFs to support detachment operations. They prepare the medical portion of area studies, operation plans and operation orders. They also conduct health threat and counter threat briefings and lessons-learned briefings. They have the capability to train, advise, and lead indigenous operating forces up to company-size. They assemble and maintain detachment medical equipment and supplies. They also supervise routine and emergency medical activities in a field or in a UW environment. Special Forces medical sergeants certify biennially as emergency medical technician-paramedic through USASOC. The SFMS also receive additional intensive training in anatomy, physiology, laboratory procedures, pharmacology, nursing care, TC3, dental care, PVNTMED, and veterinary medicine. When the SFMS is receiving sustainment training in an MTF, his scope of practice is delineated in AR 40-68.

2-22. The SOCMs (MOS 68WW1) are trained to assess and manage combat trauma at a capability level equivalent to an emergency medical technician-paramedic. To foster TC3 proficiency, the SOCMs maintain Army emergency medical technician-basic and emergency medical technician-paramedic certifications through biennial attendance at the SOCM Skills Sustainment Program. They ensure medical preparedness, and assemble and maintain medical equipment sets and supplies. They are assigned to the Ranger Regiment and its battalions, the SB(SO)(A), SOAR(A), and Active Army CA units. The group support battalion at each SFG(A) contains three SOCMs by table of organization and equipment.

2-23. The CA medical operations sergeant (MOS 68WW4) provides emergency and routine medical care for team members and associated multinational or indigenous personnel. They can also provide emergency dental and veterinary care. They train, advise, and direct other team members, multinational and indigenous personnel, in routine, emergency, PVTMED, dental, and veterinary care. They prepare medical portions of area studies, operation plans and operation orders. They conduct health threat, counter threat and lessons-learned briefs. They assemble and maintain team medical equipment sets and supplies. They receive additional intensive training in anatomy, physiology, laboratory procedures, pharmacology, nursing care, TC3, dental care, PVNTMED, and veterinary medicine.

2-24. The diving medical technicians are SFMSs with additional training to assess and manage diving-related injuries such as decompression sickness; pulmonary overinflation injuries (including arterial gas embolism barotraumas); effects of breathing gases (such as oxygen toxicity, nitrogen narcosis, hypoxia, hypercarbia, and carbon monoxide poisoning); casualty extraction; transport and management; and AHS requirements for dive operations. In the absence of a diving medical officer, the diving medical technician is authorized to initiate recompression therapy in compliance with AR 611-75.

2-25. The PVNTMED NCO (MOS 68S) assists the battalion SFMS in day-to-day operations, to include immunization program administration, immunization database entry into the medical protection system, and medical record maintenance. The PVNTMED NCO formulates and recommends PVNTMED

programs and courses of action (COA) designed to meet the needs identified through surveillance procedures and processes. He assists in the implementation of PVNTMED programs and evaluation to ensure their effectiveness in maintaining the health of the command, physical fitness, prevention of DNBI, and recommends actions to correct shortfalls to the surgeon. These actions include: training; ensuring field sanitation team supplies and equipment are maintained at each company; collecting information of medical importance; providing PVNTMED sustainment training to SFMS; and deploying with operational detachments to provide PVNTMED support, if required. The PVNTMED NCO maintains liaison with medical personnel of other military Services, multinational military forces, and civilian public health agencies, SB(SO)(A), and CA unit aligned with UW or FID missions. The PVNTMED NCO has the resources and training required to complete occupational and environmental health surveillance assessments and sampling.

2-26. The MEDLOG NCO (MOS 68J) performs or supervises requisitioning, receipt, inventory management, storage, preservation, issue, salvage, destruction, stock control, quality control, property management, repair parts management, inspection, packing and shipping, care, segregation, and accounting of medical supplies and equipment. The MEDLOG NCO is trained to accomplish all aspects of acquiring, receiving, storing, controlling, issuing, and maintaining medical supplies and equipment. Under most circumstances, a separate logistics NCO would be assigned to accomplish each of the tasks listed above. In smaller conventional units with a medical mission, and in all ARSOF units, the NCO will be responsible to perform all duties simultaneously. There are no SOF unique MEDLOG NCOs trained in the aspects of SO; only conventional force MEDLOG NCOs adapted to support the SOF community.

2-27. Medical Corps officers are advisors to the commander and staff for all matters affecting the behavioral and physical health of the battalion, its attached elements, its supported indigenous force, and as trainers for organic medical personnel. They examine, diagnose, and treat or prescribe courses of treatment for DNBI and also provide TC3 for wounded Soldiers within the capability of the unit's medical element. They can augment the capabilities of the surgical specialties through triage, stabilization, and surgical assistance. In SOF battalions, the battalion surgeon is the primary medical staff officer and planner as there are no assigned Medical Service Corps officers. In UW operations, Medical Corps officers serve as leaders/advisors of the UW AHS support for indigenous personnel. Physician positions within SFG(A) and SOAR(A) units are designated as flight surgeons. They provide aviation and diving medicine for Army aviation, diving and military free-fall personnel.

2-28. Physician assistants are commissioned officers trained and certified to practice primary or specialty medical care with significant autonomy. They focus on the management of illness and injury, disease prevention, health promotion, and may also provide minor surgery and wound care. A full description of their duties, responsibilities, and roles is outlined in AR 40-68. Each SF and Ranger battalion is authorized one PA. Duties include providing primary health care to all assigned personnel. They serve as the primary trainers for SFMS and other assigned medical personnel for sustainment training. They provide guidance on health threats, MEDLOG, and mission planning. They function as special staff officers in the absence of the battalion surgeon. Physician assistants may also be trained as an aviation medicine PA or diving medical officer and may receive advanced training in tropical medicine. In the role of the aviation medicine PA, their duties and responsibilities are similar to the flight surgeon with the exception of reinstating flight status.

2-29. Physical therapists are commissioned officers trained and certified to practice orthopedic and sports physical therapy. Each Ranger battalion and SFG(A) is authorized one physical therapist. Duties include primary care diagnosis and treatment of neuromusculoskeletal disorders and conditions to all assigned personnel and dependents. They can earn emergency medical technician-basic/intermediate certification and serve as secondary trainers for SOCM combat trauma management. They assist the surgeon and medical plans and operations officer in the provision of guidance on health threats, MEDLOG, mission planning and function as special staff officers similar to the battalion surgeon and PA. They develop rehabilitation programs, oversee regimental physical training program at the battalion level, and provide physical therapy treatment in garrison and on deployment in both developed and austere AOs. They also function as advisors for injury prevention and strength and conditioning programs.

2-30. The diving medical officer is a physician or PA that is a qualified military diver and has received advanced training in diving-related injuries and medical care. In addition, they are authorized to use

recompression therapy to treat dive-related injuries and illnesses, as needed. Each SFG(A) usually has at least two diving medical officers (physicians or PAs). Each forward-deployed SF unit, battalion-size or larger, have one diving medical officer. Other USASOC units with active combat divers normally have at least one diving medical officer assigned.

2-31. There are limited PVNTMED officers assigned within ARSOF. The PVNTMED officer is a Medical Corps officer who advises the command surgeon and staff on all matters pertaining to PVNTMED for assigned and attached elements and supported indigenous forces. He conducts and analyzes both predeployment and postdeployment surveillance. He formulates and recommends PVNTMED programs and COA designed to meet needs revealed through the survey and evaluation processes. He manages the medical intelligence program and its products. He directs the civilian public health program for the area subject to military control and coordinates this program with the military program in his capacity as the public health officer within a CA command, brigade, or battalion.

2-32. The ESEO is a Medical Service Corps officer who is the principal advisor to the group surgeon and staff on all aspects of policies, programs, practices, and operations directed toward the prevention of disease, illness, and injury. He provides assistance in executing the PVNTMED program in the areas of sanitary and public health sciences. He manages, supervises, advises, and performs professional and scientific work in PVNTMED or occupational and environmental health surveillance activities for the SFG(A). These activities include inspections, investigations, and surveys to determine compliance with existing occupational and sanitation directives, regulations for living quarters, food service facilities, water and wastewater systems, refuse disposal facilities, bivouac areas, and other installations or facilities used by military personnel. He reports the results of surveillance to the PVNTMED officer and the unit surgeon. The ESEO also maintains liaison with representatives of civilian and governmental agencies concerning public health matters.

2-33. The MEDLOG officer is the principal advisor to the group surgeon and staff on all aspects of MEDLOG and medical equipment maintenance. This officer plans, advises, manages, coordinates, and administers the organization's MEDLOG operations.

2-34. The medical plans and operations officer is the principal advisor to the SOF and Ranger Regiment surgeons and staff on all aspects of AHS planning, coordination and liaison with conventional force medical planners; in addition, they prepare patient estimates, medical materiel consumption rates, and medical intelligence and threat analysis.

2-35. The veterinarian is a Veterinary Corps officer and is the principal advisor to the group surgeon and staff for all matters relating to animal use, veterinary training, zoonotic diseases, foreign animal diseases, food safety and security inspection, and care of military working dogs. The veterinary officer is responsible for sustainment training of the SFMS in assessing and managing diseases of animals, food inspection and food hygiene in support of assigned missions. The veterinarian works with indigenous military assets and multinational or foreign government agencies. He assists in planning and executing population and resource control, civic action, and other security development and stability programs. During military and paramilitary operations, the veterinarian assists in planning and executing civic action, foreign humanitarian assistance, and other programs designed to expand the host-nation government's legitimacy within contested areas. The veterinarian also provides estimates and data on the resources essential to build an effective infrastructure for civil health and agricultural administration operations. In CA units, the veterinarian offers technical advice to the commander on issues of agricultural production systems, effects of large-scale cross-border livestock movements, veterinary services, effects from outbreaks of endemic and foreign animal disease control, and cooperation with NGOs and international organizations.

2-36. The dental officer, a commissioned Dental Corps officer and trained dentist, is the principal advisor to the group surgeon and staff for all matters relating to dental health and deployability. He is responsible for sustainment training of the SFMSs in assessing and managing dental emergencies. The dental officer at group level is assisted by a dental specialist (MOS 68E).

2-37. The ARSOF clinical psychologists apply psychological principles, theories, methods, and techniques in the assessment and selection of personnel for assignment to various positions within SOF. Special operations forces psychologists provide training, teaching, and education for personnel assigned to SOF.

They provide consultation with commanders at all levels concerning the effects of COSC on SOF personnel, make recommendations concerning team composition or individual capabilities, and feedback concerning unit morale. The SOF psychologists deploy with SOF units to provide support to the operation, and during repatriation support they can provide a key role in the rehabilitation/reconstitution of U.S. personnel who have been out from under U.S. control. This includes personnel detained by a hostile power, those who have been isolated from U.S. support, and those who have successfully evaded capture. Special operations forces psychologists are trained to provide crisis negotiation support in the form of psychological assistance to a negotiation team and can function in the role of a negotiator. In intelligence consultation or target analysis, the SOF psychologists gather information, use psychological expertise to analyze that information, and then produce behavioral intelligence evaluations. The SOF psychologist can provide support to the interrogation process. Command consultation includes providing recommendations to the chain of command on issues involving the psychological health of the command or any other issues the command deems appropriate. In the area of casualty care, SOF psychologists are trained to provide behavioral health support in crisis situations and under operational conditions. They may also assist medical/surgical teams as requested. Special operations forces psychologists provide limited clinical psychology support to SOF personnel and units while in garrison. Research projects conducted by SOF psychologists are designed to enhance the combat effectiveness of SOF personnel and their units through continuous evaluation of their selection and assessment, professional development, and training programs. Currently, SOF psychologists are assigned throughout the USASOC. The SOF psychology consultant is the Director, Psychological Applications Directorate, USASOC, and functions as a special staff officer to the USASOC commander.

Chapter 3

Army Health System and Army Medical Department Functions in Support of Army Special Operations Forces

Army SOF have limited organic medical resources and are dependent on the joint operations area medical units for the majority of their AHS support. To ensure that the ARSOF receive comprehensive and timely AHS support, organic and supporting medical planners must determine AHS requirements based on the ten medical functions. Conventional force AHS planners, in coordination with ARSOF planners, determine what support can be provided through organic assets and what support the joint operations area medical assets will provide. Early coordination and communication is the key to success for AHS support to ARSOF operations.

MEDICAL EVACUATION

3-1. The evacuation policy is established by the Secretary of Defense, with the input of the Joint Chiefs of Staff and the recommendation of the combatant commander. The joint operations area evacuation policy is driven in large part by the types of forces used in the operation, robustness of AHS assets, and operational considerations of the employment. Though guided by the evacuation policy, the actual selection of a patient for evacuation will be based on clinical judgment as to the patient's ability to tolerate and survive the movement to the next role of care. Due to the critical skills, training and experience ARSOF personnel possess, an exception to the joint operations area evacuation policy may be required to retain ARSOF personnel within the AO for longer periods of time. If the appropriate medical specialties and care are available within the joint operations area and retention will not compromise the Soldiers' health, the ARSOF commander may then request an exception to the evacuation policy.

3-2. Medical evacuation consists of collecting, sorting, transporting, and providing en route medical care. Patients are evacuated from the lower role of care by the higher role of care. Due to the limited assets and AOs in which ARSOF are deployed (austere, hostile, or denied), the use of dedicated medical evacuation assets may not be possible. The ARSOF medical planner must integrate the use of nonmedical, nonstandard evacuation assets into the medical evacuation plan. To accomplish the medical evacuation mission in hostile or denied areas, operational security dictates that the mission airframes used for the extraction of the force are used to transport patients. The ARSOF medical planner must plan for and designate extraction airframes for evacuation. These airframes are always manned with mission medical personnel. The airframes are sometimes augmented with nonmission medical personnel to manage patients during long evacuation legs or after extended operations where the mission medical personnel will not be physically or mentally ready to manage patients.

3-3. Casualty evacuation is the transport of patients on nonmedical vehicles and airframes. Special operations forces use modified evacuation equipment or purpose-built specialized equipment to meet their mission profiles. The ability to provide care en route is limited to the equipment carried by the individual providing the care; when possible, medically trained Soldiers should accompany the casualty. Casualty evacuation for ARSOF may be accomplished using a wide variety of transport options. The nature of the operation and the environment in which it is conducted will impact on the evacuation option used. The challenge for the conventional planner and ARSOF medical planners is to ensure a viable CASEVAC plan is embedded during the mission-planning phase and is thoroughly coordinated. On those missions that are covert in nature and require the infiltration and exfiltration of ARSOF, the exfiltration platforms are normally those used to extract patients.

3-4. Medical evacuation is performed by dedicated medical vehicles and aircraft staffed with MOS-qualified medical personnel to provide en route medical care. Due to the nature of ARSOF missions, direct support of ARSOF deployed in austere, hostile, or denied areas is not always possible.

3-5. Medical regulating entails identifying patients awaiting evacuation to the next role of medical care. Medical regulating provides the system for coordinating and controlling the movement of patients through the various roles of medical care and includes the functions of patient reporting and accountability. The formal system of medical regulating does not begin until the patient is admitted to a Role 3 MTF. Operational security for ARSOF units may require separate reporting and accountability methods. Patient tracking of SOF personnel is difficult due to low numbers, wide dispersion, and multiple points of entry into the AHS. One method that the USASOC (Assistant Chief of Staff [Personnel]) has favored is keeping positive control on ARSOF patients with liaison NCOs at Role 3 and 4 MTFs.

MEDICAL TREATMENT (ORGANIC AND AREA SUPPORT)

3-6. Medical treatment consists of those measures necessary to recover, resuscitate, stabilize, and prepare the casualty for evacuation. It also includes routine sick call and care of minor illness or injury. For those units who do not have organic Role 1 and Role 2 capabilities, medical treatment is provided on an area support basis. An ARSOF entry into immature joint operations areas causes unique challenges for medical coverage. Planning considerations for area medical support of ARSOF must include the unique capabilities of ARSOF health care providers and their distribution within different ARSOF units. Refer to Chapter 2 of this publication for more information.

3-7. Sick call provides the daily care for routine minor illnesses and injuries. Symptomatic care of viral upper respiratory disease, minor trauma from physical training or day-to-day base operations, and administration of routine vaccinations typify this care. The SFMS is trained to provide care independent of immediate technical supervision from a physician or PA. His abilities to care for routine minor illnesses and injuries provide SF units with sick call capability. The SOCM must be supervised by a physician or PA; in addition, the SOCM may be supervised by a physical therapist for neuromusculoskeletal conditions. Therefore, Ranger and special operations aviation (SOA) units require sick call support from their organic physicians and PAs or from the supporting joint operations area MTF.

3-8. The SFMS provides TC3 for operational casualties. This does not include resuscitative surgery. The SFMS is highly trained in the management of combat trauma. The mission profile of SF units places Soldiers at a greater time and distance from resuscitative surgical care capabilities than conventional Soldiers. The TC3 skills of the SFMS enhance the survival of wounded Soldiers in these mission profiles. The SOCMs are used in combat environments where resuscitative surgery is more rapidly accessible than the small unit missions of SF. Physicians and PAs assigned to SOCM units are trained and equipped to provide TC3. Army Health System mission planning is vital where the risk of combat penetrating trauma is high and both the time and distance to resuscitative surgery is long. It must also ensure the presence of the medical skills to perform invasive stabilization, regardless of the ARSOF unit involved.

3-9. Forward surgical teams (FSTs) provide the personnel and equipment needed to provide far forward resuscitative surgery. It does not imply that they possess definitive surgical wound care capability. The ARSOF do not possess an organic resuscitative surgical capability. This capability must be provided by the joint operations area regional or combatant command for AHS support to any ARSOF unit requiring this type of lifesaving intervention. Forward surgical team employments have been used during Operation Enduring Freedom and Operation New Dawn. One may look to both operations for examples of the lessons learned from the employment of these teams in an operational environment. One of the recurring lessons learned from Operation Enduring Freedom and Operation New Dawn is the need to provide Role 2 plus surgical resuscitative care for Soldiers. If the ARSOF surgeon and medical planner recommend options for nonstandard issue of the forward surgical team, they should ensure that medical company-like support is present to tie in with the forward surgical team. This support may be derived from the organic Role 1 abilities of the SOF battalions, SOF groups/regimental support battalions, and SB(SO)(A) provided all the critical issues of sustainment, power supply, resupply, and personnel manning are addressed and coordinated. Expeditious evacuation is and will continue to be a joint operations area supported requirement.

HOSPITALIZATION

3-10. Hospitalization is provided at Role 3 by MTFs staffed and equipped to provide care for all classes of patients. The ARSOF has no organic Role 3 hospitalization assets. Although the enhanced skills of the SFMS permit patients to be held on a short-term basis, this does not constitute a hospitalization capability. Some of this very limited and austere capability may come from the SB(SO)(A).

3-11. For nutrition care support, registered dietitians can provide nutritional advice, perform indigenous population assessments, and coordinate mass treatment/supply plans.

3-12. Role 4 hospitalization capability is available outside the theater in either a safe haven or in the continental U.S.

MEDICAL LOGISTICS

3-13. Class VIII encompasses medical supplies and equipment, medical equipment maintenance and repair support, optical fabrication, medicinal gases, and blood and blood products. Class VIII support is managed through the MEDLOG system. The ARSOF use the conventional forces MEDLOG system to satisfy its requirements. The austerity of SOF MEDLOG is due in part to long supply lines, limited storage, and transportation assets available to SOF. Numerous support requests to locations worldwide create challenges for MEDLOG support to the ARSOF. Support of local nationals and to friendly armed forces is an additional challenge SOF must meet often in austere circumstances. The SFMS is trained in blood typing and cross matching procedures; however, except in extremely unusual circumstances (such as UW), the use of blood in the management of trauma injuries occurs at Role 2 and above.

PREVENTIVE MEDICINE SERVICES

3-14. Preventive medicine services encompass those activities that are geared toward preventing or reducing the incidence of DNBI. Since ARSOF personnel are deployed into areas where the presence of endemic and epidemic diseases is high, where basic sanitation facilities and practices may not exist, where PVNTMED assets may not be readily available, and where environmental conditions may be adverse, these Soldiers are at a higher DNBI risk. Due to the fact that few PVNTMED personnel will be available during ARSOF operations, greater emphasis must be placed on the training and equipping of ARSOF personnel in small unit and individual PVNTMED knowledge, skills, and capabilities. In ARSOF units, PVNTMED programs are actively pursued and command emphasis is placed on training in PVNTMED measures. The application of PVNTMED measures is the same for ARSOF and conventional forces. The ARSOF PVNTMED support requirements exceed its organic capability. Preventive medicine support must be provided on an area support basis from joint operations area AHS assets. Significant medical information is collected by PVNTMED planners to support the intelligence preparation of the battlefield. They can be a good source of information regarding the health threat in the AO.

VETERINARY SERVICES

3-15. The Secretary of the Army is designated as the Executive Agent for the Department of Defense (DOD) Veterinary Services and is the only military Service that maintains units to provide veterinary support. Veterinary service personnel provide the following support:

- Food inspection and food safety and security.
- Surveillance and investigation of zoonotic disease or food- and waterborne illness.
- Animal medical and surgical care.
- Support to civil military operations.

DENTAL SERVICES

3-16. Dental support is designed to provide operational care to avoid the loss of trained manpower from dental disease or injury. The ARSOF and conventional applications are similar. For ARSOF, the scope of treatment may also include indigenous personnel.

COMBAT AND OPERATIONAL STRESS CONTROL

3-17. The ARSOF has a limited organic COSC capability. Depending upon security requirements, COSC support to traumatic event management is provided on an area support basis by assets within the AO.

MEDICAL LABORATORY SERVICES

3-18. Medical laboratory support consists of limited facilities, equipment, and personnel needed to analyze body tissues and fluids to assist in disease diagnosis and monitoring of therapy. The SFMS is highly trained in procedures such as microscopy and utilizing point-of-care diagnostic analyzers that enhance the ability to assess illness and injury. Army SOF has very limited organic laboratory capability.

MEDICAL MISSION COMMAND

3-19. There are no medical mission command structures within ARSOF. The control of AHS assets within ARSOF remains with the ARSOF commander.

CONVENTIONAL VERSUS SPECIAL OPERATIONS FORCES ARMY HEALTH SYSTEM SUPPORT

3-20. The unique organization of ARSOF units, the diversity of missions (often covert or clandestine in nature), and the limited number of assets (personnel and equipment) dictate the differences between AHS for conventional and ARSOF units.

SMALL UNITS AND AUSTERE AHS CAPABILITY

3-21. Army SOF possess reduced organic AHS assets capable of providing Role 2 medical care or higher. Therefore, ARSOF may require AHS support on an area basis for some Role 1 and Role 2 and higher. Special operations forces are often deployed in small units. Consequently, it is not possible to assign dedicated evacuation and area medical support assets to every ARSOF unit.

OPERATIONS IN A JOINT AND MULTINATIONAL ENVIRONMENT

3-22. Operations in these environments require officers and NCOs to have a thorough knowledge of their sister Services and multinational forces AHS capabilities, limitations, organizations, and procedures. Army SOF missions are inherently joint, combined, interagency, and multinational in nature.

REMOTE OPERATING AREAS AND LONG EVACUATION LEG

3-23. Remote operating areas and lengthy evacuation legs provide additional challenges for evacuation. Many small ARSOF units operate at a long distance from airfields suitable for evacuation. The ARSOF units must often operate in areas that impede evacuation by rotary-wing aircraft or where aviation assets are not available from U.S., multinational, or host-nation assets. This places a premium on the early application of TC3 skills to stabilize the patient for what may be a prolonged period of evacuation.

MEDICAL EVACUATION, MEDICAL REGULATING, AND PATIENT TRACKING

3-24. The function of medical regulating and patient tracking requires an understanding of the nature of potential ARSOF missions and the limited ability of the personnel replacement system to provide replacements. Listing names or units of evacuated Soldiers can compromise classified missions. Sensitive equipment or documents must be accounted for if the Soldier is still in possession of them when evacuated. Army SOF Soldiers represent a substantial investment in training time and money. Rapid replacements may not be available. Army SOF Soldiers may require exceptions to joint operations area evacuation policies (length of time for recovery within the AO) if they can recover from their illness or injuries within the capability of the joint operations area medical care assets.

INCREASED THREATS FROM GROUND FIRE, AIR DEFENSE ARTILLERY, AND LACK OF AIR SUPERIORITY

3-25. Since many ARSOF mission profiles dictate employment far forward before air superiority can be established, ARSOF often deploy into tactical situations that are more vulnerable to hostile air defense artillery and enemy aircraft. As a result, evacuation does require armed airframes that can provide movement of patients on airframes of opportunity as well as armed escort. When possible, prior planning should be made to place a medically trained Soldier on the aircraft to provide en route medical care. Furthermore, it usually requires manual evacuation over extended distances to an area suitable for pickup by air or ground assets. Therefore, it is necessary to plan for delays in ground movement associated with manual evacuation.

PREVENTIVE MEDICINE

3-26. The absence of AMEDD PVNTMED personnel in ARSOF teams and small units means that ARSOF commanders, leaders, and individuals must possess greater PVNTMED knowledge, skills, and capabilities than their conventional forces counterparts. The importance of PVNTMED activities cannot be overstated. Throughout history, more combat ineffectiveness is caused by DNBI than from operational injuries. Due to the ARSOFs employment in isolated areas of developing countries, proper hygiene, sanitation (clean water and proper waste disposal), DNBI protection, and personal protective measures are especially critical factors in ARSOF planning considerations. Army SOF Soldiers are frequently exposed to endemic and epidemic diseases, disease vectors, poisonous plants, and wild animals. Therefore, it is vital that SOF Soldiers are up to date on their immunizations well in advance of any deployment; ARSOF policy may require additional chemoprophylaxis and immunizations. Chemical, biological, radiological, and nuclear occupational and environmental hazards also may result in acute or chronic health effects to SOF Soldiers. Required pre- and postdeployment medical surveillance forms will provide a record of potentially hazardous exposures to the Soldiers and add to the medical information for the AO. However, health impacts may not be attributed to the initial exposure unless a mechanism for tracking, reporting, and utilizing environmental surveillance data is in place. The ARSOF, therefore, require PVNTMED support (above their organic capabilities) from the theater. To better identify and document occupational and environmental hazards and associated health or operational risks, environmental surveillance samples may be collected and forwarded back to Role 4 PVNTMED laboratories such as the United States Army Public Health Center (Provisional) for evaluation. The United States Army Public Health Center (Provisional) maintains a classified capability for management of the samples and the resulting data. Data can be analyzed by United States Army Public Health Center (Provisional) then channeled back to ARSOF to assist in determining health threats for current and future operations. This postmission health threat analysis provides an important benefit to current and future missions.

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Chapter 4

Planning Army Health System Support to Army Special Operations Forces

The AHS support mission is fundamentally the same for either conventional forces or ARSOF. The AHS planning process involving mission requirements, commander's intent, wargaming, development of different COA, use of the military decisionmaking process, rehearsal, implementation, and operational tracking is the same for both conventional and ARSOF. Since the ARSOF have limited organic medical resources, they will be dependent on the joint operations area medical units for much of their AHS support. Both conventional and ARSOF medical planners must ensure the AHS plan is coordinated, synchronized, and rehearsed to facilitate mission accomplishment.

HEALTH THREAT

4-1. The health threat is a composite of ongoing and potential enemy actions. These include adverse environmental, occupational, and geographic and meteorological conditions; endemic diseases; and employment of CBRN weapons (to include weapons of mass destruction) that could reduce the effectiveness of friendly forces. These actions and conditions also include wounds, injuries, diseases, and psychological stressors. Information to assess the health threat caused by enemy actions should be obtained from intelligence sources. Therefore, the health threat and operational considerations dictate the planning, preparation and subsequent execution phases of the mission to include appropriate preventive medicine measures to counter the health threat.

ARMY SPECIAL OPERATIONS FORCES PLANNING FOR ARMY HEALTH SYSTEM SUPPORT

4-2. The type of mission to be supported often dictates what specific medical functions and services are required. Although the likelihood may exist that some functions will not be required for the primary mission, it is prudent to plan for support in the event it is needed. Tables 4-1 through 4-8, on pages 4-3 through 4-15, depict the most likely support requirements for ARSOF core activities.

4-3. The AHS support planning for SOF assets involves numerous considerations that do not normally apply to conventional forces. Indeed, SOF units and personnel often operate over a wide area and in very isolated and austere locations. Conventional AHS units are normally unable to provide direct support to deployed SOF units. Support to ARSOF is provided on an as-needed basis and must be flexible to provide the required support when and where needed.

4-4. Since ARSOF Soldiers cannot be readily replaced, an exception to the theater evacuation policy may be required to ensure that SOF personnel with critical skills remain in the AO. If a SOF patient can recover within the AHS capabilities available in the joint operations area without detriment to his health, an exception may be required to allow for a longer convalescent period within the AO. For example, physical therapists are highly trained in the treatment of neuromusculoskeletal injuries and this allows SOF personnel to convalesce in the AO for longer periods of time.

4-5. The supporting medical unit's mission command headquarters must be able to establish communications links to the theater SO command. The theater SO command has robust communications capabilities ranging from single channel radios to multichannel satellite transmission systems that provide video teleconferencing; secure voice and data; and more advanced capabilities not listed in this publication.

Deployed ARSOF will have multiple communications systems as well. Medical units will establish contact and coordinate AHS support requirements to ensure they can communicate with the unit/s they are required to support.

4-6. The AHS plan is normally part of Annex F (Sustainment) Appendix 3 to the corps/division plan. It must be in sufficient detail to designate specific area support responsibilities for all medical support to ARSOF units. This level of detail in the AHS appendix of the operation plan and operation order ensures that all medical function capabilities within the supporting medical units are available for support of SOF personnel when required. Regardless of the type of operation to be conducted, the medical planner must consider all medical functions discussed in FM 4-02 when developing the AHS plan. Due to the covert nature of some ARSOF operations, direct support from conventional medical units within the AO may not be feasible during operations. However, if support is required for SOF units/personnel following the completion of the mission AO medical units will provide AHS support on an area basis to assigned and attached SOF elements. To ensure this support will be available, the ARSOF medical planner must develop a comprehensive plan and thoroughly coordinate and update the plan with the supporting medical mission command headquarters. In ARSOF operations where medical units are not available in the AO, tasking for specific AHS support requirements and capabilities are critical for adequate AHS.

Note. Casualty evacuation is not a medical mission. It is the responsibility of the SOF unit commander. When in hostile or denied areas, medical evacuation assets are not deployed in support of this operation. Once the SOF personnel are extracted from the hostile or denied territory, medical evacuation assets can be coordinated for support.

DIRECT ACTION

4-7. Direct action missions are short duration strikes that can be executed by either small unit/element deployments, such as a SF operational detachment A, or by forces in a company-size or larger contingent. Initial evacuation for SOF casualties may require CASEVAC depending on the threat and the location of the casualties. Medical evacuation vehicles are normally used when the ARSOF are no longer in hostile or denied territory. Although these operations are of a short duration, the ARSOF planner must consider all AMEDD functions to ensure services are available should the operation be prolonged or the forces transition to other missions. Table 4-1 depicts organic and joint operations area AHS requirements for direct action missions. The ARSOF AHS support requirements may include—

- Organic support required includes PVNTMED, sick call services, and CASEVAC capabilities.
- Joint operations area support required includes medical evacuation and medical regulating, TC3, resuscitative surgery, hospitalization, and MEDLOG and blood support.
- Support required after mission completion includes dental, COSC, medical laboratory services, and veterinary services.

Table 4-1. Army Health System requirements for direct action activities

Function	Mission requirement	Justification	Provided by
Medical evacuation and medical regulating <ul style="list-style-type: none"> • Casualty evacuation • Medical evacuation • Medical regulating 	Required (organic). Required (theater). Required (theater).	Extraction of casualties/patients from hostile or denied areas. Continue evacuation within or from the theater. Regulate patients within or from theater hospitals.	ARSOF airframes. Theater assets. Theater assets.
Medical treatment <ul style="list-style-type: none"> • Sick call • TC3 • Resuscitative surgery 	Required (organic). Required (theater). Required (theater).	Care of minor illness or injury. Manage combat trauma. Emergency surgical stabilization for further evacuation.	SFMS, SOCMs, physician, PA, or PT. Theater assets. FST collocated with maneuver BSMC.
Hospitalization	Required (theater).	Provide essential care and services.	Theater assets.
Medical logistics and blood management	Required (theater).	Resupply of medical equipment and Class VIII supplies not anticipated. Trauma injuries dictate additional blood requirement for supporting FSTs.	Maneuver BSMC.
Preventive medicine	Required (organic).	Identify health threats and recommend PMM.	SFMS, physician, or PA.
Veterinary	Minimal (theater).	Class I inspection or animal care-related support.	Theater assets.
Dental	Minimal (theater).	Provide operational dental care (emergency and essential).	SFMS, physician, or PA for emergency care (theater assets for operative dental care and maxillofacial surgery).
Combat and operational stress control	Minimal (theater).	Short-duration operation. Support may be required for TEM upon completion of the operation.	Theater assets.
Medical laboratory services	Minimal (theater).	Used for identification of CB agent samples collected during the mission. This support would be provided by theater assets such as the AML.	Theater assets.
LEGEND:			
AML	area medical laboratory	PMM	preventive medicine measures
ARSOF	Army special operations forces	PT	physical therapist
BSMC	brigade support medical company	SFMS	special forces medical sergeant
CB	chemical-biological	SOCM	special operations combat medic
FST	forward surgical team	TC3	tactical combat casualty care
PA	physician assistant	TEM	traumatic event management

SPECIAL RECONNAISSANCE

4-8. Like direct action, SR requires availability of AHS support for Soldiers operationally engaged in hostile, denied, or politically sensitive reconnaissance and surveillance actions. Longer mission duration places more emphasis on PVNTMED. Table 4-2 depicts organic and joint operations area AHS requirements for SR operations. The ARSOF AHS support requirements may include—

- Organic support includes CASEVAC, sick call services, and PVNTMED.
- Joint operations area support includes medical evacuation and medical regulating, TC3, resuscitative surgery, hospitalization, and MEDLOG and blood management.
- Minimal support includes veterinary, dental, COSC, and medical laboratory services.

Table 4-2. Army Health System requirements for special reconnaissance activities

<i>Function</i>	<i>Mission requirement</i>	<i>Justification</i>	<i>Provided by</i>
Medical evacuation and medical regulating <ul style="list-style-type: none"> • Casualty evacuation • Medical evacuation (not in hostile or denied territory) • Medical regulating 	Required (organic). Required (theater). Required (theater).	Extraction of casualties/ patients from the point of injury to casualty collection point, forward operating base, or nearest MTF. Medical evacuation of patient from the point of injury, casualty collection point, or forward operating base to the nearest MTF. Regulate patients within or from theater hospitals.	Available platforms. Theater assets. Theater assets.
Medical treatment <ul style="list-style-type: none"> • Sick call • TC3 • Resuscitative surgery 	Required (organic). Required (theater). Required (theater).	Care of minor illness or injury. Manage combat trauma. Emergency surgical stabilization for further evacuation.	SFMS, SOCMs, physician, PA, or PT. Theater assets. FST collocated with maneuver BSMC.
Hospitalization	Required (theater).	Provide essential care and services.	Theater assets.
Medical logistics and blood management	Required (theater).	Resupply of medical equipment and Class VIII supplies not anticipated. Trauma injuries dictate additional blood requirement for supporting FSTs.	Theater assets (medical logistics company and blood support detachment).
Preventive medicine	Required (organic).	Identify health threats and recommend PMM.	SFMS, physician, or PA.
Veterinary	Minimal (theater).	Class I rations inspection or animal care-related support.	Theater assets.
Dental	Minimal (theater).	Provide operational dental care (emergency and essential).	SFMS, physician, or PA for emergency care (theater assets for operative dental care and oral surgical).

Table 4-2. Army Health System requirements for special reconnaissance activities (continued)

<i>Function</i>	<i>Mission requirement</i>	<i>Justification</i>	<i>Provided by</i>
Combat and operational stress control	Minimal (theater).	Short to moderate duration operation. Support may be required for TEM upon completion of the operation.	Theater assets.
Medical laboratory services	Minimal (theater).	Used for identification of CB agent samples collected during the mission. This support would be provided by theater assets such as the AML.	Theater assets.
LEGEND:			
AML	area medical laboratory	PMM	preventive medicine measures
BSMC	brigade support medical company	PT	physical therapist
CB	chemical-biological	SFMS	special forces medical sergeant
FST	forward surgical team	SOCM	special operations combat medic
MTF	medical treatment facility	TC3	tactical combat casualty care
PA	physician assistant	TEM	traumatic event management

FOREIGN INTERNAL DEFENSE

4-9. Army Health System support for FID operations is characterized by a lower likelihood of traumatic injury than direct action or SR and an increased risk of DNBI from prolonged contact with the indigenous population and both domestic and wild animals. However, there is a requirement for resuscitative surgery due to the threats in the FID operational environment. Such threats can be the result of a motor vehicle collision secondary to blackout conditions, a rotary wing accident secondary to brownout, blunt trauma from falls or all-terrain vehicle accidents, negligent discharges of weapons, and overpressure or penetrating trauma from unexploded ordnance. Although the likelihood for penetrating trauma is less than in direct action, the requirement is mandated by the nature of the environment. This type of mission requires increased emphasis on PVNTMED. Table 4-3 on pages 4-6 and 4-7 depicts organic and joint operations area AHS support for FID operations. The support required for ARSOF AHS conducting FID missions may include—

- Organic support required includes TC3.
- Joint operations area support includes, medical evacuation and medical regulating, hospitalization, and MEDLOG.
- Support required from both organic and joint operations area resources includes sick call services, PVNTMED, veterinary, and dental services.
- Minimal support required includes resuscitative surgery, COSC, and medical laboratory services.

Table 4-3. Army Health System requirements for foreign internal defense activities

<i>Function</i>	<i>Mission requirement</i>	<i>Justification</i>	<i>Provided by</i>
Medical evacuation and medical regulating <ul style="list-style-type: none"> • Casualty evacuation • Medical evacuation • Medical regulating 	Minimal (organic). Required (theater). Required (theater).	Mission executed in areas accessible by dedicated medical evacuation assets. Security restrictions do not apply. May be required for serious illness or injury. May be required for serious illness or injury.	Organic. Theater assets. Theater assets.
Medical treatment <ul style="list-style-type: none"> • Sick call • TC3 • Resuscitative surgery 	Required (organic and theater). Required (organic). Required (theater).	Care of minor illness or injury. Care of traumatic injury. Surgical intervention dictated by traumatic injuries.	Capability dependent upon type of SOF unit deployed (SFMS, SOCMs, physician, PA, PT, and theater medical company (area support). SFMS/SOCM. Theater assets.
Hospitalization	Required (theater).	When recovery requires hospital care and further medical treatment.	Theater assets.
Medical logistics and blood management	Required (theater).	Resupply of Class VIII and replacement of medical equipment as required. Blood supply management dictated by mission.	Theater assets.
Preventive medicine	Required (organic and theater).	Identify health threats and recommend PMM.	SF group SFMS, ESEO, PVNTMED officer, and veterinarian. Theater support for OEH surveillance.
Veterinary	Required (organic and theater).	Class I inspection of rations, care of MWDs, and veterinary PVNTMED.	SF group and civil affairs personnel (SFMS and veterinarian).

Table 4-3. Army Health System requirements for foreign internal defense activities (continued)

<i>Function</i>	<i>Mission requirement</i>	<i>Justification</i>	<i>Provided by</i>
Dental	Required (organic and theater).	Provide emergency and essential dental care. Manage dental disease in both United States and HN personnel.	SF group (SFMS and dental officer). Theater assets for requirements exceeding organic capability.
Combat and operational stress control	Minimal (theater).	Support may be required for TEM and routine BH support.	Theater assets.
Medical laboratory services	Minimal (theater).	Limited diagnostic capability for Role 2 MTFs. For identification of CB agent samples collected during mission. Support provided by theater assets such as AML	Theater assets.
LEGEND:			
AML	area medical laboratory	PMM	preventive medicine measures
BH	behavioral health	PT	physical therapist
CB	chemical-biological	PVNTMED	preventive medicine
ESEO	environmental science and engineer officer	SF	special forces
HN	host nation	SFMS	special forces medical sergeant
MTF	medical treatment facility	SOCM	special operations combat medic
MWD	military working dog	SOF	special operations forces
OEH	occupational and environmental health	TC3	tactical combat casualty care
PA	physician assistant	TEM	traumatic event management

UNCONVENTIONAL WARFARE

4-10. Forces deployed in UW operations require support to develop a parallel system of AHS for indigenous guerrilla military operations as opposed to an AHS system for ARSOF personnel only. The indigenous parallel medical system may take many forms but its existence is required to both conserve the fighting strength of indigenous forces and to motivate partisan forces. Evacuation of injured indigenous personnel working with ARSOF can impact greatly on a commander’s mission in the AO. Selected indigenous personnel may be evacuated on U.S. aircraft depending upon the theater policies and Army regulations (ARs). Initially, ARSOF may need additional support from selected joint operations area AHS assets, but will generally rely on building organic medical capabilities within the guerrilla paramilitary organization. In UW operations, Medical Corps officers serve as leaders/advisors of the UW medical system for indigenous personnel. The expertise required is focused on training indigenous personnel and building a guerrilla medical infrastructure (rather than the actual provision of health care which must be based upon specific funding authority). The medical planner is required to initially and continuously assess the guerrilla medical capability. The desired end state is to have developed medical infrastructure capable of supporting guerrilla large-scale unit operations. Initially, medical capabilities may be very limited and may be almost completely executed by U.S. forces inserted into the AO. As guerrilla forces mature in their operational capabilities, their medical capabilities must mature in parallel. Thus, the ARSOF planner must plan for and coordinate medical support to deployed U.S. ARSOF personnel and arrange for any transportation and/or evacuation as required for routine and emergency medical treatment. Due to the expanded role of the SFMS in UW missions, augmentation of the medical capability may be required. Additional medical equipment sets may be required (dental, laboratory, or veterinary) to enhance mission accomplishment. Deploying with additional medical equipment sets enables the SFMS to maximize his ability to provide sustainment of guerrilla and ARSOF personnel. Table 4-4 on pages 4-8 and 4-9 depicts

organic and joint operations area AHS requirements for UW operations. In UW operations, the following ARSOF AHS support requirements may include—

- Organic support required includes sick call services, TC3, PVNTMED, veterinary, dental, MEDLOG, and medical laboratory services.
- Joint operations area support includes resuscitative surgery, hospitalization, and MEDLOG and blood management.
- In UW operations, host-nation support is not available.
- Minimal support required includes medical evacuation (only if authorized by theater policy and regulations, as this requires a dedicated medical evacuation platform that most likely would not be sustainable by indigenous guerrilla assets and COSC).

Table 4-4. Army Health System requirements for unconventional warfare activities

<i>Function</i>	<i>Mission requirement</i>	<i>Justification</i>	<i>Provided by</i>
Medical evacuation and medical regulating <ul style="list-style-type: none"> ● Medical evacuation ● Medical regulating 	Minimal (organic and foreign nation). Minimal (theater).	Requires a dedicated medical platform that would not be sustainable by indigenous assets. Theater support is required for ARSOF personnel. Formal medical regulating is initiated at Role 3 MTFs. Indigenous personnel will not be admitted to U.S. Role 3 MTFs.	Theater assets. U.S. personnel may need to provide training and/or develop an informal tracking system to support Army Health System being established.
Medical treatment <ul style="list-style-type: none"> ● Sick call ● TC3 ● Resuscitative surgery 	Required (organic and foreign nation). Required (organic and foreign nation). Required (organic and foreign nation).	Care of minor illness or injury. Management of trauma upon commencement of combat operations. Management of combat trauma after TC3.	SFMS, physician, PA, PT, or foreign nation equivalent. SFMS or foreign nation equivalent. Theater assets for care of U.S. personnel; foreign nation medical assets for care of foreign nation personnel. Theater assets may be required to augment foreign nation capability.
Hospitalization	Required (theater and foreign nation). Separate systems are required for U.S. personnel and indigenous forces.	Care and recuperation of combat trauma; care of serious illness and injury; and increased risk of disease and environmental injuries may necessitate hospitalization.	Theater assets for U.S. personnel; foreign nation medical assets for their forces; theater assets may be required to augment foreign nation capabilities.

Table 4-4. Army Health System requirements for unconventional warfare activities (continued)

<i>Function</i>	<i>Mission requirement</i>	<i>Justification</i>	<i>Provided by</i>
Medical logistics and blood management	Required (theater).	Resupply of Class VIII supplies and equipment dependent upon duration of operation. Blood required for far forward resuscitative surgery. ARSOF may be the sole source of Class VIII for supported indigenous forces. ARSOF MEDLOG officer may need to secure non-U.S. medical supplies to support clandestine/covert operations. Class VIII resupply system must also be established.	ARSOF and theater assets.
Preventive medicine	Required (organic and foreign nation).	Identify health threats and recommend PMM.	SF group (SFMS, ESEO, veterinarian, and PVNTMED officer) and foreign nation equivalent.
Veterinary	Required (organic and foreign nation).	Class I rations inspection and animal care-related support.	SFMS, ARSOF veterinarians, and foreign nation equivalent.
Dental	Required (organic and foreign nation for indigenous forces; theater assets for ARSOF personnel).	Restore dental health of indigenous forces. Provide operational dental support (emergency and essential) for ARSOF personnel.	SFMS, ARSOF dentists, and foreign nation equivalent. Theater assets.
Combat and operational stress control	Minimal (theater).	Theater assets if needed to support PTE and TEM.	Theater assets.
Medical laboratory services	Required (organic and foreign nation).	Establish indigenous capability.	SFMS or foreign nation equivalent.
LEGEND:			
ARSOF	Army special operations forces	PTE	potential traumatizing events
ESEO	environmental science and engineer officer	PVNTMED	preventive medicine
MEDLOG	medical logistics	SF	special forces
MTF	medical treatment facility	SFMS	special forces medical sergeant
PA	physician assistant	TC3	tactical combat casualty care
PMM	preventive medicine measures	TEM	traumatic event management
PT	physical therapist	U.S.	United States

COUNTERTERRORISM

4-11. Counterterrorism reflects direct action and SR in its AHS requirements. The accessibility of trauma care is dependent on whether the activity occurs in denied or friendly territory. As the duration of the

operation lengthens, AHS requirements will increase. Table 4-5 depicts organic and theater AHS requirements for CT operations. The ARSOF AHS support requirements may include—

- Organic support required includes CASEVAC, sick call services, and TC3.
- Joint operations area required support includes medical evacuation and medical regulating, resuscitative surgery, hospitalization, MEDLOG and blood management, and medical laboratory services.
- Support required from both organic and theater resources includes PVNTMED, veterinary support, and COSC.
- Minimal support required for dental support.

Table 4-5. Army Health System requirements for counterterrorism activities

<i>Function</i>	<i>Mission requirement</i>	<i>Justification</i>	<i>Provided by</i>
Medical evacuation and medical regulating			
<ul style="list-style-type: none"> ● Medical evacuation 	Required (theater).	Evacuation within or from theater.	Theater assets.
<ul style="list-style-type: none"> ● Medical regulating 	Required (theater).	Regulate patients within or from theater hospitals.	Theater and strategic assets.
Medical treatment			
<ul style="list-style-type: none"> ● Sick call 	Required (organic).	Care of minor illness or injury.	SFMS, physician, PA, or PT.
<ul style="list-style-type: none"> ● TC3 	Required (organic).	Manage trauma patients.	SFMS, physician, or PA.
<ul style="list-style-type: none"> ● Resuscitative surgery 	Required (theater).	Emergency surgical stabilization for further evacuation.	Theater assets. FST collocated with a BSMC).
Hospitalization	Required (theater).	Provide essential care and permit recuperation within theater if feasible.	Theater assets.
Medical logistics and blood management	Required (theater).	If the duration of the operation is extended, Class VIII resupply may be required. Trauma injuries may dictate additional blood requirements.	Theater assets.
Preventive medicine	Required (organic and theater).	Identify health threats and recommends PMM.	SFMS and theater support for OEH surveillance.
Veterinary	Required (organic and theater).	Class I rations inspection support. Care of MWDs used for security and ordnance detection.	SFMS, ARSOF veterinarians, and theater assets.

Table 4-5. Army Health System requirements for counterterrorism activities (continued)

<i>Function</i>	<i>Mission requirement</i>	<i>Justification</i>	<i>Provided by</i>
Combat and operational stress control	Required (organic and theater).	Support may be required for TEM upon completion of the operation.	SFG(A), COSC, and theater assets.
Medical laboratory services	Required (theater).	Required for the identification of suspect CB agent samples collected during the mission. This support may be provided by theater assets such as the AML.	Theater assets.
LEGEND:			
AML	area medical laboratory	PA	physician assistant
ARSOF	Army special operations forces	PMM	preventive medicine measures
BSMC	brigade support medical company	PT	physical therapist
CB	chemical-biological	SFG(A)	special forces group (airborne)
COSC	combat and operational stress control	SFMS	special forces medical sergeant
FST	forward surgical team	TC3	tactical combat casualty care
MWD	military working dog	TEM	traumatic event management
OEH	occupational and environmental health		

COUNTERING WEAPONS OF MASS DESTRUCTION

4-12. Countering weapons of mass destruction is similar to CT in its AHS requirements. The notable exception is the use of special equipment and therapeutic agents against chemical-biological agents. The accessibility of trauma care depends on whether the activity occurs in denied or friendly territory. As the duration of the operation increases, so do the AHS requirements. Table 4-6 on page 4-12 depicts organic and theater AHS requirements for counterproliferation of weapons of mass destruction mission. Countering weapons of mass destruction support requirements for ARSOF AHS may include—

- Organic support required includes TC3.
- Joint operations area support required includes medical evacuation and medical regulating, resuscitative surgery, hospitalization, MEDLOG and blood management, and medical laboratory services.
- Support required from both organic and theater resources include sick call services, PVNTMED, and veterinary services.
- Minimal support required includes dental and COSC.

Table 4-6. Army Health System requirements for countering weapons of mass destruction

<i>Function</i>	<i>Mission requirement</i>	<i>Justification</i>	<i>Provided by</i>
Medical evacuation and medical regulating <ul style="list-style-type: none"> • Medical evacuation • Medical regulating 	Required (theater). Required (theater).	Evacuate patients from friendly areas. Regulate patients within or from theater hospitals.	Theater assets. Theater and strategic assets.
Medical treatment <ul style="list-style-type: none"> • Sick call • TC3 • Resuscitative surgery 	Required (organic and theater). Required (organic). Required (theater).	Care of minor illness or injury. Manage trauma patients. Provide lifesaving surgical intervention for trauma patients.	SFMS, physician or PA, and PT theater assets. SFMS, physician or PA. Theater assets.
Hospitalization	Required (theater).	Provide essential care and permit recuperation in theater, if feasible.	Theater assets.
Medical logistics and blood management	Required (theater).	Resupply of medical equipment, Class VIII as the duration of the mission lengthens. Blood supply and management is required for the care of trauma patients.	Theater assets.
Preventive medicine	Required (organic and theater).	Identify health threats and recommend PMM.	SFMS and theater support for OEH surveillance.
Veterinary	Required (organic and theater).	Care of MWDs used to detect ordnance. Inspection of Class I ration items.	SFMS, ARSOF veterinarians, and theater assets.
Dental	Minimal (theater).	Provide emergency and essential dental care.	Theater assets.
Combat and operational stress control	Minimal (theater).	Support may be required for TEM upon the completion of the operation.	Theater assets.
Medical laboratory services	Not required unless needed for CB agent identification.	Used for identification of suspect CB agent samples collected during the mission. This support would be provided by theater medical assets such as the AML.	Theater assets.
LEGEND:			
AML	area medical laboratory	PMM	preventive medicine measures
ARSOF	Army special operations forces	PT	physical therapist
CB	chemical-biological	SFMS	special forces medical sergeant
MWD	military working dog	TC3	tactical combat casualty care
OEH	occupational and environmental health	TEM	traumatic event management
PA	physician assistant		

CIVIL AFFAIRS OPERATIONS

4-13. The limited medical personnel resources in CA units advise, evaluate, coordinate, and direct AHS activities. However, they do not execute AHS activities. Civil affairs engage the civil component of the operational environment through all phases of operations to enhance military efforts and promote legitimacy of military operations. Their responsibilities include advising the commander on CA operations. They perform medical assessments and health threat analysis and coordinate with host-nation military and civilian authorities, as well as coordinate efforts with NGOs. Table 4-7 on pages 4-13 and 4-14 depicts organic and theater AHS requirements for CA operations. Requirements for ARSOF AHS support may include—

- Organic support required includes PVNTMED and veterinary medicine.
- Joint operations area support required includes medical evacuation, medical regulating, hospitalization, and dental.
- Support required from both organic and joint operations area resources includes sick call services.
- Minimal support required includes TC3 and resuscitative surgery, MEDLOG and blood management, COSC, and medical laboratory services.

Table 4-7. Army Health System requirements for civil affairs operations

<i>Function</i>	<i>Mission requirement</i>	<i>Justification</i>	<i>Provided by</i>
Medical evacuation and medical regulating <ul style="list-style-type: none"> • Medical evacuation • Medical regulating 	Required (theater). Required (theater).	Continue evacuation within or from theater. Regulate patients within or from theater hospitals.	Theater and strategic assets. Theater assets.
Medical treatment <ul style="list-style-type: none"> • Sick call • TC3 • Resuscitative surgery 	Required (organic and theater). As required. As required.	Care of minor illness or injury. For trauma. For trauma.	Theater assets. Theater assets. Theater assets.
Hospitalization	Required (theater).	Provide essential care and permit recuperation within theater, if feasible.	Theater assets.
Medical logistics and blood management	Minimal (theater).	Class VIII resupply may be required for ongoing CA missions. Trauma incidents may increase blood requirements for supporting forward surgical teams.	Theater assets.
Preventive medicine	Required (organic).	Identify health threats and recommend PMM. Provide PVNTMED advice to host-nation personnel/agencies.	Theater assets.

Table 4-7. Army Health System requirements for civil affairs operations (continued)

<i>Function</i>	<i>Mission requirement</i>	<i>Justification</i>	<i>Provided by</i>
Veterinary	Required (organic).	Class I inspection or animal medical care-related support.	Theater assets.
Dental	Required (theater).	Provide emergency and essential dental care.	Theater assets.
Combat and operational stress control	Minimal (theater).	May be required for TEM or routine BH support.	Theater assets.
Medical laboratory services	Minimal (theater).	May be required for diagnostic procedures, consultation, and identification of suspect CB agents. This support would be provided by theater assets such as the AML.	Theater assets.
LEGEND:			
AML	area medical laboratory	PMM	preventive medicine measures
BH	behavioral health	PVNTMED	Preventive medicine
CA	civil affairs	TC3	Tactical combat casualty care
CB	chemical-biological	TEM	Traumatic event management

MILITARY INFORMATION SUPPORT OPERATIONS

4-14. The AHS requirement for MISO consists of the conventional AHS mission to a deployed force. The execution of MISO does not require AHS support. Military information support operations units are dependent upon theater assets to meet their AHS needs (see Table 4-8). Support is provided on an area basis. The ARSOF AHS support requirements may include—

- Organic support required: NA.
- Joint operations area support required includes medical evacuation and medical regulating, sick call services, hospitalization, PVNTMED, veterinary services, and dental.
- Minimal support required includes TC3 and resuscitative surgery, MEDLOG and blood management, COSC, and medical laboratory services.

Table 4-8. Army Health System requirements for military information support operations

<i>Function</i>	<i>Mission requirement</i>	<i>Justification</i>	<i>Provided by</i>
Medical evacuation and medical regulating <ul style="list-style-type: none"> • Medical evacuation • Medical regulating 	Required (theater). Required (theater).	Conventional support to a deployed force. Regulate patients within or from theater hospitals.	Theater assets. Theater and strategic assets.
Medical treatment <ul style="list-style-type: none"> • Sick call • TC3 • Resuscitative surgery 	Required (theater). Minimal (theater). Minimal (theater).	Care for minor illness or injury. Manage trauma. Provide lifesaving surgical intervention for trauma patients.	Theater assets. Theater assets. Theater assets.
Hospitalization	Required.	Provide essential care and permit recuperation within theater, if feasible.	Theater assets.
Medical logistics and blood management	Minimal (theater).	Class VIII resupply not expected.	Theater assets.
Preventive medicine	Required (theater).	Identify health threats and recommend PMM.	Theater assets.
Veterinary	Required (theater).	Class I inspection or animal care-related support.	Theater assets.
Dental	Required (theater).	Provide emergency and essential dental care.	Theater assets.
Combat and operational stress control	Minimal (theater).	May be required for TEM or routine BH support.	Theater assets.
Medical laboratory services	Minimal (theater).	May be required for diagnostic procedures, consultation, and identification of suspect CB agents. Support would be provided by theater assets such as the AML.	Theater assets.
LEGEND:			
AML	area medical laboratory	PMM	preventive medicine measures
BH	behavioral health	TC3	tactical combat casualty care
CB	chemical-biological	TEM	traumatic event management

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Chapter 5

Army Special Operations Forces in a Joint Operations Area

Joint operations are the military actions or activities of two or more Service forces. They can also be the actions of two or more elements of the same Service, such as Army and Army elements of the USASOC where only joint support or coordinating authority exists. The AHS mission in joint operations is to minimize the effects of wounds, injuries, and diseases on unit effectiveness, readiness, and morale. This mission is accomplished by a proactive PVNTMED program and a phased health care system (roles of medical care) that extends from actions taken at the point of wounding, injury, or illness to evacuation from the joint operations area for treatment at an MTF in the support base. The primary objective of AHS support is to conserve the commander's fighting strength of SO land, sea, and air forces. Army Health System support in joint operations requires continuous planning, coordination, and training to ensure prompt, effective, and unified health care delivery.

THE JOINT TASK FORCE

5-1. Generally, joint operations are directed by combatant commands and Service component commands. Combatant commands, however, may conduct operations within their AO by activating joint SO task forces. The joint SO task forces are established to accomplish specific, limited goals that require the significant and closely integrated efforts of forces from two or more Services (or elements thereof). The joint SO task force commander is appointed by the combatant commander and exercises operational control over assigned and attached forces. The joint special operations task force commander may also serve as the commander of a joint SO task force Service component.

SPECIAL OPERATIONS FORCES IN JOINT OPERATIONS

5-2. Special operations forces give the JTF commander a valuable asset towards mission accomplishment whether that mission is direct action, foreign humanitarian assistance, or other tasks. The composition of the force is dependent upon the resources available, specific type of operation, and anticipated duration of the operation. How the JTF structures the mission command of SOF is also dependent on mission, enemy, terrain and weather, troops and support available, time available, and civil considerations (mission variables) factors. The JTF commander may establish a joint SO task force. If the situation does not warrant a joint SO task force, the JTF will have a joint force SO component. The joint force SO component commander makes recommendations to the JTF commander on the proper employment of SOF and the planning and coordination of SO. Typically the JTF commander will have a surgeon and staff. If a joint SO task force is warranted, a joint special operations task force surgeon is required. It is incumbent upon the JTF surgeon and his planner to coordinate AHS support for the SOF component of the JTF.

ARMY HEALTH SYSTEM CONSIDERATIONS IN JOINT TASK FORCE PLANNING

5-3. The types of operations that may require the activation of a JTF are normally crisis or emergency situations for which there may not be an existing operation plan. The combatant command normally identifies and activates the JTF during the COA development phase. Typically, the JTF commander will have a surgeon on staff. Normally, a joint special operations task force will have a surgeon and a SOF

psychologist to provide operational psychology support. It is incumbent upon the JTF surgeon and his planner to coordinate AHS support for the SOF component of the JTF.

5-4. Upon JTF activation, the JTF surgeon begins operational planning. The surgeon must understand that SOF forces are another Service-like component of the task force that requires detailed planning, coordination and synchronization for operational success. Specifically, the JTF surgeon should perform the following functions:

- Review standing operating procedures and operations orders.
- Obtain and integrate operational medical information into the AHS planning process.
- Update and standardize AHS planning factors, as required.
- Determine the extent of and initiate planning to medically support noncombatant evacuation operations. These operations may be conducted in the environments of conflict and war.
- Obtain and review health threat and PVNTMED information pertinent to the operation. Identify any additional medical essential elements of information and request information from the JTF intelligence section.
- Develop JTF AHS policies and procedures.
- Determine deployed SOF AHS requirements.
- Coordinate with JTF operational planners during concept development and assess health risks associated with alternate COA.
- Assess multinational and NGO medical asset availability.
- Assess host-nation medical availability.
- Develop and coordinate the JTF AHS concept with component and command surgeons. The JTF surgeon should plan for joint use of assets to ensure minimum essential hospitalization and evacuation support.
- Evaluate projected force deployment flow and ensure that timely and responsive medical care, including the theater aeromedical evacuation system, is available throughout the operation.
- Determine if the combatant commander has designated a single integrated medical logistic manager and develop the MEDLOG plan as applicable. Consideration should be given to placing a SOF MEDLOG liaison at the supporting MEDLOG unit to coordinate SOF-unique combat configured loads and SOF-unique equipment.
- Activate the theater patient movement requirements center and the Area Joint Blood Program Office and disseminate medical regulating and blood management procedures.

5-5. During the operation, the JTF surgeon may be directed to begin planning follow-on stability operations and CA. As the operation nears completion, the JTF surgeon begins planning AHS for the redeployment of the JTF and/or transfer of AHS responsibilities to a follow-on command.

Chapter 6

Medical Logistics Support to Army Special Operations Forces

Army SOF units, such as the SFG(A) and SB(SO)(A), possess an organic MEDLOG capability. Army SOF units requisition and receive MEDLOG support that includes Class VIII, medical materiel, medical maintenance support, optical fabrication, and blood support from the conventional theater MEDLOG supply support activity or MEDLOG company.

THE ARMY SPECIAL OPERATIONS FORCES MEDICAL LOGISTICS REQUIREMENTS

6-1. The nature of ARSOF missions places some unique requirements on the MEDLOG system. Special concerns of the ARSOF in the MEDLOG arena include—

- Assuring proper and adequate maintenance of medical sets, kits, and outfits, and medical equipment items is of paramount importance to ARSOF units due to the possibility and likelihood of short-notice deployments. Unit medical personnel must maintain medical equipment sets through scheduled inventories, quality control and quality assurance inspections, and by requisitioning required Class VIII items to maintain basic loads. Medical equipment must be checked for serviceability and electrical safety prior to first use. Medical equipment will be scheduled for periodic maintenance. See AR 40-61 for definitive MEDLOG information. Those ARSOF units assigned a MEDLOG support role must ensure that adequate quantities of Class VIII is on hand to support customer organizations until theater Class VIII supply support activity or MEDLOG company becomes operational. The ARSOF MEDLOG officer must inform the supporting conventional medical unit of SOF Class VIII requirements to include SOF-unique items.
- Maintaining an adequate stock level of Class VIII to support deployments into undeveloped theaters. Undeveloped theaters normally will not have a developed MEDLOG system present. Depending upon the type of operation and its anticipated duration, the establishment of a joint operations MEDLOG system may not be planned. The ARSOF surgeon and staff determine the quantity of medical supplies for a specific mission. The established stockage levels are coordinated with the supporting MEDLOG facility. The MEDLOG system must plan for and anticipate supporting SOF Class VIII requirements to include SOF-unique items.
- Minimizing the waste of medical supplies through rotation of about-to-expire stocks back to an MTF where they can be used prior to expiration.
- Ensuring segregation of medical supplies purchased with different fund sites to be used for different missions. For example, medical supplies purchased with operations and maintenance funds may only be used for purposes authorized by operations and maintenance funding. Consult the supporting judge advocate and the resource management office for specific advice about proper funding.

6-2. Considerations for ARSOF mission requirements for MEDLOG support include—

- The ARSOF medical planner must understand how the operation plan is to be executed and what unique challenges may result, in order to provide effective AHS support for ARSOF.
- In direct action operations, combat trauma is anticipated to be the major AHS concern. The deployed teams must carry sufficient medical supplies to provide TC3 for the anticipated number of casualties. The ARSOF MEDLOG planner should plan for and ensure, that appropriate coordination is accomplished, to have combat configured loads of Class VIII

resupply packages developed and available in the event the duration of the operation is extended or casualty rates are higher than anticipated. The ARSOF medical planner must also consider the possibility of distributing blood down to the lowest level (the team MOS 18D), under the supervision of a responsible physician. Transfusion of blood products is not without risks. The distribution of blood and blood products should be coordinated with the Armed Services Blood Program Office. Policies on transfusion protocols should originate from the command surgeon's office and be supervised and cleared with command surgeons and medical laboratory officers. Appropriate and close technical supervision is required for Soldier safety. Blood distribution to Role 1 (team member MOS 18D) is always treated as an exceptional activity with the appropriate planning, caution, and supervision balanced against mission requirements. Resupply is accomplished using ARSOF airframes (infiltration/extraction platforms) or other special operations command assets.

- The SR teams deployed on these missions normally do not have contact with enemy forces or indigenous civilians. Therefore, the major AHS requirements are for DNBI rather than combat trauma. Due to the covert nature of these operations and the need of the forces to remain undetected, AHS is restricted to the organic capabilities of the team and Class VIII materiel deployed with the team. The duration of the operation needs to be accurately forecasted, as resupply is not feasible in clandestine operations.
- A major component of FID operations is foreign humanitarian assistance programs. These programs often include the provision of AHS to indigenous populations, which require special funding allocated for the execution of these programs under 10 USC, Chapter 6 (Combatant Commands), Sections 164 and 167. The MEDLOG planner for these operations must ensure that the funds expended to purchase Class VIII materiel are from approved sources. Medical supply requirements may include specific PVNTMED, veterinary, dental, pediatric, and geriatric supply items. Only in an emergency, and with appropriate approval, operations and maintenance funds may be used to purchase Class VIII materiel for use with host-nation military or civilian personnel. The duration of UW operations can be lengthy. The Class VIII resources initially deployed with ARSOF will be quickly depleted and will require resupply. The SOF commander must determine if the risks associated with the resupply operations (transporting and/or air-dropping) outweigh the risks of exposing the location of friendly guerrilla forces. In determining the level of acceptable risk, the ARSOF MEDLOG planner must determine the availability and accessibility of locally produced medical supplies and equipment. Since UW operations initially entail providing AHS to the guerrilla forces (and possibly their families according to specific funding authority) as a guerrilla-based medical infrastructure is built, locally accessible medical supplies and equipment may not be available in sufficient quantities to sustain the guerrilla force. The ARSOF MEDLOG planner must develop and have prepared prepackaged resupply bundles to be used to resupply the operation (these may be from U.S. or non-U.S. sources). Further, he must coordinate for their distribution, to reduce the risk of exposure during resupply operations. A unique concern of UW operations is the requirement for reuse of disposable medical items due to the mission length and resupply difficulties. In UW operations, operations and maintenance funds may be used to purchase Class VIII materiel to train U.S. medical, dental, and veterinary personnel in the conduct of medical, dental, and veterinary civic action programs. Such training is referred to as medical, dental, and veterinary readiness and training exercises. The realities of ensuring the execution of these missions to establish and/or improve a host-nation MEDLOG system may require proper storage of donated and/or purchased medical supplies and equipment. Presently there are three different types of CA battalions. The Active Army battalion and the Reserve Component SO battalions possess a significant amount of medical equipment. However, the reserve tactical CA battalions have minimal medical equipment. All efforts must be made by unit medical and logistics personnel to ensure the proper maintenance and serviceability of assigned medical equipment sets. Medical logistics, to include routine and emergency resupply of Class VIII materiel, must be included and emphasized in the overall AHS plan. Due to the nature of CA, units must rely heavily upon combat lifesaver personnel to provide limited organic capability.
- There should be very limited MEDLOG support necessary for the successful execution of the MISO mission. Military information support operations forces may benefit from guidance

provided by ARSOF MEDLOG personnel to enhance the positive aspects of ongoing MEDLOG activities in support of other ARSOF missions. Due to the nature of MISO, units must rely heavily upon combat lifesaver personnel to provide limited organic capability.

- The CT operations resemble direct action in respect to MEDLOG requirements. However, CT operations may also include the potential exposure to chemical-biological agents. Forces deployed in CT operations should have the appropriate immunizations, chemoprophylaxis, therapeutic drugs, and barrier creams to protect against the effects of these warfare agents. In this respect, the MEDLOG requirements for CT operations resemble those operations.
- Countering weapons of mass destruction operations may expose ARSOF personnel to CBRN agent. Therefore, ARSOF personnel must ensure they have the appropriate immunizations, chemoprophylaxis, therapeutic drugs, barrier creams, and other protective devices, to protect against these weapons/hazards and to counter their effects. Further, the team must deploy with expedient patient decontamination supplies to affect patient decontamination of their own forces on a limited basis in an austere environment. Due to the short duration of these operations, resupply of Class VIII is not anticipated.
- Information operations currently have no unique MEDLOG requirements.

DUTIES AND RESPONSIBILITIES FOR THE MANAGEMENT OF MEDICAL LOGISTICS

6-3. Unit surgeons are responsible for the technical supervision of all aspects of MEDLOG to include Class VIII medical materiel; medical equipment maintenance; and blood support, within their respective organizations. The unit surgeons have the final approval authority for their respective authorized stockage lists and unit basic loads, as well as the approval authority for any variances.

6-4. Medical logistics officers and NCOs advise the surgeon and detachment commanders on all matters concerning MEDLOG, assist them in developing MEDLOG annexes to operation plans, and enforce applicable policies, regulations, and command guidance on MEDLOG matters. Unit MEDLOG personnel ensure that organic medical sets, kits, and outfits, and medical equipment items are properly maintained and serviced; Class VIII stock level requirements and usage rates are determined; a medical materiel quality control program is established; Class VIII stocks are rotated to minimize unnecessary losses due to expiration; and proper procedures are followed concerning turn-in, destruction, and proper accountability of Class VIII materiel.

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Appendix A

Army Special Operations Forces and Medical Considerations in the Law of War

Principal sources for the law of war include treaties like The Hague and Geneva Conventions, which can be found in FM 27-10, and by customary international law. The 1949 Geneva Conventions treaties that have been signed and ratified by the U.S. have a force equal to laws enacted by Congress and signed by the President. In addition, customary international law is firmly established by the custom of nations and followed out of a sense of legal obligation. The U.S. is obligated to adhere to the law of war even when an opponent does not. It is the policy of the DOD and the U.S. Army to conduct its military operations in a manner consistent with the law of war. In the area of AHS support of ARSOF, the law of war sources are binding on all members of the U.S. armed forces. Questions regarding implementation and interpretation of the law of war should be directed to the supporting judge advocate. For further information refer to FM 1-04, FM 27-10, and the Operational Law Handbook.

IDENTIFICATION AND PROTECTIONS AFFORDED TO MEDICAL PERSONNEL

A-1. Article 24 of the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, 12 August 1949 (GWS) (see FM 27-10 and Web site listed in references section of this publication) provides special protection for “Medical personnel *exclusively engaged* in the search for, or the collection, transport, or treatment of the wounded or sick, or in the prevention of disease, [and] staff *exclusively engaged* in administration of medical units and establishments.” There are two separate forms of protection as follows:

- The first is protection from intentional attack. Medical personnel should wear the armlet with the distinctive emblem to facilitate their identification by the enemy.
- The second protection provided by GWS pertains to medical personnel who fall into the hands of the enemy. Article 28 states that medical personnel are entitled to “retained person” status. Such individuals are not classified as detainees, but otherwise benefit from the protections of the Geneva Conventions Relative to the Treatment of Prisoners of War, dated 12 August 1949 (see FM 27-10 and Web site listed in references section of this publication). They are authorized to carry out medical duties only, and “shall be retained only in so far as the state of health and the number of prisoners of war require.”

Note. Army SOF personnel holding MOS 18D SFMS are not considered to be exclusively engaged in medical duties and are not considered retained personnel should they be captured. The SFMS is considered to be a combatant and can be targeted. Therefore, he is entitled to the protections afforded to prisoners under the provisions of the Geneva Convention Relative to the Treatment of Prisoners of War, dated 12 August 1949 (see FM 27-10 and Web site listed in references section of this publication). In addition, veterinary service personnel are not considered medical personnel under the Geneva Convention.

PROTECTION OF MEDICAL AIRCRAFT

A-2. Article 36 of the GWS (see FM 27-10 and Web site listed in the references section of this publication) pertains to the requirements for and protections afforded medical aircraft. The treaty states: “Medical aircraft, that is to say, aircraft exclusively employed for the removal of wounded and sick and for the transport of medical personnel and equipment, shall not be attacked, but shall be respected by belligerents, while flying at heights, times, and on routes specifically agreed upon between the belligerents concerned. They shall bear, clearly marked, the distinctive emblem prescribed in Article 38 (see FM 27-10 and Web site listed in the references section of this publication), together with their national colors, on their lower, upper, and lateral surfaces. Medical aircraft shall also be provided with any other markings or means of identification that may be agreed upon between the belligerents upon the outbreak or during the course of hostilities. Unless agreed otherwise, flights over the enemy or enemy-occupied territory are prohibited. Medical aircraft shall obey every summons to land. In the event of a landing thus imposed, the aircraft and its occupants may continue its flight after examination, if any. In the event of an involuntary landing in enemy or enemy-occupied territory, the wounded and sick, as well as the crew of the aircraft shall be prisoners of war. The medical personnel shall be treated according to Article 24 and the articles following.

A-3. Medical aircraft may not be armed with crew-served weapons, machine guns, hand grenades, antitank weapons, or other offensive weapon systems. Airframes used by ARSOF for personnel infiltration/exfiltration are not engaged solely in the transport of patients. Consequently, they are not protected under the provisions of GWS or marked with the distinctive emblem.

PROTECTION OF MEDICAL SUPPLIES AND EQUIPMENT

A-4. Medical materiel (supplies and equipment) is protected under the provisions of GWS. Captured medical materiel is to be used first to treat the patients in the captured unit. If there are no patients in the captured unit or when all patients have been evacuated, the captured medical materiel is to be used for the treatment of other sick and wounded personnel. The medical materiel of fixed and mobile medical units is not to be intentionally destroyed, even to prevent it from falling into enemy hands.

Appendix B

Planning Medical Evacuation for Army Special Operations Forces

Army SOF routinely operates in austere, denied, hostile, and immature AOs. As a result, careful and flexible planning for medical evacuation must occur. Well-coordinated and executed medical evacuation will assist in ensuring the continued operational effectiveness of the deployed force.

CONSIDERATIONS FOR PLANNING MEDICAL EVACUATION

B-1. Army SOF does not have an organic medical evacuation system. The ARSOF is dependent upon the conventional joint operations medical evacuation system for this support. The ARSOF does have an organic capability to affect CASEVAC using ARSOF airframes (those used for infiltration/extraction of ARSOF personnel). During CASEVAC, the casualty may not receive en route medical care unless specific planning and coordination is accomplished to staff the airframe with medically trained personnel prior to the execution of CASEVAC operations.

B-2. The challenge for the medical planner is to provide patient movement without the benefits of organic dedicated medical evacuation assets, which are available to the conventional force. Special operations missions are often conducted in sensitive or denied areas beyond the conventional AHS evacuation umbrella. Medical evacuation of ARSOF casualties is an operational responsibility and must reflect the commander's concept of the operation. A successful medical evacuation plan must be integrated with the tactical plan and logistics operations.

MEDICAL EVACUATION PLANNING FACTORS

B-3. Planning effective medical evacuation for ARSOF requires an understanding of ARSOF missions and units. Planning for ARSOF medical evacuation may differ from conventional AHS planning in the following areas:

- Inability to assign dedicated medical evacuation platforms to all the teams and small units that are often widely dispersed throughout the AO and/or are in hostile or denied territory.
- Lack of U.S. Air Force-approved airfields in many locations in which ARSOF must operate.
- Security requirements of some missions.
- Individually tailored evacuation plans are required to support numerous small teams deployed to separate locations.
- Accountability of sensitive equipment carried by some ARSOF Soldiers. If the ARSOF Soldier is ambulatory, he retains responsibility for any sensitive equipment he has in his possession. If he is unconscious, the equipment is turned over to a team member accompanying the patient. However, if the patient is not accompanied by another team member, the equipment must be secured until it can be transferred back to the parent unit.

B-4. Although the ARSOF have no dedicated medical evacuation assets, the ARSOF medical planner must be able to plan and coordinate an efficient chain of CASEVAC from isolated locations anywhere in the world. This evacuation chain requires identification of all specific military assets required to complete the mission. Then, he must ensure the dissemination of point of contact and for every link of the evacuation down to the SOF user level. If required, this should include the point of contact for medical regulating. Once the ARSOF Soldier enters the conventional AHS system, medical regulating support is provided by medical regulating officers assigned to the theater-level units of medical command (deployment support). The ARSOF medical planner and the ARSOF surgeon must be able to rapidly tailor a CASEVAC plan for ARSOF missions and/or operations. If ARSOF are assigned to a joint SO task force,

the ARSOF surgeon (if designated as the joint SO task force surgeon) plans for medical evacuation of the joint forces. The ARSOF medical planner should plan for medical evacuation in two distinct phases— intratheater and intertheater.

B-5. Within the joint operations area (intratheater evacuation), ARSOF patients/casualties are often evacuated on the aircraft responsible for extracting the rest of the team. Prolonged exfiltration legs in black-out conditions on board aircraft flying over hostile or denied territory make in-flight patient care delivery difficult. These extraction aircraft must be able to affect rapid communications with the appropriate medical units upon entry into U.S./multinational controlled airspace. Coordination for dedicated medical evacuation platforms must be accomplished to meet the incoming aircraft to evacuate the patient to the appropriate role of care. Sensitive equipment and documents in the possession of the patient should be retained by the ARSOF team and not transferred to the evacuation platform. Due to the classified nature of many ARSOF missions, it may be necessary to segregate the ARSOF patient from conventional patients to ensure that classified missions parameters are not compromised.

B-6. Once the patient is moved out of the AO and enters the conventional AHS, intertheater evacuation and medical regulating are affected by medical regulating officers at theater levels of command. The ARSOF medical planner must continuously monitor the situation to ensure the plans remain sufficiently flexible to provide the necessary support when it is required. The medical planner must maintain active liaison with the conventional AHS units which will provide support once the ARSOF patient is extracted from the AO. The ARSOF surgeon continues to track ARSOF Soldiers being evacuated out of the AO to keep the ARSOF chain of command apprised and to ensure security concerns are addressed. The ARSOF medical planner should—

- Determine the airfield that ARSOF patients will be evacuated.
- Determine if any medical equipment and supplies (patient movement items) are required to sustain the ARSOF patient while in flight.
- Coordinate for augmentation of medically trained personnel to be present on board the airframe when the ARSOF patient is picked up. This asset may come from organic ARSOF personnel (SFMS or PA) due to the classified parameters of the mission being supported, or because of the use of unique medical items and/or seriousness of the patient.
- Coordinate for dedicated medical evacuation support to be present at the destination airfield. Army SOF patients extracted from hostile or denied territory are normally taken to an MTF for evaluation and stabilization prior to further evacuation. They are not normally evacuated directly to an en route patient staging system, as these units are neither staffed nor equipped to provide stabilizing medical care.

EVACUATION FROM HOSTILE OR DENIED TERRITORY

B-7. The ARSOF planner and the SF operational detachment A leader must develop a tentative plan for the evacuation of ARSOF patients from hostile or denied territory, when feasible. The planners must consider all options that will not compromise the security of the operation. Conventional medical evacuation platforms normally cannot provide support while the ARSOF team is deployed. The ARSOF planner should consider—

- Classified nature of the mission and the probable outcome if compromised.
- Availability of opportune vehicles and aircraft (such as resupply platforms).
- Infiltration and exfiltration routes.
- Requirements for special medical equipment and supplies.
- Availability of foreign national MTFs, equipment, and supplies to stabilize the patient for an arduous ground evacuation.

- Probable weather in the AO. For example, reduced visibility may enhance the chance of successfully exfiltrating the patient, or inclement weather (such as snow or extreme cold) may impose special requirements for sustaining the patient until he can be evacuated.
- Landing area requirements and the maximum time the airframe can loiter while awaiting the patient pick up.

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Appendix C

Mission Command Structures and Integrating Elements of Special Operations Forces in the Joint Campaign

Special operations forces are most effective when closely integrated into the support of a JFC, geographic, or country campaign plan. The SOF mission command structures are based upon joint doctrine, which evolved through SOF operational experience across the range of military operations. The key to effective integration is a mission command structure that provides two essential functions:

- Mission command of SOF operating within the theater or JFC AO.
- Staff coordination to ensure that SOF is employed effectively in support of a campaign plan.

A JFC has wide latitude to create a mission command structure based on the mission, enemy, terrain and weather, troops and support available, time available, and civil considerations (mission variables).

COMBATANT COMMAND SPECIAL OPERATIONS FORCES

C-1. In peacetime, each combatant commander has a special operations command assigned. This command is a subordinate combatant command which serves as the functional special operations component. In the joint operations area, special operations commands normally exercise operational control of SOF (except for MISO and CA units) within their AOs. The special operations combatant commander is the AO joint force special operations component commander and reports directly to the geographic combatant command. The joint force special operations component commander is the geographical combatant command's principal special operations advisor. It is important to note that while the USASOC provides funding and personnel for the special operations commands, they work directly for the combatant commander. It is important to note that special operations commands do not have permanently assigned surgeons or staff medical personnel.

C-2. Unity of effort among SOF and conventional forces is accomplished through a number of various SOF integrating elements.

C-3. The special operations mission command element is based on an SF operational detachment B and is augmented with a special communications package and personnel as required. The special operations mission command element assists the joint SO task force commander in the accomplishment of his supporting commander responsibilities. The special operations mission command element can exercise mission command of designated ARSOF (less MISO and CA units) when the joint SO task force commander determines the need. The special operations mission command element also provides a monitoring capability for SF units under the control of the Army forces. This is designed to improve the Army forces commander's ability to employ subordinate multinational forces.

C-4. The SO liaison element is composed of SOF air operations planners and liaison officers from other SOF elements. It is the joint special operations force component commander's liaison to the joint force air component commander that ensures that SOF air and surface operations are integrated with all joint air operations. The special operations liaison element accomplishes this through the air tasking order system by reconciling duplicative targeting, resolving airspace conflicts, and preventing fratricide. The special operations liaison element reports directly to the joint force special operations component commander.

C-5. The Naval special warfare (NSW) task unit is a provisional subordinate unit of a NSW task group. It provides mission command, coordinates administrative and logistical support, and integrates special operations with maritime operations. Designated NSW forces may be under the operational control of the

naval component commander or a joint force special operations component commander. Naval special warfare forces often are assigned to conventional naval component commanders, as well as to operational joint force special operations component commands. Several NSW task units could be operationally subordinate to a NSW task group, as well as having a NSW task unit under the operational control of a joint force special operations component commander.

SPECIAL OPERATIONS FORCES OPERATIONAL MISSION COMMAND

C-6. During operations, three types of SOF JTFs may be formed to support a JFC in the mission command of assigned SOF; the joint special operations task force; the joint MISO task force; and the joint civil-military operations task force (JCMOTF). These JTFs are organized along the lines of a conventional JTF and normally are established to accomplish a specific mission (such as SR, MISO, or CA) or conduct a campaign of limited duration. Special operations forces JTFs are flexible in size, composition, and can be tailored based on the anticipated duration of the operation.

C-7. A joint special operations task force is composed of units from more than one Service. The task force is formed to carry out a specific mission or prosecute special operations in support of a JFC's campaign or other operations. The joint special operations task force may have conventional units assigned or attached to support specific missions. These missions include the core activities described in Chapter 2.

C-8. A joint MISO task force is composed of MISO units from more than one Service. The task force is formed to carry out MISO in support of a JFC's campaign or other contingencies. Responsibility for MISO planning and supervision lies with a JFC, assisted by the operations directorate of a joint staff MISO officer and forward liaison teams from the Active Army MISO group. During peace operations, the JFC may form a joint functional component command to plan, coordinate, and execute all MISO in the theater. The joint MISO task force commander is normally tasked to command this operation. The JFC may designate the senior MISO unit commander as the joint forces MISO component commander. Some MISO forces may be assigned or attached to other component commands (for example, joint special operations task force or Army elements) as the mission dictates. At all times, the joint MISO task force commander should retain overall responsibility for the execution of MISO in support of the JFC campaign plan.

C-9. A JCMOTF is composed of civil-military operations units from more than one Service or U.S. Government agency. It is formed to carry out CA in support of a JFC's campaign or other contingencies. Responsibility for CA planning and supervision lies with a JFC, supported by the CA operations officer. Additional planning support may be provided by the CA plans, programs, and policy team, the CA operational planning team, or a liaison team. The JCMOTF may be established by a JFC to assist in carrying out missions of either limited or extended duration involving military forces' coordination with other DOD, U.S. Government agencies, multinational and host-nation forces, and NGOs. The JFC may designate the senior CA unit commander as the JCMOTF commander. Some CA assets may be assigned or attached to other component commands (such as joint special operations task force or Army elements) as the mission dictates. At all times, the JCMOTF commander should retain all responsibility for the execution of civil-military operations support of the JFC's campaign plan.

OPERATIONAL SPECIAL FORCES INTEGRATING ELEMENTS

C-10. In addition to SO mission command, SO liaison elements, and NSW task units, two additional integration elements may be used for operational mission command of SOF, the civil-military operations center (CMOC) and joint special operations air component—

- The JFC may establish a CMOC to integrate and harmonize the various political, humanitarian, and military aspects of a mission. The CMOC is a standing capability formed by all Army CA units from the company to the CACOM level. A CMOC is tailored to the specific tasks associated with the mission and normally augmented by available assets (medical, engineer, transportation) to the supported commander. The CMOC serves as the primary coordination interface for U.S. forces and humanitarian organizations, intergovernmental organizations, NGOs, multinational forces, host-national governmental agencies, and other civil agencies of the U.S. government. The CMOC is designed to receive, assign priority to, and validate civilian

requests for support and to produce one single coordinated effort in crisis situations. The CMOC is flexible in size and composition, and provides a venue for necessary communications, coordination, and cooperation between military and civilian authorities. For additional information about the CMOC, refer to FM 3-57.

- The joint special operations air component commander is the aviation component commander under a joint force special operations component command or joint force command responsible for planning and executing joint SOA missions. Ordinarily, all SOA is under the operational control of the joint special operations air component commander. The joint force special operations component command's special operations liaison element integrates the joint special operations air component commander's missions with joint force air component commander's operations.

SPECIAL OPERATIONS SUPPORT TO UNITED STATES AMBASSADORS

C-11. An embassy's country team may also initiate requests for SOF support. The specific request will originate with the ambassador, defense attaché, or military assistance group commander. These requests are passed through the appropriate combatant commander to the Joint Chiefs of Staff who ensure proper interagency coordination. If the forces are available in the joint operations area from assigned forces, and there are no restrictions on their employment (as there are for counterdrug operations), the request can be approved by the operational special operations command. If there are insufficient forces available in the theater, the combatant command will make a request for USASOC forces through the Joint Chiefs of Staff. Once a deployment has been approved by all concerned (such as the State Department and DOD), the combatant commander is notified of the SOF/units/elements to be deployed. With a few exceptions, these forces will be under the operational control of the combatant commander when they enter the AO. The combatant commander will normally exercise operational control through the U.S. military assistance group commander or the chief of the in-country security assistance organization, who in turn keeps the ambassador informed of plans and activities during the deployment. Under no circumstances will SOF operate in a combatant commander's AO or in a U.S. ambassador's assigned country without prior notification and approval of the combatant commander and ambassador.

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Glossary

This glossary lists acronyms and terms with Army or joint definitions. Where Army and joint definitions differ, (Army) precedes the definition. This publication is not the proponent for any Army terms.

SECTION I – ACRONYMS AND ABBREVIATIONS

ABCA	American, British, Canadian, Australian, and New Zealand (Armies)
ADRP	Army doctrine reference publication
AHS	Army Health System
AMEDD	Army Medical Department
AO	area of operations
AR	Army regulation
ARSOF	Army special operations forces
ATP	Army techniques publication
CA	civil affairs
CASEVAC	casualty evacuation
CBRN	chemical, biological, radiological, and nuclear
CMOC	civil-military operations center
COA	courses of action
COSC	combat and operational stress control
CT	counterterrorism
DA	Department of the Army
DNBI	disease and nonbattle injury
DOD	Department of Defense
DODD	Department of Defense directive
DODI	Department of Defense instruction
ESEO	environmental science and engineer officer
FHP	force health protection
FID	foreign internal defense
FM	field manual
FST	forward surgical team
GWS	Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, 12 August 1949
HSS	health service support
JCMOTF	joint civil-military operations task force
JFC	joint force commander
JP	joint publication
JTF	joint task force
MEDLOG	medical logistics
MISO	military information support operations
MOS	military occupational specialty

MTF	medical treatment facility
NATO	North Atlantic Treaty Organization
NCO	noncommissioned officer
NGO	nongovernmental organization
NSW	Naval special warfare
PA	physician assistant
PVNTMED	preventive medicine
SB(SO)(A)	sustainment brigade (special operations) (airborne)
SF	special force
SFG(A)	special forces group (airborne)
SFMS	special forces medical sergeant
SO	special operations
SOA	special operations aviation
SOAR(A)	special operations aviation regiment (airborne)
SOCM	special operations combat medic
SOF	special operations forces
SR	special reconnaissance
STANAG	standardization agreement
TC3	tactical combat casualty care
U.S.	United States
USASOC	United States Army Special Operations Command
UW	unconventional warfare

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ATP 4-02.43
17 December 2015

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MARK A. MILLEY
General, United States Army
Chief of Staff

Official:

A handwritten signature in black ink, appearing to read "Gerald B. O'Keefe". The signature is written in a cursive style with a large initial "G" and a distinct "O'Keefe" ending.

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