

# Fleet Medicine Pocket Reference 2010



**Surface Warfare Medicine Institute,  
a component detachment of the  
Naval Operational Medicine Institute**



**CVN Aircraft Carrier**



**LHA Amphibious Assault Ship**



**LHD Amphibious Assault Ship**



**LPD Amphibious Transport Dock**



**LSD Dock Landing Ship**



**CG Cruiser**



**DDG Guided Missile Destroyer**



**FFG Frigate**

This booklet is designed to be a useful guide to medical department personnel assigned to operational medical billets to specifically include Task Force/Expeditionary Strike Groups, Officers-in-Charge of Fleet Surgical Teams, and Carrier Strike Group Medical Officers. The information herein is derived from primary sources that are usually identified within the text. Non-referenced information is included in order to tap the experience of previous operational medical department personnel.

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Please send all correspondence concerning the content and style of this reference to CAPT Flinn, MC, USN, at the address below. Feedback is always welcomed to keep our fellow operational medical department personnel well informed and prepared.

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## ACRONYMS and ABBREVIATIONS

AABB.....	American Association of Blood Banks	CATF.....	Commander, Amphibious Task Force
ACLS.....	Advanced Cardiac Life Support	CBR.....	Chemical, Biological, and Radiological
ACU.....	Assault Craft Unit	CBTZ.....	Combat Zone
ADAL.....	Authorized Dental Allowance List	CCIR.....	Commander Critical Information Requirements
AFMIC.....	Armed Forces Medical Intelligence Center	CCO.....	Combat Cargo Officer
AJBPO.....	Area Joint Blood Program Office	CE.....	Combat Element
ALCC.....	Airlift Control Center	CECO.....	Combat Evacuation Control Officer
AMAL.....	Authorized Medical Allowance List	CHOP.....	Change to Operational Command
AO.....	Area of Operation; Air Officer; Administrative Officer	CI.....	Counter-Intelligence
AOR.....	Area of Responsibility	CIA.....	Central Intelligence Agency
ARG.....	Amphibious Readiness Group	CIC.....	Combat Information Center
ASBP.....	Armed Services Blood Program	CIFS.....	Close-In Fire Support
ASBPO.....	Armed Services Blood Program Office	CLF.....	Commander, Landing Force
ASWBPL.....	Armed Services Whole Blood Processing Laboratory	CLZ.....	LCAC Landing Zone
ATF.....	Amphibious Task Force	CLZA.....	LCAC Landing Zone Support Area
ATLS.....	Advanced Trauma Life Support	CME.....	Continuing Medical Education
BAS.....	Battalion Aid Station	CMOC.....	Civil Military Operations Center
BES.....	Beach Evacuation Station	CNO.....	Chief of Naval Operations
BLS.....	Basic Life Support	COC.....	Combat Operations Center
BPD.....	Blood Product Depot	COG.....	Center of Gravity
BSU.....	Blood Supply Unit	COMMZ.....	Communications Zone
BTC.....	Blood Transshipment Center	COMLANFLT.....	Commander, U. S. Atlantic Fleet
C2.....	Command and Control	COMPACFLT.....	Commander, U. S. Pacific Fleet
C2W.....	Command and Control Warfare	CONREP.....	Connected Replenishment
C4I.....	Command, Control, Communication, Computer & Intelligence	COMSEC.....	Communications Security
CAS.....	Close Air Support	CONUS.....	Continental United States
CAT.....	Crisis Action Team	CP.....	Command Post
		CPG.....	Commander, Amphibious Group (ONE, TWO, or THREE)
		CPR.....	Cardio Pulmonary Resuscitation
		CRRC.....	Combat Rubber Raiding Craft
		CRTF.....	Casualty Receiving and Treatment Facility
		CRTS.....	Casualty Receiving and Treatment Ship
		CSG.....	Carrier Strike Group
		CSAR.....	Combat Search And Rescue
		CSFTP.....	Commander Strike Force Training Pacific

CSO .....	Chief Staff Officer (of amphibious squadron – PHIBRON)	ERSS.....	Expeditionary Resuscitative Surgical System
CSS.....	Combat Service Support	ESF.....	Emergency Support Function
CSSD .....	Combat Service Support Detachment	ESG.....	Expeditionary Strike Group
CSSE .....	Combat Service Support Element	EW .....	Electronic Warfare
CTF .....	Commander, Task Force	FAC.....	Forward Air Controller
CVBG.....	Carrier Battle Group	FCC.....	Federal Coordinating Center
DAS.....	Deep Air Support	FCSSA .....	Force Combat Service Support Area
DASC .....	Direct Air Support Center	FDC.....	Fire-Direction Center
DESRON....	Destroyer Squadron	FEBA.....	Forward Edge of the Battle Area
DET .....	Detachment	FEMA .....	Federal Emergency Management Agency
DEW.....	Directed Energy Weapon (usually laser)	FEP.....	Final Evaluation Period
DFAS.....	Defense Finance & Accounting Service	FFA .....	Free-Fire Area
DFC.....	Detachment for Cause	FFP .....	Fresh Frozen Plasma
DIA .....	Defense Intelligence Agency	FIC .....	Fleet Intelligence Center
DNBI.....	Disease and Non-Battle Injury	FISC.....	Fleet and Industrial Supply Center
DOD .....	Department of Defense	FLTCINC.....	See COMPACFLT
DOS .....	Department of State (State Department)	FMF.....	Fleet Marine Force
DOWW .....	Disease Occurrence Worldwide	FOB.....	Forward Observer
DRAW .....	Demonstration, Raid, Assault, Withdrawal (amphibious ops)	FOD .....	Foreign Object Damage
DSCA.....	Defense Support Civil Authorities	FORSCOM...	Forces Command
DTG.....	Date-Time Group (messages)	FOS.....	Full Operating Status
DZ .....	Drop Zone	FP .....	Frozen Platelets; or Family Practice
EAF .....	Expeditionary Airfield	FRBC .....	Frozen Red Blood Cells
EEI .....	Essential Elements of Information	FRSS.....	Forward Resuscitative Surgery System
ELINT .....	Electronic Intelligence	FSCC .....	Fire-Support Coordination Center
EMB .....	Embarkation	FST .....	Fleet Surgical Team
EMCON.....	Emission Control	GCE .....	Ground Combat Element (MAGTF)
EMF.....	Expeditionary Medical Facility	GPMRC.....	Global Patient Movement Requirements Center
EMT.....	Emergency Medical Technician	GPS .....	Global Positioning System
EPW .....	Enemy Prisoner of War	GQ .....	General Quarters
		GYN .....	Gynecology
		H&S.....	Headquarters and Service Company
		HANDSCO ..	Headquarters and Service Company
		HCS .....	Helicopter Coordination Section
		HDC .....	Helicopter Direction Center
		HE .....	High Explosive
		HHS .....	Health Service Support
		HLSC .....	Helicopter Logistics Support Center
		HNS .....	Host-Nation Support

HSAP.....	Health Service Augmentation Program Formerly (MAP)	KIA.....	Killed In Action
HSS.....	Helicopter Service Support	LANTFLT .....	See COMPACFLT
HST.....	Helicopter Support Team	LF.....	Landing Force
HUMINT .....	Human Intelligence (vs. satellite imagery, radio signal, etc.)	LFOC .....	Landing Force Operations Center
IA.....	Individual Augmentee	LFSP .....	Landing Force Support Party
IADS.....	Integrated Air Defense System	LOC.....	Line of Communication
IAW .....	In Accordance With	LOD.....	Line of Departure
IDC.....	Independent Duty Corpsman	LOI .....	Letter of Instruction
IDTC.....	Inter-Deployment Training Cycle	LZ.....	Landing Zone
IFF.....	Identification, Friend or Foe	LZCP .....	Landing Zone Control Party
IOT.....	In Order To	LZSA .....	Landing zone Support Area
IP.....	Initial Point	MAGTF .....	Marine Air-Ground Task Force
IPB.....	Intelligence Preparation of the Battlefield	MANMED .....	Manual of the Medical Department
IRR.....	Individual Ready Reserve	MAA .....	Master-At-Arms
ISO.....	International Standardization Organization	MAO.....	Medical Administrative Officer
ISIC .....	Immediate Superior In Command	MAP .....	Medical Augmentation Program (HSAP)
ITT.....	Interrogator and Translator Team	MARDIV .....	Marine division
IV.....	Intravenous	MARG .....	Marine Amphibious Readiness Group
JAG.....	Judge Advocate General	MASF .....	Mobile Aeromedical Staging Facility
JBPO.....	Joint Blood Program Office	MCLL .....	Marine Corps Lessons Learned
JCS .....	Joint Chiefs of Staff	M-Day .....	Mobilization Day
JDS .....	Joint Deployment System	MEDCAPS .....	Medical Capabilities Study
JIC.....	Joint Intelligence Center	MEDEVAC .....	Medical Evacuation
JMBO .....	Joint Military Blood Office	MEF .....	Marine Expeditionary Force
JMRO .....	Joint Medical Regulating Office	MEF (FWD) .....	Marine Expeditionary Force (forward)
JOPES .....	Joint Operations Planning and Execution System	MEPES .....	Medical Planning and Execution System
JTF .....	Joint Task Force	MEU.....	Marine Expeditionary Unit
JULL.....	Joint Unified Lessons Learned	MIA.....	Missing In Action
		MIO.....	Maritime Interdiction Operations
		MLL.....	Medical Lessons Learned
		MLG.....	Marine Logistics Group
		MMART .....	Mobile Medical Augmentation Readiness Team
		MMSO.....	Military Medical Support Organization
		MOOTW. ....	Military Operations Other than War
		MOPP .....	Mission-Oriented Protective Posture
		MPF .....	Maritime Pre-Positioning Force

MRCC .....	Medical Regulating Control Center	OOTW .....	Operations Other Than War
MRCO .....	Medical Regulating Control Officer	OPCON .....	Operational Control
MRRS .....	Medical Readiness Regulating System	OPLAN .....	Operational Plan
MSC .....	Military Sealift Command; or major subordinate command	OPNAV .....	Office of the Chief of Naval Operations
MSOC .....	Medical Support Operations Center	OPNAVINST	Naval Operations Instruction
MSR .....	Main Supply Route	OPORD .....	Operations Order
MTF .....	Medical Treatment Facility	OPSEC .....	Operations Security
MWR .....	Morale, Welfare, and Recreation	OPSUM .....	Operational Summary (a daily report)
NATO .....	North Atlantic Treaty Organization	OPTEMPO .....	intensity of operations (e.g., low, high, extreme)
NATOPS .....	Naval Air Training and Operating Procedures	OSC .....	On-Scene Commander
NBC .....	Nuclear, Biological, and Chemical	OTC .....	Officer in Tactical Command
NBG .....	Naval Beach Group	OTH .....	Over-The-Horizon
NCA .....	National Command Authority	PACFLT .....	See COMPACFLT
NDMS .....	National Disaster Medical System	PAHO .....	Pan American Health Organization
NEO .....	Non-Combatant Evacuation Operation	PCO .....	Primary Control Officer
NGO .....	Non-Governmental Organization	PCRTS .....	Primary Casualty Receiving and Treatment Ship
NMAWC .....	Navy Mine and Amphibious Warfare Command	PCS .....	Primary Control Ship
NOFORN .....	Not Releasable to Foreign Nationals	PHIBRON .....	Amphibious Squadron
NOTAM .....	Notice To Airmen	PIM .....	Position of Intended Movement
NSA .....	National Security Agency	PMI .....	Patient Movement Item
NSN .....	National Stock Number	POE .....	Projected Operational Environment
NWP .....	Naval Warfare Publications	POL .....	Petroleum, Oil, and Lubricants
O&M .....	Operation and Maintenance	POM .....	Program Objective Memorandum
OAS .....	Offensive Air Support	POM .....	Pre-Overseas Movement (as in POM period)
OCONUS .....	Outside Continental United States	POMI .....	Plans, Operations, and Medical Intelligence Officer
OIC .....	Officer-In-Charge	POTUS .....	President of the United States
OMFTS .....	Operational Maneuvers From The Sea	PRC .....	Personnel Casualty Report
		RAS .....	Regimental Aid Station
		RBC .....	Red Blood Cells
		RCA .....	Riot-Control Agent
		RFF .....	Request for Forces
		RLT .....	Regimental Landing Team
		ROC .....	Required Operational Capability
		ROE .....	Rules Of Engagement
		ROPU .....	Reverse Osmosis Processing Unit
		RORO .....	Roll On - Roll Off
		ROS .....	Reduced Operating Status
		RSO .....	Regional Support Organization

SAM .....	Surface-to-Air Missile	TEWA.....	Threat Evaluation and Weapons Assignment
SAR.....	Search-And-Rescue	TF.....	Task Force
SATCOM.....	Satellite Communications	TFMRS.....	Task Force Medical Regulating System
SCM .....	Ship's Cargo Manifest	TFOM.....	Time Figure of Merit
SEAL.....	Sea-Air-Land	TOC .....	Tactical Operations Center
SERE .....	Survival, Evasion, Resistance, Escape	TOW.....	Tube-launched, Optically-tracked, Wire-guided (missile)
SIGINT .....	Signal Intelligence	TPFDD .....	Time-Phased Force and Deployment Data
SLOC .....	Sea Lines Of Communication	TPMRC .....	Theater Patient Movement Requirements Center
SOP.....	Standard Operating Procedure	TRAC2ES .....	USTRANSCOM's Regulating Command and Control Evacuation System
SORM .....	Standard Organization and Regulations Manual of the US Navy (OPNAV 3120.32 series)	TRANSCOM.....	Transportation Command
SORTS.....	Status Of Readiness and Training	TRAP .....	Tactical Recovery of Aircraft and Personnel
SPLT .....	Shore Party Liaison Team	TYCOM.....	Type Command
SPECAT .....	Special Category	UDT.....	Underwater Demolition Team
STANAG .....	Standardization Agreement	UNREP .....	Underway Replenishment
STP .....	Shock-trauma Platoon	USAF .....	United States Air Force
SURGCO .....	Surgical Company	VERTREP .....	Vertical Replenishment
T-AH.....	Hospital Ship	V/STOL.....	Vertical/Short Take-Off and Landing
TAML.....	Theater Area (or Army) Medical Lab	WB .....	Whole Blood
T/O .....	Table of Organization	WIA .....	Wounded In Action
TAC.....	Tactical Air Commander	WHO .....	World Health Organization
TACAN .....	Tactical Air Navigation System	WMCCS .....	Worldwide Military and Command Control System
TACC .....	Tactical Air Control Center		
TACLOG .....	Tactical-Logistical Group		
TACRON .....	Tactical Air Control Squadron		
TAD.....	Tactical Air Director		
TADC .....	Tactical Air Direction Center		
TAO.....	Tactical Air Observer		
TAOC .....	Tactical Air Operations Center		
TAR.....	Tactical Air Request (net circuit)		

# **AUGMENTED AFLOAT MEDICAL ASSETS**

## **FLEET SURGICAL TEAMS (FSTs)**

FSTs augment primary CRTS. They are distinct, freestanding, (non-BSO 18) assets of the Atlantic and Pacific Fleets. They operate with their own UIC, and permanent OIC-coded billets. Currently the ADCON ISIC is the COMPHIBRON to which the FST is assigned and the OPCON ISIC is typically the same COMPHIBRON, the CATF (Commodore). When not aboard the ship, the FST members are ADDU to a regional MTF with the Admin cell at PHIBRON.

## **MISSION**

Provide medical and surgical support, level II HSS capabilities, to designated operating forces (CRTS) of the Atlantic and Pacific Fleets during Fleet and Fleet Marine Force (FMF) exercises and routine deployment of CATF/ESG.

## **LOCATION**

## **ISIC**

FST # 1 San Diego	PAC PHIBRON
FST # 2 Norfolk	LANT PHIBRON
FST # 3 San Diego	PAC PHIBRON
FST # 4 Norfolk	LANT PHIBRON
FST # 5 San Diego	PAC PHIBRON
FST # 6 Norfolk	LANT PHIBRON
FST # 7 Okinawa / Sasebo	ESG-7/CTF-76
FST # 8 Norfolk	LANT PHIBRON
FST # 9 San Diego	PAC PHIBRON

## **TYPICAL FST CHAIN(S) OF COMMAND**

### **Administrative (inport)**

FST  
PHIBRON  
CNSL/CNSP  
USFF/CPF

### **Operational (at sea)**

FST  
PHIBRON / ESG/CSG  
NUMBERED FLEET  
NAVAL COMPONENT COMMAND

**(Note: ADCON relationships may change in the near future with FSTs reporting to the respective EHS LANT/PAC, FST-7 / ESG-7 relationship will not change)**

**BILLET STRUCTURE AND GENERAL MEDICAL CHARACTERISTICS:**

	Title	Rank	NOBC / NEC
Officers (7)	OIC/ESG Surgeon	05 / 6	21XX
	FP / IM / ER / PED	N/A	21XX
	General Surgeon	N/A	21XX
	Anesthesia	N/A	21XX or 29XX
	Charge / CCRN	N/A	29XX
	Perioperative RN	N/A	29XX
	MRCO / MAO	N/A	23XX
Enlisted (9)	LPO	E6/7	0000/8404
	General Duty (4)	N/A	0000/8404
	O.R. Tech (2)	N/A	8483
	Adv Lab Tech	N/A	8506
	Respiratory Tech	N/A	8541

**M+1 (WARTIME MANNING)**

The current peacetime medical department of the Casualty Receiving and Treatment Ship (CRTS), even with a Fleet Surgical Team, is inadequate to fulfill the wartime medical mission of the LHA/LHD; therefore 84 additional health services augmentation personnel are assigned to the CRTS upon request and approval of OPNAV N931 and BUMED.

**MISSION**

Required Operational Capability (ROC) and Projected Operational Environment (POE), for the LHA/LHD provides surgical capability of four ORs, 15 ICU/Recovery beds, 45 ward/holding beds, and a blood bank capacity of 500+ frozen blood units, FFP and a walking blood bank. The M+1 mission is to meet the ROC/POE requirements of the medical department. Additionally, these assets may be used for humanitarian and disaster relief missions.

## **TRAINING**

Appropriate military training of medical personnel is the cornerstone for effective force health protection. Military readiness training must include any possible contingency from medical support in combat and homeland defense to DSCA or foreign humanitarian assistance (FHA) and disaster relief (DR). Medical personnel identified as M+1 HSAP augmentees shall perform a minimum of 5 days of medical readiness training during each training cycle. Military Departments shall program for medical personnel to physically train at least once every other training cycle with their designated operational unit and equipment. Per BUMEDINST 6440.5 enclosure (1), alternative methods for achieving readiness skills training are highly encouraged. Examples include: mission support, operational deployments, field exercises, other military or civilian training evolutions, classroom instruction, GME, Continuing Medical Education, and Continuing Education unit opportunities. Training for the M+1 HSAP Augmentees is coordinated by Surface Warfare Medicine Institute, EHSPAC/LANT, MTF (POMI/MMPO and senior leadership), SMO and medical department of identified LHA/LHD and FST.

## **BILLET STRUCTURE AND GENERAL MEDICAL CHARACTERISTICS**

The specific billets of the M+1 augmentation team are under continuing evaluation but presently consist of the following:

### **MC- 11**

2 Internal Medicine; 1 Psychiatrist; 3 Anesthesiologist;  
3 General and 2 Orthopedic surgeons

### **DC-1**

1 Oral Maxillo-Facial Surgeon

### **MSC-1**

HCA (unless specified)

### **NC-22**

1 Senior Nurse; 2 CRNAs; 5 Perioperative nurses;  
6 Critical care nurses; 2 ER nurses; 6 Med-Surg nurses

**HM-48:**

- 24 General duty corpsman; 10 Surgical techs;
- 2 medical admin; 2 Xray techs; 1 Lab tech; 1 BMET;
- 1 Pharmacy tech; 2 Psych techs; 2 Ortho techs;
- 3 Respiratory techs

**TEAMS LOCATIONS AND SOURCE**

The CATF/ESG surgeon and SMO should work with the MMPO of the MTF and senior leadership of the M+1 augmentees for effective contingency planning. Each CRTS's M+1 personnel come from a specific MTF. There are 11 CRTS teams from MTF/ Budgeting Submitting Office (BSO) 18:

<b>Naval Medical Center San Diego:</b>	<b>Teams 1, 3, 5</b>
<b>Naval Medical Center Portsmouth:</b>	<b>Teams 2, 4, 6</b>
<b>National Naval Medical Center Bethesda:</b>	<b>Teams 10, 11</b>
<b>Naval Health Clinic, Great Lakes:</b>	<b>Teams 7, 9</b>
<b>Naval Hospital Jacksonville:</b>	<b>Team 8</b>

<b>M+1 Platforms</b>	
USS SAIPAN (LHA 2)	Norfolk, VA
USS NASSAU (LHA 4)	Norfolk, VA
USS PELELIU (LHA 5)	San Diego, CA
USS WASP (LHD 1)	Norfolk, VA
USS KEARSAGE (LHD3)	Norfolk, VA
USS BOXER (LHD 4)	San Diego, CA
USS BATAAN (LHD 5)	Norfolk, VA
USS BONHOMME RICHARD (LHD 6)	San Diego, CA
USS IWO JIMA (LHD 7)	Norfolk, VA
USS MAKIN ISLAND (LHD 8)	San Diego, CA

**Expeditionary Resuscitative Surgical System (ERSS)**

At the time of this publication, ERSS a component to the Global Naval Expeditionary Care System for forward resuscitative surgery

has not been fully implemented. A highly responsive, mobile and flexible system of trained personnel and equipment to provide tailored, mission specific medical capability, close to the point of injury, that supports the range of military operations afloat and ashore. Focus is on having immediate life and limb saving surgery, trauma care, medical evacuation and en-route care, at or near combat operations. This will be an expansion of the SSS initiative and existing FST, able to support split operations, special operations, etc.

The ERSS will be made up of 3 interacting components based upon the Fleet Surgical Team (FST) with Health Service Augmentation Program (HSAP) personnel, as noted below:

### **1. Expeditionary Surgical Team (EST):**

Provides forward initial emergency (damage control) surgery; capable of functioning from a small platform or from a shore based position. Team consists of 1 General Surgeon, 1 Anesthesia provider, 1 Critical Care Nurse, and 2 OR Tech. Set up within 45 minutes, up to 5 damage control cases, and hold patients up to 2-4 hours.

### **2. Expeditionary Trauma Team (ETT):**

Capable of functioning from a small afloat and ashore platform to provide initial emergency life and limb saving actions. Team consists of 1 Emergency Physician, 1 Physician Assistant, and 1 Independent Duty Corpsman.

### **3. En-Route Care Team (ERCT):**

Safely transports and provides critical/required medical care of patients at risk of clinical status changes during movement between capabilities in the continuum of care. Capable of medically managing two stabilized casualties for two hour transits. Team consists of 1 Flight Corpsman; ETT Critical Care Nurse can move with patient to provide continuity.

#### References

- a. *CINCPACFLT/CINCLANTFLTINST 5450.5B dtd 14 FEB 00 "Fleet Surgical Teams"*
- b. *DOD Directive 1322.24 dtd 12 JUL 2002 "Medical Readiness Training"*
- c. *BUMED 6440.5C dtd 24 Jan 2007 "Health Service Augmentation Program"*

## BLOOD PROGRAM

**CONCEPT OF OPERATIONS:** Fluid and blood product availability at different taxonomy continuum of healthcare capabilities.

- **First Responder Capability:** Ringers Lactate and human albumin
- **Forward Resuscitative Capability:** Ringers Lactate, human albumin, Group O red blood cells, liquid
- **Theater Hospitalization Capability:** Ringers Lactate, albumin (25 percent), red blood cells (liquid and frozen), fresh frozen plasma, platelet concentrate
- **Definitive Capability:** Ringers Lactate, albumin (25 percent), red blood cells (liquid and frozen), fresh frozen plasma, platelet concentrate
- **CONUS MTF Capability:** Full range of resuscitation fluid and blood products

### Frozen Blood Capabilities:

Ship	Deployment	RBCs	FFP	Platelets*
LHA	Contingency	400-450	20	50
	Mobilization	400-450	40	TBD
LHD	Contingency	400-450	20	50
	Mobilization	400-450	40	TBD
T-AH	Contingency	1400	100	25
	Mobilization	1400	110	TBD
Fleet Hospital	(no frozen blood)	-	-	-

**Disclaimer:** Blood and blood products capabilities are dependent on projected operational environment, type of deployment, availability of products, equipment capacity aboard ships, and medical personnel manning (FST, M+1).

\* We are not licensed by the FDA for frozen platelets, therefore references to platelets should include “if available” since the five-day shelf life means

providing them may be impossible. The ASBPO will probably not meet theater needs until platelets with longer shelf life are available or frozen platelets become licensed.

### **PLANNING FACTORS AND ISSUES:**

- Four units of red blood cells per initial admission of each WIA and DNBI.
- One technician and four cell washers can deglycerolize 96 units of frozen blood cells in 24 hours. Assign staff for 12-hour shifts and 7-day work weeks.
- There is NO FROZEN BLOOD RESUPPLY TO SHIPS. Once frozen red cells are used by the LHDs, LHAs, and T-AHs, expect no additional frozen blood from the blood product depots (BPDs). Frozen blood is a transition into liquid blood; count on it for the first few days until the liquid blood pipeline is established. Hence, the early establishment of the pipeline of BSUs, BTCs, AJBPO, and JBPO is imperative. Frozen red blood cells should be incorporated into the routine inventory so that the medical staff is familiar with its use.
- Walking Blood Bank: This is a tertiary source of blood (i.e., to be used only after liquid and frozen blood sources have been depleted (CNSF 6000.1 series). However, walking blood bank response should be checked frequently. Activate the Walking Blood Bank (or parts of it) during mass-casualty drills. Activating the walking blood donor program requires follow up of recipients by BUMED and the medical treatment facility where the ship is home ported. All transfusion records should be turned over to the medical treatment facility responsible for supporting the ship in homeport.
- **EXTREMELY IMPORTANT:** Meet OPNAV 6530.4A requirements: Save the donor card, a frozen plasma sample, and the correct donor / unit numbers. Report transfusions on ships to BUMED Navy Blood Program Office and the medical treatment facility where the ship is home ported for subsequent

tracking in the future. This is a BIG ISSUE now, especially with HIV, HTLV, and hepatitis C.

- Prior to deployment, acquire all message “go-bys” for bringing blood to the ship if needed (a task for the senior advanced lab tech).

## **BLOOD SUPPORT ACTIVITIES**

### **Blood Resources Management and Support**

**Joint Blood Program Office** - Each unified command has been requested by the Armed Services Blood Program Office to designate a joint health office to implement DOD blood program policies and coordinate the blood programs of the unified command components. The JBPO will be the single interface with the Armed Services Blood Program Office in CONUS. Normally, the JBPO will collocate with the Theater Patient Movement Requirement Center (TPMRC). The JBPO will redistribute blood among regions in the theater and will request blood supply from CONUS. The JBPO will submit a daily blood situation report to the Armed Services Blood Program Office during the contingency using the appropriate format (Annex A). Information copies will be provided to each AJBPO and other agencies as required.

**Area Joint Blood Program Office** - Unified commands have been requested by the Armed Services Blood Program Office to establish AJPBOs as required. They will implement the unified command blood program policies, coordinate the blood programs of the unified command components within their area, and manage blood products in the assigned BTC. Normally, the AJPBO will collocate with the Area TPMRC. The AJPBO will redistribute blood among components in the theater or request blood supply from the JBPO. The AJPBO will submit a daily blood situation report to the JBPO using the appropriate format (Annex A). Information copies will be provided to each component blood products depot unit and other agencies as appropriate.

**Blood Transshipment Centers** - The USAF operates the BTCs. The USAF is planning to staff and equip these centers to store and issue up to 3,600 units each of liquid and frozen blood products on a daily basis. Determining the numbers and locations of the centers

is a responsibility of the unified command and will be adequate to support each unified command component's blood requirements on an area basis. Normally, the Navy or Marine Corps will arrange transportation to obtain blood from the BTC for Navy or Marine Corps units. Blood issue to the Navy and Marine Corps will be based on a daily allocation system established by the theater JMBO. The allocations will be modified as required.

**Frozen Blood Depots** - The Navy operates one frozen blood depot in Sigonella, Sicily, and one in Okinawa, Japan. These depots have the capability to store 40,000 and 10,000 units of frozen blood, respectively. Each depot has one Medical Service Corps officer, Naval Officer Billet Code 0866; one enlisted technician, Navy Enlisted Classification 8506; and four civilian technicians, GS-644-04/05. These depots will provide frozen blood products to appropriate medical platforms upon direction by the AJBPO. The Army is also planning to establish frozen blood depots to store a total of 75,000 units of frozen blood products. The USAF is planning to store 50,000 units of frozen blood in Armed Services Whole Blood Processing Laboratories in CONUS.

**Blood Supply Units** - The Navy and Marine Corps will establish BSUs as recommended by the JBPOs. Personnel at these supply points will, upon direction by the AJBPO, arrange or provide transportation for blood products from the BTCs to the BSUs and then coordinate shipment to Navy or Marine Corps field medical units, Fleet Hospitals, and ships. The following units are likely to function as BSUs:

- Frozen blood depots.
- USMC units where medical personnel are responsible for coordinating blood and clinical fluids support.
- FSSG detachments in the theater of operations.
- Blood processing centers at Naples, Italy; Rota, Spain; and in the United Kingdom.

**Medical Field Refrigerator** - A lightweight, refrigerated blood box (NSN 410-01-287-7111) operating from direct or alternating current, containing 30 to 50 units of red blood cells. It has been shipped to the field medical supply activities by the Defense Personnel Support Center.

**Frozen Blood Container** - The USAF developed a shipping and storage container for frozen blood products to transport them without dry ice. It can be ordered through the local medical stock. The stock number is 814013571551 on the Management Data Listing.

**Blood Box Management** - Whenever possible, blood will be transported from blood supply points in boxes provided by the intended recipient. When the recipient has no box, attempt will be made to return boxes used to ship blood to the blood supply point or to exchange empty for full boxes.

**Frozen Blood Management** - Assure that Standard Operating Procedure (SOP) is clear on the new USAF frozen blood container and explains the proper handling of the eutectic solutions. To reuse the solutions, they must be COMPLETELY thawed to room temperature and then refrozen at -65C or lower.

**Communications** - All blood reports and blood shipment reports are sent using standard Armed Services Blood Program Office voice, message, and/or computer-generated blood report formats. The US Message Text Format is the basis for voice and message blood reports. The Armed Services Blood Program Office plans to have the Defense Systems Support Command automate the ASBP blood banks by developing the Defense Blood Standard System. The Theater Army Medical Management Information System has been designated to automate Army activities in the theater and modernized to support the Navy Fleet Hospitals as the Fleet Hospital blood bank module. Any computer systems purchased for CONUS blood collection stations will be compatible with the Defense Blood Standard System, and computer systems purchased for OCONUS MTFs shall be compatible with the Theater Army Medical Management Information System. The Armed Services Blood Program Office requires that the Theater Army Medical Management Information System and the Defense Blood Standard System also be compatible.

**Walking Blood Bank** - SOP will be clear that blood from walking donors is collected properly. OPNAV instruction require completion of donor cards, saving of frozen blood samples, and correct donor / unit numbers to identify the donor card, donor frozen sample, and

unit number. This allows the donated units to be tested for HIV, HCV, etc., to be accurately accomplished.

Pre-qualifying walking donors in CONUS military blood banks just prior to deployment is a method used by some deploying units. However, regardless of pre-qualification, SOP must be followed for each donated unit.

### **BLOOD ISSUES ASHORE — LANDING FORCE**

#### **First Responder, Unit Corpsman and Battalion Aid Station**

Resuscitation fluids: Ringers Lactate, human albumin.

Blood / blood products: None.

#### **Forward Resuscitation, Shock-trauma Platoons**

Resuscitation fluids: Ringers Lactate, human albumin.

Blood / blood products: Frozen blood, Group O liquid blood

#### **Forward Resuscitation, Surgical Company**

Resuscitation fluids: Ringers Lactate, human albumin.

Blood / blood products: Liquid / frozen blood, fresh frozen plasma, platelet concentrate.

**Operational Aspects** - The CATF/CLF Surgeon will assess blood resources / requirements daily and report to the AJBPO. The CATF Surgeon will coordinate blood and fluid support for the medical battalion from the CRTS, using medical field refrigerators and standard blood boxes. When the [CRTSs](#) leave the amphibious ops area, the medical battalion must rely on the medical logistics company or the AJBPO for blood. If no liquid blood is available, blood may be harvested from LF personnel or from the ship's crew (before leaving the amphibious ops area).

**Shock-Trauma Platoon** - Each STP can draw 240 units of blood and can process and crossmatch 1,000 units. Each STP can store 120 units in field refrigerators. Occasionally, a STP may be augmented with a surgical support platoon, which has a blood bank capacity equivalent to that of a STP.

**Amphibious Assault** - Personnel responsible for management of clinical fluids and blood products will report to the CATF Surgeon or LF Surgeon daily. Consider locating a clinical fluids squad with the Surgical Company and a clinical fluids platoon with the Medical Logistics Company. These squads can thaw and wash frozen blood and receive and distribute liquid blood. Submit daily blood

reports to the AJBPO. The CRTS will supply thawed and washed using standard blood boxes and medical field refrigerators. Frozen blood will be transported in the new shipping and storage containers for frozen blood. Prior to the CRTS leaving the amphibious ops area, or the blood supply aboard the CRTS being depleted, the CLF Surgeon will request more blood / blood products from the AJBPO.

**Surgical Company** - If liquid or frozen blood is unavailable or unobtainable, each Surgical Company has the capability to draw 720 units and process and cross-match 3,000 units. Storage capability in current field refrigerators is 360 units.

**Organizational Aspects** - Resuscitation fluids and blood products transported ashore will be handled by the STP, the evacuation platoon at the Beach Evacuation Station, the helicopter support team evacuation station, and medical personnel charged with coordinating blood / clinical fluids for the Surgical or Medical Logistics Company. The CLF Surgeon or representative will manage blood resources and requirements. If frozen blood is needed on the beachhead, deglycerolize it on the LHA / LHD and then ship it ashore.

**Transportation** - Resuscitation fluids and blood products will be transported ashore primarily by helicopters dispatched to evacuate casualties. A secondary means is ground vehicle landing craft or amphibious landing craft. Transport of resuscitation fluids forward to regimental and BAS will be by any means available, depending heavily on vehicles used for medical evacuation. Additional delivery methods - Navy emergency air cargo delivery systems, low-altitude parachute extraction systems, and high-speed low-altitude - have been successfully tested and may be available. Blood products requested from and assigned by the AJBPO can be picked up or delivered by helicopter from the nearest BSU or BTC assigned by the AJBPO.

#### References

- a. *DOD Inst 6480.A dtd 5 August 1996, "Armed Services Blood Program (ASBP) Operational Procedures*

# COMMUNICATIONS

## DISCUSSION

As the CATF/ESG Surgeon/SMO/SMDR you will need to communicate with other providers in your task group regarding patients, patient transfers, and to ask or provide advice to other providers and or commanding officers therefore you need to have some understanding of what type of communications are available to you (your ship). Establish a good rapport with PHIBRON, MEU and ship's communication officers. Ask for a brief tour of the communications capabilities that are available prior to you actually needing the services. These people are professional and they find creative solutions to help Medical get in touch with the outside world or other units.

## PATIENT CONFIDENTIALITY

A communication net is not private. Everyone from the Commodore to the sailor or marine on watch is listening. When conducting consultation or patient transfers on the radio, KEEP PATIENT PRIVACY IN MIND.

## **Telephone Communication**

### POTS (Plain Old Telephone Service)

Unsecure telephone system used on ships.

### **Nets used for normal deployment on a day to day basis:**

**SATHICOM:** The SATellite High-level COMMunication circuit is used to pass essential information to and from an echelon commander. SATHICOM is guarded (monitored) by all underway units and shore stations and is one of the most essential and reliable of voice circuits.

**NAVY RED:** a UHF net, using line-of-sight voice, used for short range (within 30 miles) communication. Navy Red is a high-priority circuit for ships traveling in close range to pass specific information such as operational maneuvers, exercises, and emergencies. All ships must guard this circuit while underway. This is the most frequently used net while deployed. Most of the medical emergencies from other ships will be heard on this net.

**ESG/CSG Command Net:** a satellite voice circuit for long-range communications for ships traveling within a specific group (ESG/CSG). Only ships in the group are assigned satellite access will maintain a guard for this circuit. This circuit allows ships in the group to separate and still maintain reliable communications.

**SIPRNET CHAT:** a secured form of instant messaging that is guarded by all underway units and shore stations and is one of the most essential and reliable means of communication. SIPR CHAT can be used at a set time as a means of group discussion of medical issues afloat. Due to SIPR CHAT being located on the HI-SIDE a secret clearance is required.

### **Nets used for wartime or contingency purposes:**

#### **Medical Regulating Net Afloat (HF)**

MED-REG-NET provides communication between the ARG or task force medical regulating control officer (ESG MRCO) in the medical regulating center (MRC) and the medical regulating teams (MRT) afloat and ashore regarding current information on the capabilities of the different medical facilities. Priorities of patient evacuation and patient tracking occur in this net. The quality of the Med Reg Net has been a difficult recurrent issue for the task force medical department. This net does not just happen. Close interaction and attention by the CATF Surgeon with all the communication officers is required.

#### **Marine Air-Ground Task Force (MAGTF) Alert/Broadcast Net (HF)**

For alert warnings or general traffic pertaining to all units assigned to the net. It is also used for passing Nuclear-Biological-Chemical (NBC) warnings.

#### **Color Beach Administrative Net (HF)**

The CBAN is for passing administrative information, requesting supplies and equipment, coordinating supply and equipment deliveries to specific beaches, and evacuating casualties from landing beaches.

#### **Tactical Air Request - Helicopter Request [TAR-HR], (HF, VHF)**

For forward ground combat units to request immediate air support from the tactical air control center (TACC) or the direct air support center (DASC). Intermediate ground combat echelons monitor this

net and may modify, disapprove, or approve a specific request. The TACC / DASC use this net to brief the requesting unit on the details of the mission and may pass along target damage assessments and emergency helicopter requests. In the initial stages of an amphibious operation or any Marine Expeditionary Force (Special Operations Capable) [MEU(SOC)] operation, this may be the only net the unit can use.

**Helicopter Direction Net [HD], (UHF, VHF, HF):** used by the Helicopter Direction Center (HDC) for positive control of inbound helicopters in the amphibious objective area (AOA). This is where inbound casualty details can be found; it is monitored in the flagship HDC.

### **Miscellaneous:**

The following networks are also available.

Local area network (LAN)

Wide area networks (WANs)

World Wide Web, (NIPRNET, SIPRNET).

Saltgrams (a supply Email network)

OPREP-5 Feeder (ship's daily message, with a medical section covering the previous day's medical events)

## **CREDENTIALS AND PERFORMANCE ASSESMENT AND IMPROVEMENT (PA & I)**

### **PURPOSE**

The purpose of the Process Assessment and Improvement (PA & I) Program is to ensure that all Sailors and Marines receive the highest quality of care available. The Credentials Program ensures that all our health care professionals are properly trained and qualified to carry out their medical duties.

### **DISCUSSION**

The TYCOMs rely on shipboard medical officers to carry out the provisions of references (a) through (h) and the management of the Shipboard PA & I Program. The Shipboard PA & I Program consists of the following areas:

- medical readiness
- provider care: physician and non-physician
- inpatient nursing and provider care

- performance appraisal reports (PARS)
- AMMAL change proposals
- quarterly PA & I meeting
- platform capability monitoring

### **RESPONSIBILITY**

The overall responsibility for the Shipboard PA & I Program resides with the COMNAVSURFOR Medical Officer. When underway, the CATF Surgeon is responsible for implementing the PA & I Program for the ships assigned to the Expeditionary Strike Group. As such, the CATF Surgeon is responsible for:

- Holding quarterly PA & I meetings while deployed. These meetings should be scheduled in port whenever possible to allow the fullest participation of all medical officers and Senior Medical Department Representatives (SMDRs).
- Preparing and submitting Performance Appraisal Reports (PAR) on all embarked credentialed medical personnel practicing on Ship's in the ARG or strike group. NOTE: this includes MARFOR Medical Officers. PARs can be completed during the return to CONUS or homeport so the information is ready for the member's parent command. After completing PARs, forward them to the TYCOM via ISIC Medical Officer.
- Performing medical records review on IDCs assigned to the ESG on a monthly basis. IDCs require a 10% chart review, during which the physician preceptor will hold medical training for the IDC. Quarterly, submit a summary of the IDC chart reviews to TYCOM Medical via ISIC.
- Performing Monthly Medical record reviews of medical officers assigned to the ARG or strike group. A quarterly summary of these reviews must be completed and forwarded to TYCOM medical via ISIC (Enclosure (2)). A carbon copy (cc) should be forwarded to the Medical Representative for the ISIC for inclusion in the IDC file.

- During the quarterly PA & I meetings, conduct medical training for embarked medical officers and non-physician health care providers.
- Ensuring that all clinical notes on patients seen by non-IDC HM's in a clinical area are reviewed and signed by a designated provider (MO, IDC, PA, NP, etc.) before the patient departs the clinical area.
- Ensuring that Inpatient Nursing Care and Surgical Case reviews are completed. Identified discrepancies will be addressed and resolutions documented during the Quarterly PA & I meetings.
- Documenting suggested changes to the Ship's AMAL in the quarterly PA & I minutes. AMAL change requests (ACR's) should also be submitted via ISIC to the TYCOM.
- Completing and reviewing all Occurrence Screens, forwarding them to ISIC for review and appropriate action. Forward all Level III/IV occurrences to the TYCOM Medical Officer for review and action.
- Include the Platform Capabilities Monitoring in the monthly QA/QI Report after discussion in the monthly QI meeting. Areas of particular interest are changes or deletions of medical equipment and changes to the physical plant of the medical departments (i. e. SHIPALTS) that alter the department's capabilities.

### **CREDENTIALING**

The TYCOM Medical Officer is responsible for professional oversight of Shipboard Credentialing and Privileging Program. When embarked on the ARG or strike group, the CATF Surgeon is responsible for reviewing the credentials of all embarked medical personnel and completing their PARs. Upon mobilization to a deploying platform, the member's parent activity is responsible for [transmitting an electronic forwarding a Credential Transfer Brief](#) to the respective TYCOM Medical Staff Services Professional located at either USFF or COMNAVSURFPAC for approval of primary and

special privileges before arrival. USFF / CNSP will forward approval of credentials to the ship.

## **REPORTS**

Examples may be found in the below references.

- IDC Chart Review
- IDC Quarterly Review Form
- Physician Chart Review Form
- Physician Quarterly Review Form
- Inpatient Nursing Evaluation Form
- Guidelines for Inpatient Nursing Eval Form Utilization
- Inpatient Provider Evaluation Form
- Performance Appraisal Report (PAR)
- Nurse Corps Performance Appraisal Report
- Quality Improvement Meeting Minutes Format Checklist and Worksheet
- Occurrence Screen Report
- Non-inclusive List of Special Occurrences

### References

- COMNAVSURFORINST 6000.1 series*
- COMNAVSURFORINST 6000.2 series*
- COMNAVSURFORINST 6320.1 series*
- USFF/CPF 6320.2 series*
- OPNAVINST 6400.1 series*
- BUMEDINST 6230.66 series*
- BUMEDINST 6010.13 series*

## **CRISIS MANAGEMENT BASICS**

WHAT HAS HAPPENED? WHAT IS HAPPENING?  
WHAT IS LIKELY TO HAPPEN NEXT?  
WHAT IS THE WORST THAT COULD HAPPEN NEXT?  
WHO IS IN CHARGE?  
WHAT IS THE CHAIN OF COMMAND?

WHAT HAS BEEN DONE? WHAT IS BEING DONE?  
WHAT SHOULD BE DONE NEXT?  
WHAT SHOULD NOT BE DONE?

WHO HAS BEEN INFORMED? WHO SHOULD BE INFORMED?  
WHO SHOULD NOT BE INFORMED?

WHAT DO WE NEED?  
WHO ARE THEY?  
WHAT ARE THEY?  
WHERE ARE THEY?

## **FOREIGN HUMANITARIAN ASSISTANCE (FHA) AND DISASTER RELIEF OPERATIONS**

Support must be requested by Host Nation. When directed by President of the United States (POTUS) or SECDEF, COCOM, supporting the DOS, conducts Foreign HA / Disaster Relief Operations in order to alleviate human suffering.

### **END STATES**

- Efficient provision of immediate life-saving supplies and services
- Successful transition of support efforts to other responsible authorities
- Creation of a stable, secure environment for the restoration of peace
- Enhanced U.S. prestige and influence in the affected region

### **PHASES**

- Phase I Crisis assessment and preparation
- Phase II Deployment
- Phase III Mission Operations
- Phase IV Transition
- Phase V Redeployment

### **COMMAND AND CONTROL**

- DOS (usually USAID) is lead USG agency working closely with host nations
- COCOM will designate a CJTF or JTF commander

### **MILITARY SUPPORT REQUESTS**

- Mission dictates priority order:
  - Medical support and casualty evacuation

- Delivery/distribution of food, water, clothing, blankets, medicine
- Construction of temporary roads, bridges and shelters
- Repair of local critical infrastructure
- Clearing of debris
- Emergency power
- Bathing facilities
- Traffic control

### **CONSIDERATIONS**

- Balance between thorough planning and timely life-saving support
- Assessment plan needs to be well coordinated with:
  - Country Teams (DOS, DOD)
  - Foreign Disaster Assistance Response Teams (DOS)
- DOS provides early direction on likely U.S. DOD role/responsibilities to allow focused crisis action planning

### **SAMPLE FHA/DR MISSION**

Provide humanitarian assistance in the form of resuscitative or restorative medical/surgical care to affected residents.

Deploy a task organized FHA/DR medical team with security IOT provide medical care to the citizens while maintaining a solid force protection posture throughout.

Endstate: FHA/DR medical/surgical care provided, medical supplies distributed, FHA/DR readiness skills improved and team safely redeployed to ship or Forward Operating Base.

### **CONCEPT OF OPERATIONS**

**Phase I** - Receive guidance from JTF Commander and conduct mission planning.

**Phase II** - Conduct medical & security recon of medical treatment or clinic site. Draw medical supplies from ship or FOB. Confirm interpreters, and security plan. Conduct convoy & security rehearsal.

**Endstate**- Medical team prepared to conduct FHA/DR

**Phase III** - Conduct mission pre-brief (Security/ROE, convoy ops, COMMS). Load COMMS, personnel, supplies/equipment into vehicles. Assemble convoy and count (personnel and vehicles). Depart FOB, arrive FHA/DR site, COMMS and security set-up. Conduct FHA/DR mission.

**Endstate** - FHA/DR medical care safely provided

**Phase IV** - Prepare for FHA/DR mission transition to IO's, NGO's or HN.

**Phase V** - FHA/DR Team redeploys

**Endstate** - All personnel and equipment accounted and secure.

## **PLANNING CONSIDERATIONS**

### **• DELIVERY SITE AND PROPOSED RECIPIENTS**

- Clinic site: Are there fixed structures with water and electricity?
- Medical Personnel: Are there doctors and nurses (veterinarians) etc?
- Approximate Population: Men, women, children, disabled population, and language.
- Local POCs to coordinate with (medical professionals / Village Elder)
- Translators (knowledge of medical terminology and appropriate gender)

### **• SECURITY AND DESCRIPTION OF THE AREA**

- Security threat in the area?
- Types and number of US / Coalition medical personnel required?
- Medical Class items required, example Class VIII
- Forces available to provide security?

## **INTEGRATION WITH IO / NGOs**

Are there any medical NGOs in the area? POCs  
What services have they or are they providing?

## **VILLAGE HEALTH ASSESSMENT**

- **Village**
  - Location / Grid

- Security Threat
  - Local Security. HN promised 10. Accept no fewer than 5
  - Population
  - Clinic Site
  - Local Leader
  - Women / Men / Children
  - Medical Personnel
  - Vaccinations Programs
  - IOS / NGOS
  - Interpreters (Women Needed). If 6 planned, accept no fewer than 3
- **FP Plan:** HN or US security forces for FP. Weapons requirements, Rules for use of forces (RUF)/ Rules of Engagement (ROE) brief
  - **Priority of work:**
    - Make liaison with local authorities
    - Set-up exam areas with med consumables
    - Begin FHA/DR operations
    - End FHA/DR operations
    - Roll-up security
    - Retrograde
  - **Develop Communication Plan:** Establish emergency COMMS via SATCOM or Cell Phone. Contact FOB/ship, AT/FP security force. Motorola Radios for convoy & on site internal comm. No Commo Plan: If no contact in one hour, re-deploy to FOB or ship.
  - **Develop a casualty plan:** COMMS, evacuation means, location and routes. Identify nearest possible LZ (i.e. soccer field). Provide Grid coordinates.

### CONDUCT FHA/DR ORM (Sample)

HAZARD	RISK	CONTROL	AFTER CNTRLS
Kidnapping	MED	US personnel armed guards. Local populace friendly. Local officials have personal interest in ensuring	LOW

		Team's security. Team is alert and avoids "crowding".	
Assassination	LOW	Travel w/vehicle windows open & Team alert to personnel and terrain out side of vehicle – 360 visibility. On Site: HN Security outside clinic. US security inside clinic area.	LOW
IED	LOW	Eyes on vehicles while parked at clinic. Visually inspect vehicles prior to movement. MPs inspect upon return to FOB.	LOW
Mines In Road	LOW	Do not announce which route we are taking to FHA/DR treatment or clinic site or which route we will return by. Avoid water, loose surfaces. Local Population uses road. Avoid anything they avoid.	LOW
Veh Accident	MED	Tasks planned with adequate time for completion without rushing. Small unit supervision. Experienced personnel.	LOW
FP / Asymmetric Attack	LOW	JTF and AT/FP personnel conscious of current threat reporting. Local populace friendly. Locals will identify outsiders. Limited population. Good 360 visibility. Security posture.	LOW
Heat Illness	LOW	Personnel Acclimatized. Proper hydration supervised by leaders.	LOW
Malaria	MED	All on antimalarial prophylaxis. No stagnant water, mosquito breeding in vicinity of village.	LOW
Rodents, Insects, Animals, Snakes, etc	LOW	Personnel briefed on poisonous varieties and instructed to leave wildlife alone.	LOW
Personnel getting lost	MED	FHA/DR Team unfamiliar w/area. Others maintain close proximity. Use of strip maps & front/rear guides for convoy.	LOW
Disease contracted from local personnel	MED	Medical Providers take appropriate precautions.	LOW

## DEFENSE SUPPORT of CIVIL AUTHORITIES (DSCA)

**DSCA:** Refers to Department of Defense support provided by Federal military forces, DOD Civilians and contract personnel, and DOD agencies and components, in response to requests for

assistance during domestic incidents to include terrorist threats or attacks, major disasters, and other emergencies. *National Response Plan December 2008*

Two circumstances exist for DOD providing Defense Support to Civil Authorities:

- In emergency circumstances, such as managing the consequences of a terrorist attack, major disaster, or other emergency, DOD could be asked to act quickly to provide capabilities that other agencies do not possess or that have been exhausted or overwhelmed.
- In non-emergency circumstances of limited scope or planned duration, DOD could be tasked to plan for and support civil authorities where other Federal agencies have the lead – for example, providing security at a special event such as the Olympics, or assisting other Federal agencies to develop capabilities to detect chemical, biological, nuclear, and radiological threats.

Under the provisions of the Stafford Act, DOD support for disaster relief must be requested. (The other principal statute under which DOD provides emergency support is the Economy Act, under which any Federal agency can request support on a reimbursable basis from DOD.) Requests for Defense Support are made through DOD Executive Secretary and a Defense Coordinating Officer (DCO) is assigned.

### **DSCA: What it is NOT**

Homeland Defense

Programs under separate mandate (Counter-Drug Operations, some Intelligence support, Community Affairs or IRT Programs)

Foreign Disasters

Sensitive support per DODD 5210.36

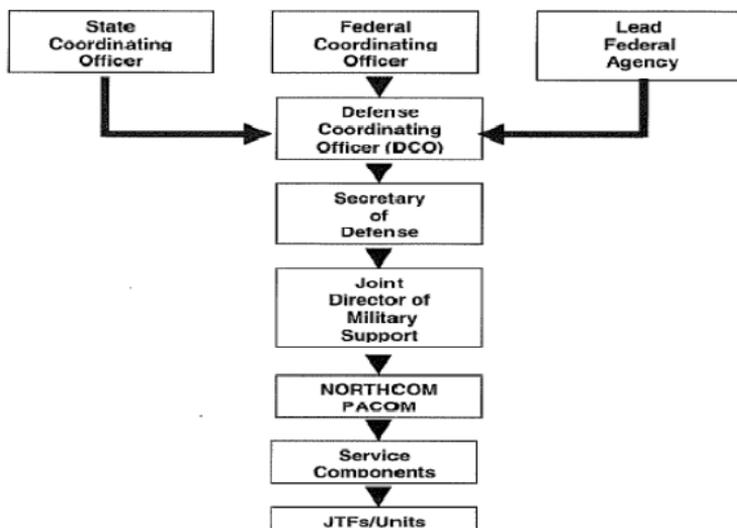
US Army Corps of Engineers (USACE) as a primary agency IAW

ESF #3 of the NRP

Mutual Assistance

### **DSCA: What it is**

Response to a SECDEF approved Request for Federal Assistance before, during, or after domestic incidents (includes CBRNE CM)  
 Approved support to other Federal Departments or Agencies (NSSE, special events, WFF)  
 Civil Strike/Augmentation (Postal, FAA, Federal Prisons)  
 Civil Disturbance Operations



Role of the DCO in coordinating requests for assistance

### **Defense Coordinating Officer (DCO)**

- Act as the designated DOD on-scene representative at JFO.
- Act as the DOD single point of contact (POC) at the incident management location for coordinating and processing requests for military support assistance by DOD.
- Coordinate request for assistance [Assistance Request Form ARF] and mission assignments with the FCO or designated Federal representative.
- Operate as DCO/DCE within the Joint Field Office (JFO).
- Direct on-scene support of Defense Coordinating Element (DCE), comprised of administrative staff and liaison personnel, including

Emergency Preparedness Liaison Officers (EPLO).

- Forward mission assignments to appropriate military organizations through DOD-designated channels.
- Assign military liaisons, as appropriate, to activated Emergency Support Functions (ESF).

Figure IV-1. **Defense Coordinating Officer**

(Source: National Response Plan, Dec 2005, 37and 42, and JHM)

### **PURPOSE OF ESF 8:**

Emergency Support Function (ESF) #8— Public Health and Medical Services, provides the mechanism for coordinated Federal assistance to supplement State, local, and tribal resources in response to public health and medical care needs (including veterinary and/or animal health issues when appropriate) for potential or actual domestic incidents and/or during a developing potential health and medical situation. ESF #8 is coordinated by the Secretary of the Department of Health and Human Services (HHS) principally through the Assistant Secretary for Public Health Emergency Preparedness (ASPHEP). ESF #8 resources can be activated through the Robert T. Stafford Act or the Public Health Service Act (pending the availability of funds) for the purposes of Federal-to-Federal support or in accordance with the memorandum for Federal mutual aid included in the National Response Plan (NAP) Financial Management Support Annex.

### **SCOPE:**

ESF #8 provides supplemental assistance to State, local, and tribal governments in identifying and meeting the public health and medical needs of victims of a domestic incident. This support is categorized in the following core functional areas: Assessment of public health/medical needs (including behavioral health); public health surveillance; Medical care personnel; and Medical equipment and supplies. As the primary agency for ESF #8, HHS coordinates the provision of Federal health and medical assistance to fulfill the requirements identified by the affected State, local, and tribal authorities. ESF #8 uses resources primarily available from: HHS, including the Operating Divisions and Regional Offices; The Department of Homeland Security (DHS); and Other ESF #8 support agencies and organizations.

## **ANTICIPATED MISSION ASSIGNMENT:**

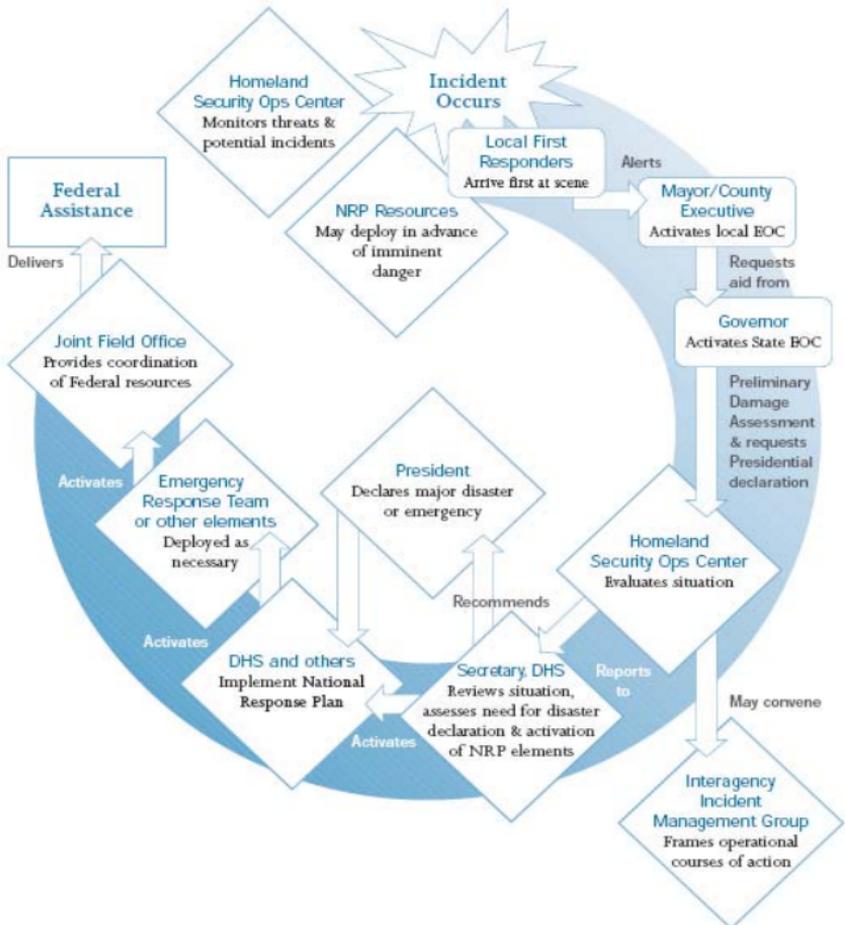
“Consider utilizing Local, State, and National Guard capabilities to perform this mission.”

- Rotary Wing Medical Evacuation / Casualty Evacuation
- Temporary Medical Treatment Facilities

### References

a. *National Response Plan December 2008*

### Overview of initial Federal involvement under the Stafford Act



# DECEDENT AFFAIRS

## INTRODUCTION

The Navy's Decedent Affairs Program encompasses the search, recovery, identification, care, and disposition of remains of all personnel for whom the Department of the Navy is responsible. The management of the program onboard naval vessels is the responsibility of the commanding officer and the senior medical representative. The decedent affairs procedures are outlined in the Decedent Affairs Manual, NAVMEDCOMINST 5360.1.

## MEDICAL DEPARTMENT RESPONSIBILITIES

- **Decedent Affairs Officer (DAO):** The medical administration officer onboard the LHA/LHD and CV/CVN is often designated the decedent affairs officer. The DAO is responsible for coordinating with the personnel and supply departments, MMSO (Military Medical Support Organization), and the nearest mortuary facility to carry out the procedures outlined in the Decedent Affairs Manual. The DAO will ensure all necessary forms, body pouches, and transfer cases are available onboard prior to getting underway. He/She is also responsible for the decedent affairs programs on the smaller ships within the battle group.
- **Initial Report:** Immediately after a death occurs within the command, the SMO or senior medical representative submits an initial memorandum report to the commanding officer according to MILPERSMAN 4210-100 and NAVMEDCOMINST 5360.1. An entry is also made in the medical department journal with all available information regarding the death.
- **Death Certificate:** The DD Form 2064, Certificate of Death (Overseas) must be completed for all deaths occurring onboard naval vessels or OCONUS. This form needs to be signed by the medical officer or another American medical doctor, either civilian or military. Three copies of the completed DD Form 2064 must accompany the remains. MANMED, Chapter 17, provides further information concerning death certificates.

- **Medical Record Entries:** After documenting the details surrounding the death and enclosing the completed DD Form 2064 in the medical record, the health record is closed and sent with the remains inside the transfer case.
- **Disposition of Remains:** As soon as possible, the remains should be transferred to the nearest military medical facility for preservation and further disposition. The Decedent Affairs Manual lists the available overseas military mortuary facilities. Also refer to Annex D of the Fleet AOR OPORD. The American Embassy and MMSO may be able to assist in locating an appropriate mortuary facility when overseas. If a foreign facility is used, a DD2062, Record of Preparation and Disposition of Remains (OCONUS) must be completed.
  - To prepare the body for temporary storage, refer to NAVMED P-5083. Affix waterproof body ID tags, marked with waterproof ink, with wire ties to the right great toe and to each end of the body bag. The body can be temporarily refrigerated at 36-40 degrees Fahrenheit until transfer is possible.
  - The following items must accompany the remains:
    - Medical and Dental Records, Dental X-rays
    - Three copies of DD 2064 Certificate of Death (overseas), signed by an American physician.
    - Two completed DD Form 565, Statement of Recognition. The form must be signed by two different shipmates who knew the deceased, if remains are recognizable.
    - Escort

## **PERSONNEL DEPARTMENT RESPONSIBILITIES**

- **Personnel Casualty Report (PCR):** A personnel casualty report should be submitted as soon as possible after a death occurs. Such reports are required on all members of the Armed Forces, civilians serving with or attached to Navy commands, and retired members whose deaths occur on naval reservations or aboard ships. The report should be sent by priority message within 4 hours to COMNAVPERSCOM in accordance with MILPERSMAN 1770-030. The report can also

be scanned and sent unclassified via e-mail to MILL\_NavyCasualty@navy.mil. Once submitted to COMNAVPERSCOM, the report will automatically be routed to the remaining action and information addressees. Refer to MILPERSMAN 1770-030 for a complete list of addressees and the proper format and required information for the PCR. If a CRTS receives another unit's deceased, the CRTS will draft and submit the initial PCR. The deceased's unit will then be notified to draft/submit a more complete PCR to supplement the initial report.

- **Page 2/SGLI**: The personnel department will verify and immediately submit the deceased's page 2 and SGLI information to PERS-62.
- **Escort**: Assign a mature person of the same rank, job, and unit as the deceased, preferably a friend, to be the escort. The escort ensures effective transportation of the remains from place of death to place of final disposition. MMSO will pay TAD for 1 escort; member's ship/unit can pay for additional escorts. Escort will hand carry member's personal effects after inventoried (see Supply Dept responsibilities).
- **Uniform Items**: Prepares the member's service dress blue uniform with authorized insignia, devices, badges, and decorations for burial. If the appropriate items are not available in the member's personal effects, they must be purchased.
- **CO Condolence Letter**: Prepared by the CO to the NOK within 48 hours of casualty with sufficient facts relating to the incident. Copy is sent to CHNAVPERS and JAG Investigations Division.

## **SUPPLY DEPARTMENT RESPONSIBILITIES**

- **Temporary Storage**: Remains are stored in the morgue or freezer at 36-40 degrees Fahrenheit. The space must contain no other items and be cleaned and disinfected before reuse.
- **Inventory**: For enlisted personnel, the division officer (or other officer if DIVO not present) and the master-at-arms will inventory the deceased's personal effects, using NAVSUP

Form 29. For officers, two officers are required. The effects are turned over to the Supply Officer and either transported with escort/remains or forwarded to NOK.

#### References

- a. NAVMEDCOMINST 5360.1 "Navy Decedent Affairs Manual"
- b. COMNAVSURFORINST 6000.1 "Shipboard Medical Procedures" (Ch 4-1-13), and (Ch 5-20)
- c. MILPERSMAN 1770-030 "Military Personnel Manual" Personnel Casualty Reports
- d. NAVMED P-5083 "Storing of Remains"
- e. NAVPERS 15955-F "Manual for Escorts"

## HEALTH SERVICES SUPPORT AFLOAT CAPABILITIES

### **Amphibious Task Force CRTSsCRTS**

After troops debark for ship-to-shore movement, specific ships of the ESG/ATF are designated as primary CRTSsCRTS to provide Forward Resuscitative Capability (Echelon Level II) HSS to the LF during amphibious operations. Primary CRTSsCRTS (LHA/LHD) have laboratory (including blood) and radiology capability to support surgical suites. During amphibious ops, primary CRTSsCRTS are staffed as necessary to provide extensive trauma support. The CATF/ESG may designate other amphibious ships as secondary CRTSsCRTS. These may include any class ship with the capability to receive and treat casualties, if appropriate medical materiel and personnel are available to provide resuscitative care. Ships normally designated as secondary CRTSsCRTS include LPD, LSD, and LCC class ships.

### **LHA [Amphibious Assault Ship (General Purpose)]**

The LHA can transport approximately 1,900 troops along with the helicopters, boats, and amphibious vehicles required for landing them. LHAs are capable of receiving casualties from helicopter and waterborne craft and are designed to function as primary CRTSsCRTS in amphibious operations. The LHA(R6) Class is expected to will replace the current Class LHAs - in the future.

### **LHD [Amphibious Assault Ship (Multi-Purpose)]**

The LHD is the newest, largest, and most versatile amphibious assault ship. Externally, it resembles an aircraft carrier. The LHD is capable of transporting approximately 1,800 troops along with the

helicopters, boats, and amphibious vehicles required for landing them. LHDs have the largest medical capability of any amphibious ship currently in use. LHDs are capable of receiving casualties from helicopter and waterborne craft and are designed to function as primary CRTS in amphibious operations.

LHD/LHA CAPABILITY	STAFFING		
	Ship's Company/FST	Ship's Company / FST / HSAP	
Operating Rooms	1	4	
Intensive Care Unit Beds	3	15	
Ward Beds	12	45	
Ancillary Capabilities	Laboratory, x-ray, pharmacy, preventive medicine, biomedical repair, aviation physical examination.		
Complement	Ship's Company	FST	MAP
Medical Corps	2	3	11
Dental Corps	1		1
Nurse Corps		3	22
Medical Service Corps	1	1	1
Hospital Corpsmen	19	9	49

### LPD (Amphibious Transport Dock)

The mission of the (LPD) is to transport and land Marines, their equipment and supplies by embarked landing craft or amphibious vehicles augmented by helicopters. The LPD San Antonio class contains enhanced command and control features and a robust communications suite that improves its ability to support embarked landing forces, joint and friendly forces. They could be used as emergency or overflow CRTS if augmented with medical personnel and supplies.

### LPD 17 San Antonio Class

The primary mission is amphibious warfare and will be the replacement class of LPD 4, LSD 36. It is designed to execute Operational Maneuvers from the Sea (OMFTS) and Ship to Objective maneuvers.

OR .....2  
 Ward beds.....24  
 Dental .....2 OR rooms

### LSD (Dock Landing Ship)

The mission of the dock landing ship (LSD) is to transport and land Marines, their equipment and supplies either by embarked landing craft or amphibious vehicles augmented by helicopters and to support amphibious operations including landings via landing craft air cushion (LCAC). Although called a 'landing ship,' the LSD does not beach. These ships are similar to LPDs with larger well decks but limited troop and cargo carrying capacities. LSDs offer limited use as [CRTSs](#)[CRTS](#) if augmented with medical personnel and supplies.

<b>LSD CAPABILITY</b>	<b>STAFFING</b>
Operating Rooms	
Intensive Care Beds	
Ward Beds	8 (2 isolation beds)
Ancillary Capabilities	Laboratory and x-ray
<b>Complement</b>	
Medical Corps	1
Dental Corps	1
Hospital Corpsmen	9

### LCC (Amphibious Command Ship)

LCCs serve as command centers for amphibious operations. These ships are equipped with sophisticated electronic and communications equipment and normally serve as the flagship of both the CATF/ESG and CLF. LCCs have adequate medical facilities to care for embarked personnel but their limitations preclude use as [CRTSs](#)[CRTS](#).

#### LCC MEDICAL FACILITIES

OR (minor surgery) .....	1
ICU Beds .....	0
Ward Beds .....	20
Overflow Beds .....	0
Quiet / Isolation Beds .....	4
Ancillary	
Lab and X-ray .....	yes

#### LCC MEDICAL MANNING

Medical Corps .....	1
Dental Corps .....	0
Nurse Corps .....	0
Anesthesia Provider .....	0
Medical Service Corps .....	0
Hospital Corpsmen .....	12
Dental Technicians .....	0

### **CVN and CV (Aircraft Carriers)**

The mission of the CV / CVN is to operate offensively in a high density, multi-threat environment as an integral member of a Carrier Strike Group (CSG) or expeditionary strike group (ESG); and to provide credible, sustained forward presence, conventional deterrence, and support aircraft attacks in sustained operations in war. Supportive missions, including medical support of the crew members aboard, are facilitated by a self-sufficient carrier hospital, which is a 52-bed, level "2-plus" facility.

<b>CVN CAPABILITY</b>	<b>STAFFING</b>
<b>Operating Rooms</b>	1
<b>Intensive Care Unit Beds</b>	3
<b>Ward Beds</b>	52
<b>Ancillary Capabilities</b>	Laboratory, x-ray, pharmacy, preventive medicine, biomedical repair, aviation physical examinations, radiation health, spectacle fabrication
<b>Complement (Ship's Company and Air Wing)</b>	
<b>Medical Corps</b>	6* - * Includes embarked physicians
<b>Dental Corps</b>	5
<b>Nurse Corps</b>	2** - **Includes certified registered nurse anesthetist if anesthesiologist is not on board
<b>Medical Service Corps</b>	5
<b>Hospital Corpsmen</b>	47

The carrier's medical department also serves as a consultative and primary MEDEVAC facility for the other vessels within CSG/ESG, which may consist of another six ships and some 2,000 crew members.

The CSG/ESG/ARG is a tactical organization of surface and subsurface combatants, maritime aviation, assault and transport troops and their equipment for expeditionary operations. The notional ESG elements are:

- Amphibious assault ship
- Amphibious transport docks
- Surface combatants (guided missile cruisers, destroyers or frigates)
- Attack submarine

### **T-AH (Hospital Ships)**

<b>T-AH Capability</b>	<b>STAFFING</b>
Operating Rooms	12
Intensive Care Unit Beds	100 (includes 20 post-surgical recovery beds)
Intermediate Care Beds	400
Minimal Care Beds	500
Ancillary Capabilities	Laboratory, x-ray, pharmacy, CT scanner, blood storage (3,000 frozen/2,000 fresh)
<b>Complement (staffing for 1000 beds)</b>	
Medical Corps	66
Medical Service Corps	20
Nurse Corps	168
Hospital Corpsmen	698
Non-Medical Officer	14
Non-Medical Enlisted	244
Dental Corps	4

Hospital ships (T-AH) are operated by a Military Sealift Command (MSC) and are designed to provide emergency, on site care, Echelon III, for U.S. combatant forces deployed in war and other operations. The mission of the T-AH is to provide a mobile, flexible, rapidly responsive afloat medical capability to provide acute medical and surgical care in support of CSG/ESG/ATF and Navy/joint forces elements. Functioning under the provisions set forth in the Geneva Convention, they have capabilities equivalent to a CONUS general hospital. The T-AHs secondary mission is to provide full mobile-hospital services by designated Government agencies HA/DR or limited humanitarian care to these missions worldwide or peacetime military operations.

### **(AS) Submarine Tender**

The mission of the submarine tender (AS) provides at-sea support capability.

<b>CAPABILITIES</b>	<b>STAFFING</b>
Operating Rooms	1
Intensive Care Unit Beds	
Ward Beds	12
Ancillary Capabilities	Laboratory, x-ray, and pharmacy
<b>Complement</b>	
MC / MSC/ IDC	2 / 1 (RadHlth) / 2
Hospital Corpsmen	10

### **Surface Combatants**

The surface combatant ships, cruiser (CG), destroyer (DD/G), and frigate (FFG) have limited HSS capabilities (First Responder) and staffing. Their ancillary capability consists of basic laboratory. They are manned by at least one Independent Hospital Corpsman (NEC 8425) and one general duty junior HM.

- Cruiser (CG)
- Destroyer (DD/G)
- Frigate (FF)

## **HEALTH SERVICES SUPPORT (USMC)**

### **THE MARINE CORPS MISSION**

Naval expeditionary force, that while deployed unobtrusively in international waters, is instantly ready to help any friend, defeat any foe, and convince any potential enemy of the wisdom of keeping the peace. *Source: "Operational Maneuver from the Sea"*

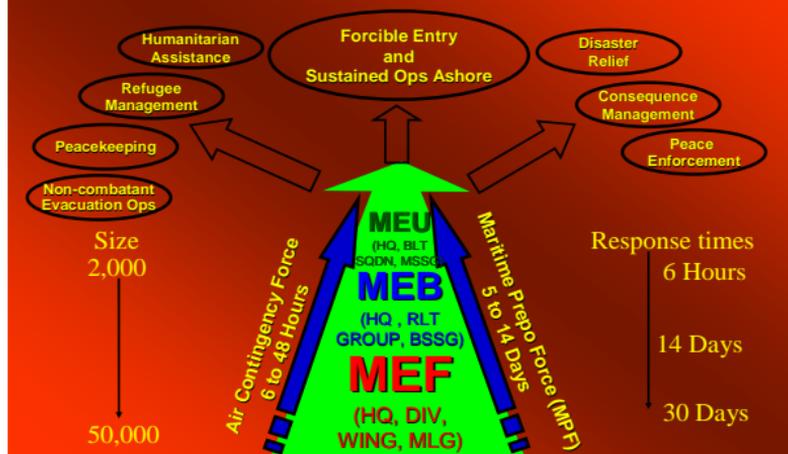
### **ORGANIZATION**

Marines are organized as a "force-in-readiness" to support national needs. They are divided into 3 broad categories:

Operating Forces // Reserves // Supporting Establishment

- **Operating Forces**
  - MARFORPAC: I MEF & III MEF
  - MARFORCOM: II MEF
- **Marine Reserves**
  - MARFORRES: IV MEF
- **Supporting Establishments**
  - MCB, MCAS, MCRD, MCCDC, MARCORSYSCOM, etc.
- **Marine Air Ground Task Force (MAGTF)**
  - Marine Expeditionary Force (MEF)
  - Marine Expeditionary Brigade (MEB)
  - Marine Expeditionary Unit (MEU)
  - Special Purpose MAGTF (SPMAGTF)

## The MAGTF: Combined Arms Force... Scaleable, Flexible, Expeditionary



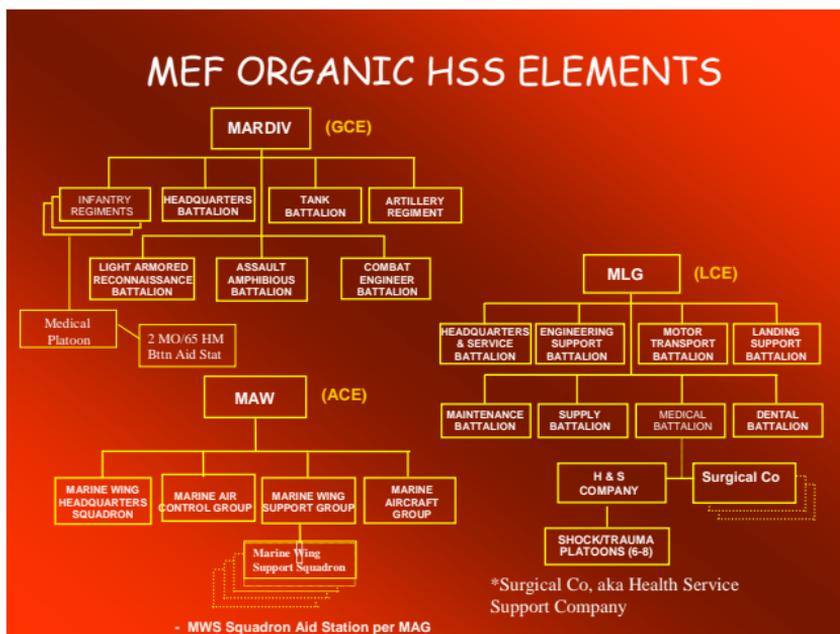
### Core Elements to the Marine Air Ground Task Force (MAGTF):



## Core Elements to the Marine Expeditionary Force (MEF):



A large percentage of USMC medical assets are Med Augmentation Program (MAP)/Health Service Augmentation Program (HSAP) personnel, assigned during deployments - work in MTFs when units are in garrison.



### **Division/GCE Medical Assets:**

- **HQ:**
  - Division Surgeon, Medical Administrative Officer, Environmental Health Officer, Division Psychiatrist, Enlisted Personnel
- Battalion Surgeon
- Battalion Aid Station {Level I-First Responder}
- 1-2 MO (GMO) = Battalion Aid Station (BAS)
- 21 HM's = Battalion Aid Station
- 11 HM's = Weapons Company
- 33 HM's = Rifle Companies (3)

### **MLG/LCE Medical Assets:**

- **HQ:**
  - Group Surgeon, Medical Admin Officer-Planner, Enlisted Personnel Assistants
- **Surgical Co. 1-3/Med Battalion of MLG {Level II-Fwd Resuscitation}:**
  - Triage/Evacuation Platoon -Holding Platoon
  - Surgical Platoon -Combat Stress Platoon
  - Ancillary Service Platoon -FRSS
  - Dental Detachment
  - Assets
    - 17 MC, 7 MSC, 23 NC, 127 HM, 19 USMC
    - 3 ORs, 60 BEDS

### **FRSS 1/Health Service Support Company, Med Battalion of MLG {Level II-Fwd Resuscitation}**

- **Definition/Purpose:**

A rapidly deployable, highly mobile, small footprint for various missions/operations
- **Characteristics:**
  - 8-10 Personnel (2 Surgeons, 1 Anesthesiologist, Critical Care NC, 3 OR Techs, 1 IDC)
  - Less than 500 cubic feet // Less than 5,000 lbs
  - Approx 1400 lbs of med equip and consumables

- Treat 18 casualties without re-supply for 48 hours of continuous operation
- Provide pre-, peri-, and post operative care. Administer local and general anesthesia.

**Shock Trauma Platoon 8/Health Service Support Company, Med Battalion of MLG {Level 1(+)} - First Responder}**

- **Stabilization Section:**
  - 2 – MO (EM), 1 – IDC, 1 – PA, 6 - HM's
- **Collecting/Evacuation Section:**
  - 1 – NC, 7 HM, 7 – USMC
  - 0 ORs; 10 COTS

**WING/ACE MEDICAL ASSETS:**

- **HQ:**
  - Wing Surgeon (MC), Med Admin Officer-Planner, Environmental Health Officer, Industrial Hygiene Officer, Enlisted Personnel Assistants
- **Wing Aid Station 1/Marine Air Group {Level I}:**
  - 5 MO's and 34 HM's: routine sick call, aviation medicine, preventive medicine, and laboratory, x-ray, pharmacy services.
  - 0-ORs. May include satellites, i.e. Flight Line Aid Station with FSs
- **Squadron:**
  - Flight Surgeon and 2-3 HMs/squadron

**USMC INITIATIVES**

**En Route Care (ERC):**

Manpower and Equipment for transporting patients from Level 2 to Level 2+ - Fwd Resuscitation/Theater Hospitalization utilizing designated, primarily USMC CH46 or USA Air Ambulance H60s.

- Medical attendant(s) NC and/or HM
- Equipment and supplies for two critical patients
- Medical supervision/protocols
- Rapid cabin re-configuration

- Move critical & post-op patients from FRSS/STP to Shore and Sea Level II+ -Fwd Resuscitation.

**CASEVAC:**

Manpower and Equipment for transporting patients from Point of Injury (POI) or Casualty Collection Point (CCP) utilizing Lift of Opportunity or Designated aircraft to Level 2+ - Fwd Resuscitation.

- Medical attendant HM
- Equipment and supplies at PHTLS/TCCC level
- Rapid Cabin Reconfiguration
- Move injured patients from combat zone or Level 1 to Level 2+

## IMPORTANT POCs

The Internet is a massive information resource; therefore, sites listed below are only a beginning guide to numerous Navy and medical sites. Routinely, everyone will have their own favorite sites and preferences for information searching.

### **MILITARY SITES**

Naval Operational Medicine Institute  
TEL: (850) 452-4554 DSN: 922- 4554  
<http://www.med.navy.mil/sites/navmedmpte/nomi/Pages/default.aspx>

Commander, U. S. Central Command  
Tel: (813) 827-1110 DSN: 651-1110  
<http://www.centcom.mil/>

Commander, U. S. Pacific Command (USPACOM)  
Tel: (808) 477-1341 DSN477-1341  
<http://www.pacom.mil/>

Commander, Fleet Forces Command  
TEL: (757) 836-3644  
<http://www.cffc.navy.mil/>

Commander, U. S. Pacific Fleet  
TEL: (808) 471-3769 DSN: 471-3769  
<http://www.cpf.navy.mil/>

Commander, Marine Forces Pacific  
Tel: (808) 477-8308  
<http://www.mfp.usmc.mil/>

Commander, Seventh Fleet  
TEL: (808) 653-2152 DSN: (315) 453-2152  
<http://www.c7f.navy.mil/>

Navy Knowledge Online  
Toll Free: (877) 253-7122 DSN: 922-1001  
<https://wwwa.nko.navy.mil/portal/home/>

Navy.mil  
<http://www.navy.mil/>

Navy Medicine Online  
TEL: (202) 762-3221  
<http://navymedicine.med.navy.mil/>

Naval Personnel Command  
TEL: (866)-U-ASK-NPC DSN 882-5672  
<http://www.npc.navy.mil/channels>

My Pay  
<https://mypay.dfas.mil/mypay.aspx>

Marine Corps Locator  
TEL: (703) 784-3941  
<http://www.usmc.mil/searchcenter/Pages/Results.aspx?k=locator&s=All%20Sites>

### **OTHER USEFUL SITES**

National Library of Medicine  
<http://www.ncbi.nlm.nih.gov/PubMed/>

Hardin Meta Directory of Internet Health Sources  
<http://www.lib.uiowa.edu/hardin/md/idx.html>

The Centers for Disease Control and Prevention  
TEL: 800-CDC-INFO  
<http://www.cdc.gov/>

Center for Excellence in Disaster Management and Humanitarian Assistance  
TEL: 808-433-7035  
<http://coe-dmha.org/>

Surface Warfare Officer School Command  
TEL: (401) 841-4957/4958  
<http://www1.netc.navy.mil/swos/>

American Medical Association  
TEL: (800) 621-8335  
<http://www.ama-assn.org/>

National Institute of Mental Health  
TEL: (866) 615-6464 (toll-free)  
<http://www.nimh.nih.gov/>

International Society for Infectious Diseases  
<http://www.isid.org/>

New York Times Health Navigator  
<http://www.nytimes.com/library/national/science/health/health-navigator.html>

### **MTFs**

Naval Medical Center San Diego  
TEL: (619) 532-6400  
<http://www.med.navy.mil/sites/nmcsd/Pages/default.aspx>

National Naval Medical Center Bethesda  
TEL: (301) 295-4611 OR 1-800-526-7101 (toll free)  
<http://www.bethesda.med.navy.mil/>

Naval Medical Center Portsmouth  
TEL: (757) 953-5000  
<http://www-nmcp.mar.med.navy.mil/>

US Naval Hospital Yokosuka  
TEL: from US: 81-468-16-7144  
<http://www.med.navy.mil/sites/nhyoko/Pages/default.aspx>

US Naval Hospital, Guantanamo Bay  
<http://imcenter.med.navy.mil/gitmo/>

Naval Hospital Camp Pendleton  
TEL: (760) 725-1211  
<http://www.cpen.med.navy.mil/>

Naval Hospital Lemoore  
TEL: (559) 998-4481  
<https://lemoore.med.navy.mil/>

Naval Hospital Twentynine Palms  
TEL: (760) 830-2978  
<http://www.med.navy.mil/sites/nhtp/Pages/default.aspx>

US Naval Hospital Rota  
TEL: 011 (34) 956-82-3305 DSN: (94)-314-727-3305  
<http://www.med.navy.mil/sites/nhrota/Pages/Home.aspx>

Naval Hospital Jacksonville  
TEL: (904) 542-7300  
<http://navalhospitaljax.com/>

Naval Hospital Pensacola  
TEL: 850-505-6601  
<http://www.med.navy.mil/sites/pcola/Pages/default.aspx>

US Naval Hospital Guam  
TEL: (671) 344-9340  
<http://www.usnhguam.med.navy.mil/home.htm>

Naval Health Clinic, Great Lakes  
TEL: (847) 688-5328 X3110 DSN: 792-5328 X3110  
<http://www.med.navy.mil/sites/nhcgll/Pages/default.aspx>

Naval Hospital Camp Lejeune  
TEL: (910) 451-3079  
<http://www.med.navy.mil/sites/nhcl/Pages/default.aspx>

Naval Hospital Cherry Point  
TEL: (252) 466-0266  
<http://cpoint-www.med.navy.mil/>

US Naval Hospital Okinawa  
TEL: 011(81) 611-743-7555 DSN 315-643-7555  
<http://www.med.navy.mil/sites/nhoki/Pages/default.aspx>

Naval Hospital Beaufort  
TEL: (843) 228-5600 DSN: 335-5600  
[http://www.med.navy.mil/sites/nhbeaufort/Pages/Welcome\\_Page.aspx](http://www.med.navy.mil/sites/nhbeaufort/Pages/Welcome_Page.aspx)

Naval Hospital Charleston  
TEL: (843) 743-7000 DSN: 563-7000  
<http://www.nhchasn.med.navy.mil/>

Naval Hospital Bremerton  
TEL: (800)422-1383 (360) 475-4000  
<http://www.med.navy.mil/sites/nhbrem/Pages/default.aspx>

Naval Hospital Oak Harbor  
TEL: (360) 257-9500 DSN: 820-9500  
<http://www.med.navy.mil/sites/nhoh/Pages/default.aspx>

US Naval Hospital Naples  
TEL: 011-39-081-811-6000 DSN: 314-629-6000  
<http://northstar.med.navy.mil/>

US Naval Hospital Sigonella  
TEL: 011-39-095-56-3842 DSN: 314-624-3842  
<http://www.med.navy.mil/sites/sigonella/Pages/default.aspx>

Naval Health Clinic Hawaii  
TEL: (808) 473-1880 x 2210  
<http://www.med.navy.mil/sites/nhch/Pages/default.aspx>

## OTHER MILITARY RESOURCES

Armed Forces Institute of Pathology  
TEL: (202) 782-2100  
<http://www.afip.org/>

## FLEET MEDICINE TELEPHONE LIST

NUMBERS VERIFIED SEPTEMBER 2009

Location .....	Voice
ACU-4 (Little Creek LCACs).....	(757) 462-7004
ACU-5 (Camp Pendleton LCACs) .....	(760) 725-2219
AFMIC Operations.....	(301) 619-7574
Armed Forces Institute of Pathology .....	(202) 782-2111
Armed Services Blood Program (Policy) .....	(703) 681-8024
BUMED Aerospace Medicine .....	(202) 762-3453
BUMED Career Plans .....	(202) 762-3519
BUMED Dental Corps .....	(202) 762-3019
BUMED Deputy Chief .....	(202) 762-3824
BUMED Education, Training, Personnel .....	(202) 762-3397
BUMED Current Operations.....	(202) 762-3550
BUMED Force Master Chief .....	(202) 762-3137
BUMED Legal .....	(202) 762-3090
BUMED MSC .....	(202) 762-3375
BUMED Nurse Corps .....	(202) 762-3356
BUMED Future Plans & Strategies .....	(202) 762-3551
BUMED Prev Med & Occ Health.....	(202) 762-3477
BUMED Public Affairs .....	(202) 762-3317

BUMED Quarterdeck.....	(202) 762-3211
BUMED Surgeon General .....	(202) 762-3701
COMLANTFLT .....	(757) 836-3644
COMPACFLT .....	(808) 471-3769
COMNAVSURFOR .....	(619) 437-3262
Detailer, GMO.....	(901)874-4045, DSN 882-4045
Detailer, FP, Aerospace, flight, undersea.....	(901) 874-4037, DSN 882-4037
Detailer, Non-Surgical Subspecialty.....	(901) 874-4046, DSN 882-4046
Detailer, Surgical Subspecialty.....	(901) 874-4094, DSN 882-4094
Expeditionary Warfare Training Group, Atlantic.....	(757) 462-7000, DSN 253-7000
Expeditionary Warfare Training Group, Pacific .....	(619) 437-3726
EHSPAC .....	(619) 556-1465
EHSLANT.....	(757) 464-8554
Global Patient Movement Requirements Center...	(618) 256-4938, DSN 576-4938
I MEF Medical - Camp Pendleton.....	(760) 725-4111
II MEF Medical - Camp Lejeune .....	(910) 451-8952
III MEF Medical - Okinawa .....	011-81-611-722-7331
Medical Letter.....	(914) 235-0500, (800) 211-2769
Military Sealift Command .....	(888) SEALIFT (732-5438)
National Institutes of Health .....	(301) 496-4000
National Library of Medicine.....	(301) 594-5983
Naval Institute .....	(800) 233-8764
Naval Medical Information Management Command (NMIMC) .....	(301) 295-1032
Naval Medical Logistics Command .....	(301) 619-2157
Naval Undersea Medical Institute.....	(860) 694-2876, DSN 694-2877
Naval Warfare Development Command - Norfolk .....	(757) 322-2916
Naval Warfare Development Command – Newport.....	(401) 841-4264
NAVMED MPT&E.....	(301) 295-3948
Navy Federal Credit Union .....	(888) 842-NFCU (6328)
NEMTI.....	(760) 725-9862, (866) 873-9862
ESG 7 - Okinawa .....	011-81-6117-742-1553, DSN 742-1555
Seventh Fleet.....	(808) 653-2123, DSN 315-453-2123
Sixth Fleet .....	39-081-568-4901, DSN314-626-4901
SPAWAR.....	(619) 553-1111
Surface Warfare Development Group .....	(757) 464-7942
Surface Warfare Medicine Institute (SWMI) .....	(619) 532-6195
Telemedicine Programs (CAPT Bakalar) .....	(301) 319-1327
US Central Command .....	(813) 827-1110
US European Command .....	011-49-711-680-113, DSN 314-626-4901
US Joint Forces Command.....	(757) 836-6375
US Naval Forces, Europe.....	011-44-71-409-4774
US Pacific Command .....	(808) 477-6282, DSN (315) 474-6282
US Pacific Fleet.....	(808) 471-3769, DSN (315) 471-3769
US Southern Command .....	(305) 437-1000, DSN(567) 437-1000
US Space Command.....	(719) 554-6889
US Special Operations Command .....	(813) 826-4600, DSN 299-4600
US Strategic Command.....	(402) 294-4130
US Transportation Command.....	(618) 229-4828
Uniforms, Navy Uniform Support Center (CONUS).....	(800) 368-4088
UPS toll-free.....	(800) 742-5877
USAA Insurance.....	(800) 531-USAA (8722)
USUHS.....	1-800-772-1743, (301) 295-3101, DSN 295-3101
Walter Reed Army Institute of Research .....	(301) 319-9100

## Overseas Commands

Location .....	Voice
Bahrain.....	011-973-3914-6793, DSN 318-439-4520
Cuba - Guantanamo.....	011-5399-4520, DSN 660-4520
Diego Garcia.....	011-246-370-3680, DSN 315-370-3680
Ger - Frankfurt.....	011-49-69-1541-7555, DSN 325-7555
Ger - Landstuhl .....	011-49-6371-86-8107, DSN 486-8107
Ger - Ramstein .....	011-49-6371-47-2476, DSN 314-480-2476
Greece - Souda Bay .....	011-30-28210-21244, DSN 314-266-1244
Guam .....	(671) 339-2115, DSN 315-339-2115
Italy - Naples .....	011-39-568-5907, DSN 314-626-5907
Italy - Sigonella, Sicily .....	011-39-095-86-5440, DSN 314-624-5440
Japan - Atsugi .....	011-81-467-63-4455, DSN 315-264-4455
Japan - Misawa .....	011-81-3117-66-4363, DSN 315-226-4363
Japan - Okinawa .....	011-81-611-734-8434, DSN 315-634-8434
Japan - Sasebo .....	011-81-956-50-3029, DSN 315-252-3029
Japan - Yokosuka .....	011-81-46-816-1110, DSN 315-243-1110
Korea - Chinhae .....	011-82-2-7913-7251, DSN 315-723-7251
Spain - Rota .....	011-34-956-82-1680, DSN 314-727-1680
United Kingdom – Mawgan.....	011-39-081-568-4722, DSN 314-626-4722
United Kingdom – Mildenhall.....	011-39-081-568-4722, DSN 314-626-4722

## Travel

American Express .. (800) 528-4800  
Amtrak.(800) 872-USA- RAIL (7245)

## Airlines

American Airlines...(800) 433-7300  
Continental..... (800) 523-3273  
Delta Airlines..... (888) 750-3284  
US Airways..... (800) 428-4322  
United..... (800) 428-4322

## Car Rentals

Alamo..... (877) 222-9075  
Avis .....

(800) 331-1212  
Dollar..... (800) 800-3665  
Enterprise..... (800) 261-7331  
Hertz..... (800) 654-  
3131National..... (877) 222-9058

## Hotels

Clarion (877) 424-6423  
Dragon Hill (Seoul, Korea)  
..... DSN 315-723-1011  
Hale Koa (Military, Waikiki, Hawaii)  
.....(800) 955-0555  
Hilton .....

(800) HILTONS  
Howard Johnson ....(800) 446-4656  
  
Hyatt .....

(888) 591-1234  
La Quinta .....

(800) 753-3757  
Marriott .....

(888) 236-2427  
Navy Lodge.....(800) NAVY INN  
Quality Inn .....

(877) 424-6423  
Ramada .....

(800) 272-6232  
Sheraton .....

(800) 325-3535

# INTERNATIONAL SOS

## **Discussion:**

Prior to 2002, **urgent and emergent** medical / dental care for members aboard ships while in a remote overseas location (OCONUS) was paid for using a special BUMED line of accounting. In 2002, TRICARE started funding for those services in the Pacific area. In late 2003, TRICARE went global, expanding the services via a contract with International SOS. ADSM and providers in remote overseas locations are required to use ISOS unless not instructed to do so by the operational commander in the AOR.

## **Program Specifics:**

- **TRICARE Covered areas**
  - Latin America & Canada = 31 countries
  - Europe = 91 countries
  - Pacific = 23 countries
  
- **Eligibility**
  - ADSM Deployed, TAD/TDY or Leave Status
  - ADFM special rules apply. Contact TRICARE/ISOS.
  
- **Procedure**
  - Call centers available 24/7 – 365
  - Emergent medical/dental care – Seek care & contact ISOS call center as soon as possible
  - Urgent care – Contact ISOS call center prior to receiving care
  - Routine care – Not covered
  - Copy of military ID and orders or leave form required – Fax to ISOS
  - If proper procedures followed, payment is guaranteed by ISOS - Cashless and claimless
  - If SOS is not utilized/contacted, be prepared to pay provider at time of service then submit claim for reimbursement with TRICARE region where enrolled
  - SOS will facilitate movement to another area if care not available or not recommended in-country
  - If an escort accompanies the patient from a ship/deployed unit – the command is responsible for travel orders for

- patient & escort
- SOS will assist in repatriation of patient to permanent duty station or other designated location

### **ISOS WORLDWIDE NETWORK**

**Medical Alarm Centre  
International SOS**

**331 North Bridge Road #17-00 Odeon Towers  
Singapore 188720**

**Website: [www.internationalsos.com](http://www.internationalsos.com)**

#### **Singapore 24-Hr Alarm Center**

**Tel: (65) 6338 7800**

**Collect: 61-2-9273-2760**

**Fax : (65) 6338 7611**

**[sin.tricare@internationalsos.com](mailto:sin.tricare@internationalsos.com)**

**[sin.medical@internationalsos.com](mailto:sin.medical@internationalsos.com)**

#### **London 24-Hr Alarm Center**

**Voice: (44) 20-8762-8008**

**Patient can call collect**

**Fax: (44) 20-8748-7744**

**[tricareLon@internationalsos.com](mailto:tricareLon@internationalsos.com)**

#### **Sydney**

**Tel: 61 2 9372 2468**

**Fax: 61 2 9372 2455**

**E-mail for**

**[Sin.tricare@internationalsos.com](mailto:Sin.tricare@internationalsos.com)**

**[sydricare@internationalsos.com](mailto:sydricare@internationalsos.com)**

#### **Philadelphia 24-Hr Alarm Center**

**Tel: (215) 942-8226**

**Toll Free: 1-800-834-5514**

**Fax: (215) 354-2338**

**[phlopsmed@internationalsos.com](mailto:phlopsmed@internationalsos.com)**

#### References

- "Tricare Guidance for Active Duty Personnel in Remote Locations"*  
(OCONUS)

## **Taxonomy Continuum Of Health Care Capabilities (Former Echelons/Levels of Care)**

The Health Service Support (HSS) mission in joint operation is to minimize the effects of wounds, injuries, and disease on a unit's effectiveness, readiness, and morale. This is accomplished by a proactive preventive medicine program and a phased health care system (levels of care) that extends from actions taken at the point of wounding/ injury, or illness to evacuation from a theater for

treatment at a hospital in the continental United States (CONUS). The primary objective of HSS is to conserve the commander's fighting strength.

Five Capabilities along the taxonomy continuum, which are often used interchangeably with Level/Echelon, of Care make up the HSS system. However Doctrine has replaced Level/Echelon with Capabilities of Care.

### **LEVEL I: FIRST AID / EMERGENCY MEDICAL CARE** **FIRST RESPONDER CAPABILITY**

Care is rendered at the unit level and includes self/buddy aid, examination, and emergency lifesaving measures such as maintenance of airway, control of bleeding and further injury.

In the fleet, trained HMs staff medical departments on small ships and provide emergency care independent of a medical officer. On ships with medical officers, more advanced care is possible. In the FMF, HMs represents the portal of entry where sick, injured, or wounded Marines receive medical care. Corpsmen provide examination and evaluation followed by emergency or lifesaving measures. The medical officer treats at the BAS, providing initial resuscitation and routine health care.

### **LEVEL II: INITIAL RESUSCITATIVE CARE** **FWD RESUSCITATION CAPABILITY**

Care is administered by a team of physicians, supported by appropriate medical, technical, or nursing staff. As a minimum, this echelon of care includes basic resuscitation and stabilization and may include surgical capability, basic laboratory, limited x-ray, pharmacy, and temporary holding facilities. This care saves life and/or limb and stabilizes patients for evacuation to Level III. Blood and blood products are available at Level II.

In the fleet, general surgeons and anesthesia providers man the facilities. Other specialties may be present. Ancillary support, particularly lab and radiology, is limited. This level of care is available on CVN and LHD/LHA - CRTS ships. In the FMF, the Med Battalion consisting of three Surgical Companies (Level II) and 6-8 Shock Trauma Platoons STPs (Level I+), provide this care.

### **LEVEL III: RESUSCITATIVE CARE** **THEATER HOSPITALIZATION CAPABILITY**

Care delivered requires clinical capabilities normally found in a MTF that is located in a lower-level enemy threat environment. The MTF is staffed and equipped to provide resuscitation, initial wound surgery, and post operative treatment. This level of care may be the first step toward restoration of functional health, as compared to procedures that stabilize a condition.

The HSS team is augmented with general surgeons, orthopedists, and other surgical specialists. In the fleet, examples are the T-AH, fleet hospitals and Expeditionary Medical Facility (EMF).

**LEVEL IV: DEFINITIVE CARE**  
**DEFINITIVE CARE OCONUS CAPABILITY**

This Level of care will provide surgical capability as provided in Level III, but also further definitive therapy for patients in the recovery phase who can return to duty within the theater evacuation policy. Definitive care is normally provided by a Fleet Hospital, General Hospital, or OCUNS MTF.

**LEVEL V: CONVALESCENT, RESTORATIVE, AND REHABILITATIVE CARE**  
**DEFINITIVE CARE CONUS CAPABILITY**

Care is convalescent, restorative, and rehabilitative and is normally provided by military, Department of Veterans Affairs, or civilian hospitals in CONUS.

**Evacuation**

Patient evacuation in the combat zone or from Echelons I, to Echelon II, from Echelon II to Echelon III, and within Echelon III is normally the responsibility of the component command and is coordinated by a Theater Patient Movement Requirements Center (TPMRC). Strategic/Intertheater aeromedical evacuation from the AOR is normally the responsibility of the Air Force Component. Patient evacuation from the theater is the responsibility of U.S. TRANSCOM.

The concept of care at each echelon of the HSS system is constricted by the following four interacting factors:

1. Urgency of the patient's needs.
2. Requirements for mobility of medical personnel and facilities.
3. Capabilities, equipment, and supplies of HSS personnel.
4. The workload at each echelon of care, relative to its treatment capacity.

Casualties are evacuated through the HSS system until they reach a facility capable of beginning decisive intervention, with sufficient time to perform necessary procedures and the bed capacity to retain the patient. This MTF or Level of care is defined as the site of principal treatment.

References

- a. *Joint Pub 4-02, OCT 06, "Doctrine for Health Service Support in Joint Operations"*

## MASS CASUALTY

### **DEFINITION:**

Any large number of casualties produced in a relatively short period of time, usually as the result of a single incident such as a military aircraft accident, hurricane, flood, earthquake or armed attack that exceeds local logistical support capabilities (DOD). In laymen's terms you and your team are overwhelmed by this volume of patients.

During a **mass casualty situation** the goal is the disposition/triage of as many patients as possible to other MTFs either within or outside of the area of operations.

A **patient overload situation** exists when the capability of any echelon of care is overwhelmed beyond the point where it can no longer receive additional casualties. Patient overload situations require prompt and aggressive action so that normal treatment capability of the affected facility can be restored.

Factors which may lead to a patient overload situation include a surgical backlog, high census, manpower shortages directly due to casualties or indirectly due to the staff being fatigued, depletion of stores and lack of available equipment and/or blood or component products.

The components of Triage are applicable and are constantly being applied to the extent that patients may be re-triaged several times during the disaster. This should be a part of each underway as the drilling for a Mass Casualty in a variety of different circumstances and conditions will enable the crew to perform, if needed, to their utmost. As the Marines have taught us, "We fight the way we train".

The CATF/ESG Surgeon and the SMO should coordinate and insert these exercises into the course of the underway, as to incorporate different warfare conditions (Condition IV, Condition III, Condition I). This will help in preventing the drills from degrading into a table top or paper drill. Other factors to be considered are the movement of the triage area from Casualty Receiving area to one of the alternative Battle Dressing Stations. Along with the changing of the scenarios, which are limitless, complete debriefs/"hot washes" must be incorporated into the plan. One consideration would be to in the midst of a drill, mobilize the "walking blood bank", this is a resource we all talk about and weave into our plans, but seldom if ever have the opportunity to use.

Another consideration that the Fleet faces today is the potential for a CBR attack. The primary advisor to the commanding officer for CBR decontamination actions is the Damage Control Assistant (DCA). The damage control organization includes the personnel assigned to damage control repair stations, standoff detector operators, countermeasure washdown system operators, ventilation control personnel, on-station monitors, survey teams, decontamination teams, and personnel decontamination station operators coordinated through the Damage Control Center (DCC). Medical personnel are integrated into the shipboard chemical, biological, and radiological defense (CBRD) organization. Shipboard personnel may be required to conduct CBRD actions with a variety of routinely embarked units, including USN staffs, USN aviation squadrons and detachments, USMC units, USN special warfare units, EOD personnel, elements of Naval beach groups (NBGs) assault craft units, USCG law enforcement detachments, and USA units.

Countermeasure Washdown System (CMWDS) will vary from specific platforms and it is the responsibility of the SMO and CATF/ESG Surgeon to be familiar with these (See the commander's repair party manual (Commander Naval Surface Forces Instruction [COMNAVSURFORINST] 3541.1) for a particular ship class. For decontamination with detergents, in the absence of an oxidizer, the contaminants are not chemically neutralized and remain toxic. The possibility exists that the agent-contaminated water may drain or flow in such a way that contamination remains on the ship. Decontamination operations should be planned and

conducted so that most of the runoff flows into the sea and that areas of heavy traffic and sensitive areas are not re-contaminated. Care should be taken to minimize spraying or splashing of the contaminated liquid.

References

- a. "Army, Marine Corps, Navy, Air Force Multiservice Tactics, Techniques, and Procedures" April 2006
- b. <https://atiam.train.army.mil/soldierPortal/atia/adlsc/view/public/22662-1/FM/3-11reference>

## **MEDICAL EVACUATION**

### **INTRODUCTION**

It is important to know that during wartime or peacetime operations patient movement guidelines are dictated by the AOR Commander (numbered fleet) via OPLAN/OPORDERS, Appendix Q. When in a remote overseas location, consider using ISOS for urgent, emergency treatment and MEDEVAC if not contrary to OPLAN/OPORDERS. See ISOS section of this guide. Patient movement within ESG/ATF will be coordinated via the CATF surgeon and accepting ship's SMO. Use the checklist below as guide when patient movement is necessary.

### **AIR FORCE MEDEVAC SYSTEM**

The Air Force Aeromedical Evacuation System is infrequently used for routine deployment patient movement, but knowledge of how and when to access this system may be beneficial. A POC for initiating a patient movement request (PMR) is available. GPMRC Call 1-800-874-8966; TPMRC-USAFE or Call DSN 314-480-2235

### **Patient Movement Checklists**

TASK DESCRIPTION	VERIFIED
<b>Approval to MEDEVAC (SMO/SMDR)</b>	
<ul style="list-style-type: none"> <li>● Recommendation/concurrence to MEDEVAC from Provider, ESG/ATF Surgeon, SMDR and accepting physician (afoat or ashore, civilian or military).</li> </ul>	
<ul style="list-style-type: none"> <li>● Permission to MEDEVAC from AOR Patient Movement Center</li> </ul>	

<ul style="list-style-type: none"> <li>Agreement to MEDEVAC from International SOS (if using ISOS network)</li> </ul>	
<ul style="list-style-type: none"> <li>Permission to MEDEVAC obtained from Patient's COC</li> </ul>	
<ul style="list-style-type: none"> <li>Recommendation to EVAC obtained from the Provider's COC</li> </ul>	
<b>Administrative Issues. Administrative Officer(AO) and Patient's COC</b>	
<ul style="list-style-type: none"> <li>Funded orders for a period of 30 days for patient and attendant/escort (consider cash advancement) (AO)</li> </ul>	
<ul style="list-style-type: none"> <li>Proper attire (civilian and military) (COC)</li> </ul>	
<ul style="list-style-type: none"> <li>Personal Items (shaving gear, dental paste, toothbrush, etc.,) (COC)</li> </ul>	
<b>TASK DESCRIPTION</b>	<b>VERIFIED</b>
<ul style="list-style-type: none"> <li>Patient Identification (military ID card and/or passport if available)</li> </ul>	
<ul style="list-style-type: none"> <li>Patient luggage. (max 2 pieces: seabag less than 70 lbs and a carry-on)</li> </ul>	
<b>Air/Operations, Supply and Communications Officers (AIR/OPS/SUPPO/COMMO)</b>	
<ul style="list-style-type: none"> <li>Send Naval message (drafted by the Medical Provider) to MEDEVAC and or ask for assistance and or notify numbered fleet and nearest MTF (COMMO)</li> </ul>	
<ul style="list-style-type: none"> <li>Provide email / chat capabilities to provider (NIPERNET/SIPERNET) if Naval message is not indicated (COMMO)</li> </ul>	
<ul style="list-style-type: none"> <li>Provide telephone capabilities as necessary (COMMO)</li> </ul>	
<ul style="list-style-type: none"> <li>Set-up air, and or ship-to-ship, and or boat evacuation (AIR/OPS)</li> </ul>	
<ul style="list-style-type: none"> <li>Set-up ground transportation if ship is inport (SUPPO), or medical for local ambulance</li> </ul>	
<b>Notification and Patient Tracking (SMDR/MRCO/XO)</b>	
<ul style="list-style-type: none"> <li>Notify numbered fleet surgeon (Naval message/Email/Tel) (SMDR/MRCO)</li> </ul>	

<ul style="list-style-type: none"> <li>Notify ISIC Medical (SMDR/MRCO)</li> </ul>	
<ul style="list-style-type: none"> <li>Notify nearest MTF (Naval message/Email/Tel) (SMDR/MRCO)</li> </ul>	
<ul style="list-style-type: none"> <li>Notify Fleet Liaison of receiving or closest MTF (Naval message/Email/Tel) (SMDR/MRCO)</li> </ul>	
<ul style="list-style-type: none"> <li>Notify U.S. Embassy Defense Attache Office (DAO). If patient remains hospitalized in the host nation(Naval message/Email/Tel) (SMDR/MRCO)</li> </ul>	
<ul style="list-style-type: none"> <li>Husbanding Agent Medical Rep of host nation, if inport. Medical Rep will assist in arranging care, reports and medical payment of services rendered. (SMDR/MRCO)</li> </ul>	
<ul style="list-style-type: none"> <li>Notify NOK, if indicated. (XO/CMC or Senior Marine Corps Rep) if possible allow patient to speak with NOK</li> </ul>	
<ul style="list-style-type: none"> <li>SMO/accepting physician/Hospital/Clinic (SMDR/MRCO)</li> </ul>	
<b>TASK DESCRIPTION</b>	<b>VERIFIED</b>
<b>TASK DESCRIPTION</b>	<b>VERIFIED</b>
<ul style="list-style-type: none"> <li>Patient Tracking (SMDR/MRCO)</li> </ul>	
<ul style="list-style-type: none"> <li>Send sitrep and safety message to appropriate agencies if indicated (SMDR/XO)</li> </ul>	
<b>Brief the Patient and / or Escort (SMDR/SMO)</b>	
<ul style="list-style-type: none"> <li>Where is the patient going? Specify installation/command</li> </ul>	
<ul style="list-style-type: none"> <li>To whom does the patient report? Specify person's name</li> </ul>	
<ul style="list-style-type: none"> <li>What are the patients restriction? Diet, ambulatory, litter, 24/7 watch (if Psych)</li> </ul>	
<ul style="list-style-type: none"> <li>Enough medication for travel period. Recommend 7-10 days</li> </ul>	
<ul style="list-style-type: none"> <li>Enough medical supplies available for travel period</li> </ul>	
<ul style="list-style-type: none"> <li>Latest documentation of current medical problems including Medical/Dental, labs, X-rays, physician orders, international certificate of vaccinations, etc. (give to patient or escort)</li> </ul>	

<ul style="list-style-type: none"> <li>List of POCs. Ship, Hospital, Clinic, Physicain and Fleet Liaison names and numbers given to patient or escort</li> </ul>	
<ul style="list-style-type: none"> <li>Who do I call if everything goes wrong? Normally ISIC Medical POC (provide name and number if available)</li> </ul>	
<ul style="list-style-type: none"> <li>Provide a full itenerary with final and all known intermidiate destinations</li> </ul>	
<ul style="list-style-type: none"> <li>Write all of above info and include in records to be given to patient/escort</li> </ul>	
<b>Equipment (Medical Team)</b>	
<ul style="list-style-type: none"> <li>Supplies needed for the patient (dressings, bandages, etc.)</li> </ul>	
<ul style="list-style-type: none"> <li>Verify all equipment is fully operational, if required</li> </ul>	
<ul style="list-style-type: none"> <li>Label all equipment with the Ship's name and address. Easier to claim at completion of MEDEVAC</li> </ul>	

### MEDEVAC LIST (VITAL INFORMATION)

Date / Time Initiated:		
Rank:	Full Name:	
PT SSN:	PT Command / Unit:	
Date / Time Completed:		
PT Diagnosis (IDC-9):		
PT Classification:		
PT Status: (Circle One)		
Stable	Conscious	Unconscious
Ambulatory	Stretcher	
Medical Attendant	Non-Medical Attendant	Guard Required
Attending Medical Officer (Name):		
Contact gaining accepting MTF MO (Use Flag Plot POTS):		
Accepting Physician Information:		
Narrative Summary (Write legibly):		
Discharge orders, en route orders and prescriptions		
Prepare to talk with NOK; NOK information		
Nurse (Name):		
PT is ready to leave per NWP 4-02.2, Navy appendices		
PT records and baggage tags prepared		
Records Checklist:		

	Funded TAD orders		Service Record		Pay Advance		Medical Record
	Dental Record		Narrative Summary		Consult		Labs/X-rays
	In-patient Record Copy				Valuables		
	Fill prescriptions						
	Uniform, civilian clothes, ID, passport, and toiletries accompany PT						
	SMDR/MRCO (Name):						
	Notify chain-of-command and medical authority						
	Debrief; include blue and green side administrative and disbursing personnel						
	Arrange for orders through personnel						
	Make flight arrangements with HDC						
	Pick up checks or advances from Disbursing						
	Prepare MEDEVAC MSG within 24 hours of MEDEVAC						
	Enter information into database						
	Start PT tracking						

#### References

- a. *US Navy, NTPP 4.02.2 / USMC MRCP 4-11.1G (draft) dtd NOV 06 "Navy Tactics, Techniques and Procedures"*

## MEDICAL INTELLIGENCE

### INTRODUCTION

The **National Center for Medical Intelligence (NCMI)**, formerly the **Armed Forces Medical Intelligence Center (AFMIC)**, located at Fort Detrick in Frederick, Maryland, produces finished, all-source, medical intelligence in support of the Department of Defense (DOD) and its components, national policy officials, and other federal agencies. NCMI produces a wide variety of medical intelligence assessments based on customer requirements. Major product families include the following:

### Medical, Environmental, Disease Intelligence and Countermeasures (MEDIC)

The MEDIC CD-ROM provides worldwide infectious disease and environmental health risks hyperlinked to the Joint Service-approved countermeasure recommendations, military and civilian health care delivery capabilities, operational information, disease vector ecology information, and reference data.

### Infectious Disease Risk Assessment (IDRA)

IDRAs assess the risk from infectious diseases of operational military significance on a country-by-country basis worldwide. IDRAs are available via INTELINK (see INTELINK)

### **Environmental Health Risk Assessment (EHRA)**

EHRAs assess environmental health risks of operational military significance on a country-by-country basis worldwide. EHRAs are available via INTELINK and the MEDIC CD-ROM. The most current assessments are available on INTELINK.

### **Health Services Assessment (HSA)**

The HSA is designed to provide consumers the bottom-line assessment of the health services capability of a country, with limited descriptive data and examples relating only to critical elements of the civilian and military health care systems. These studies are produced on countries with a validated production requirement by an intelligence consumer or with a high potential for US force deployment.

### **Urban Medical Capabilities Study**

The urban study is designed to meet the needs of the U.S. Special Operations Command (USSOCOM) and is produced as a reference aid. It includes a map of the urban area, general health information, and locations, descriptions, and images of key medical treatment facilities.

### **Disease Occurrence Worldwide (DOWW)**

The DOWW provides time-sensitive updates to the IDRAs. It is published monthly as an unclassified message, with a classified supplement, if necessary.

### **Life Sciences and Technologies**

These studies assess foreign basic and applied biomedical and biotechnological developments of military medical importance, foreign civilian and military pharmaceutical industry capabilities, and foreign scientific and technological medical advances for defense against nuclear, biological and chemical warfare.

### **Requests for Information (RFI)**

The RFI is your way of asking NCMI for answers to questions which are not found in published studies. Generally, a RFI is a project requiring 40 or fewer hours for NCMI to complete. RFIs should be directed to AFMIC through the Community On-line Intelligence

System for End- Users and Managers (COLISEUM) or by contacting AFMIC Operations at its 24 hour contact number, DSN 343-7574 or Comm (301) 619-7574. Telephones are secure via STU-III through the TS-SCI level.

### **SUBMITTING REQUESTS FOR INFORMATION (RFI'S) TO NCMI**

Identify and clarify your medical intelligence needs. Write them down. Check with your intelligence officers (S-2's, G-2's, J-2's, N2's) first; they may already have what you need.

Provide sufficient lead time for NCMI to respond to your request. Tell NCMI the latest date and time it can provide the information. Provide feedback.

- Upon receipt, tell NCMI you received the response.
- Upon mission completion, report items of significance, submit after action reports, comment on medical intelligence and submit recommendations for improvement.

### **SYSTEMS FOR DISSEMINATION OF INTELLIGENCE / INFORMATION**

**INTELINK** has been described as the "classified on ramp to the information superhighway." The ultimate goal is to have INTELINK available at all battalion level and higher intelligence sections. All national level intelligence organizations, including AFMIC, have home pages on INTELINK. All AFMIC products are placed on INTELINK. In addition, each Unified Command Joint Intelligence Center has a home page. Within the Intelligence Community, INTELINK is rapidly becoming the preferred method of dissemination, with hardcopy publication a secondary method. Many recent intelligence publications are found on INTELINK. If preferred, INTELINK has a print capability.

<http://www.fas.org/irp/program/disseminate/intelink.htm>

### **INTERNET**

The INTERNET contains a variety of other unclassified sources. The Central Intelligence Agency has a home page where users may access the CIA World Factbook. The State Department home page contains State Department Country Fact Sheets, Embassy information, and travel advisories. Other commercial data bases are available (with more being added every day) that address areas of interest to medical planners, such as travel medicine.

## **TELECONFERENCING**

Joint Worldwide Intelligence Communication System (JWICS) is a secure telecommunications system which links sites throughout the intelligence and operations communities. It allows, among other things, secure teleconferencing. In support of time-sensitive or complex requirements, a teleconference can be set up with AFMIC's country analysts. See your intelligence officer to determine if there is a JWICS site on your installation, then, work with the site manager and AFMIC Operations to set up a conference.

## **PROCEDURES FOR OBTAINING THE NCMI WIRE AND DOWW**

To be added to distribution for any NCMI message product, please send your name, organization, mailing address, routing indicator, plain language address, DSN and Commercial telephone numbers and a brief justification to AFMIC, ATTN: MA-OP, 1607 Porter Street, Ft. Detrick, MD 21702-5004 or DIRAFMIC FT DETRICK MD//MA-OP//, DSN 343-3837 or Comm (301) 619-3837.

## **PROCEDURES FOR RECEIVING AFMIC HARDCOPY, CD-ROM, AND OTHER INTELLIGENCE PRODUCTS**

If your office is not receiving hardcopy intelligence products directly, check with your Intelligence Office (IN) or Security Office. Hardcopy publications produced by AFMIC and other producers are disseminated by the Defense Intelligence Agency (DIA) through the Joint Dissemination System (JDS) based on requirements registered by the organization in a Statement of Intelligence Interest (SII). In most organizations, the SII is maintained by the IN or the Security Office. Once the document is published, it is automatically mailed to that office and they should redistribute within the organization.

If your organization has an SII registered, your IN should modify the SII to reflect the addition of the appropriate Intelligence Function Codes (IFCs) and country codes to indicate your interest in medical intelligence.

To request a change in the distribution requirements for your organization or your organization does not have an SII registered with DIA, submit a request in writing or via electron message to DIA (ATTN: SVD-2) Washington DC, 20340-5100 (or to DIA WASHINGTON DC//SVD-2//) according to the following guidelines:

OSD/JCS and non-DOD national-level organizations:

Submit directly to SVD-2.  
Other DOD organizations:  
Submit all requests via your Dissemination  
Program Manager/administrative chain of  
command.

## **NCMI POINTS OF CONTACT**

<https://www.intelink.gov/ncmi/index.php>

For clarification of intelligence needs, guidance in reporting medical intelligence data, or "quick-response taskings," contact NCMI. The numbers are STU III compatible.

- Commercial: (301) 619-XXXX, DSN 343-
- Operations Division: 7574
- 24-Hour Service: 7574
- Quick Reaction Taskings: 7574
- Clinical and Medical Sciences Consultant: 7511
- Chief Scientist: 7511
- Production Office: 2181
- Global Health Division: 7581
- Medical Capabilities: 7154
- Epidemiology / Environmental Health: 7269
- Life Sciences Technologies Division: 7409
- Information Systems Division: 7214
- Automation: 2686
- Bulletin Board Systems Operator: 7214
- Messages: DIRAFMIC FT DETRICK MD
- Correspondence to: Armed Forces Medical Intelligence  
Center, Fort Detrick  
Frederick MD 21702-5004

## **Navy Environmental and Preventive Medicine Units Addresses**

NEPMU-2, Officer in Charge  
1887 Powhatan Street  
Norfolk, VA 23511-3394  
TEL : (757) 953-6600 DSN 377-6600  
Fax 953-7212/7213

Message: NAVENPVNTMEDU TWO NORFOLK VA  
NEPMU2Norfolk-FleetandFMFSupport@med.navy.mil  
<http://www.med.navy.mil/sites/nmcp/Partnerships/nepmu2/Pages/default.aspx>

NEPMU-5, Officer in Charge  
Naval Station Box 368143  
3235 Albacore Alley  
San Diego, CA 92136-5199  
TEL : (619) 556-7070 DSN 526-7070  
FAX : (619)556-7071 DSN 526-7071  
Message: NAVENPVNTMEDU FIVE SAN DIEGO CA  
nepmu5@med.navy.mil  
<http://www.med.navy.mil/sites/nmcsd/nepmu5/Pages/index.htm>

NEPMU-6, Officer in Charge  
1215 North Road  
Pearl Harbor, HI 96860-4477  
TEL : (808) 473-0555 DSN (315) 473-0555  
FAX: (808)473-2754 DSN (315) 473-2754  
Message: NAVENPVNTMEDU SIX PEARL HARBOR HI  
Nepmu6admin@med.navy.mil  
<http://www.med.navy.mil/sites/nmcsd/nepmu6/Pages/index.html>

## **Navy Medical Research Units**

U.S. Naval Medical Research Unit No.3 (NAMRU-3)  
PSC 452, Box 5000  
FPO AE 09835-9998  
NAVMEDRSCHU THREE CAIRO EG  
TEL: 011-2-02-342-1375  
Fax 011-2-02-2-342-1382  
<http://www.med.navy.mil/sites/namru3/NAMRU3%20Wiki/NMSC%20Commander%20Visits%20NAMRU-3.aspx>

US Naval Medical Research Unit No. 2 (NAMRU-2)  
The Global Emerging Infections Surveillance and Response System (GEIS) has been integrated into the Armed Forces Health Surveillance Center (AFHSC).  
Armed Forces Health Surveillance Center  
503 Robert Grant Avenue  
Silver Spring, MD 20910  
TEL: (301) 319-3240 (DSN: 285)  
Fax: (301) 319-7620 (DSN: 285)  
E-mail: AFHSC.Web@amedd.army.mil  
<http://afhsc.mil/home>

## **MEDICAL INTEL REPORT CHECKLIST**

(Send to AFMIC through your N2)

- Hospital: Name, location, distance from port / pier / helipads / airport / other hospitals / military bases.

- Geographic location: Lat/long – GPS
- Vital stats: No. of beds, ICU, CCU, Burn unit, ORs.
- Capability of labs. Blood bank. Emergency room capability.
- Key telephone / fax / email information
- Ambulance capability.
- Biography sketch / CV of Key personnel and POCs: Administrator, Medical director, key physicians and others. Need for translator.
- Need for nursing care or other support from the ship (i.e., nursing care not available at local hospital)
- # of doctors, nurses, ancillary staff.
- Level and location of training of medical and nursing staff.
- Availability of higher echelons of care.
- Lab, xray, imaging (ultrasound? CT?), pharmacy, blood bank information.
- Description of helipad: size, location, surrounding obstacles (and height), availability at night.
- How to pay local hospitals and medical personnel?
- POC at local embassy, consul, husbanding agency.
- Decedent affairs: local coroner requirement and customs, local requirement for autopsy. Get embassy involved ASAP.
- Name of the Husbanding Agent and degree of helpfulness.

#### References

- a. *Armed Forces Medical Intelligence Center (AFMIC) CD*

## **NAVAL OPERATIONAL MEDICAL LESSONS LEARNED CENTER**

The Naval Operational Medical Lessons Learned Center (NOMLLC) is a directorate under Naval Operational Medicine Institute (NOMI) which was established to collect, review, validate, and disseminate key observations, insights, and lessons of medical support to Navy and Marine Corps operations. The use of lessons learned is required for improvement of Navy medical readiness. While in an operational environment, lessons learned will serve as the principle source for the design of future naval medical education and training curricula, courseware, training events, and execution of medical operational support of the warfighter. In order to improve readiness, lessons learned from medical support of operational missions must be systematically captured, utilized in ongoing exercises, and integrated into concept development to generate new tactics, techniques, procedures, and doctrine.

NOMLLC provides both Unclassified (NIPR) and classified databases (SIPR) that form the basis for a "knowledge portal" which enables all authorized users to collaborate and share information. These portals are a knowledge management and information tool that provides Navy Medicine with a method to identify, capture, and share information collected from medical observations in support of operations, exercises, training events, and other activities for the purpose of improving HSS warfighter capabilities. Bottom line, this enhances collaboration between all Navy and Marine Corps medical support commands and organizations as well as support a collaborative, technology solution to facilitate the sharing and integration of joint observations, findings, and lessons learned across the joint lessons learned community of practice. The ideal goal is to share knowledge highlights in both positive and negative experiences, as well as provide direct support to issue resolution processes.

### **NOMLLC Points of Contact**

Questions regarding this system or guide should be directed to the NOMLLC Staff. A component of the Naval Operational Medicine Institute (NOMI), NOMLLC is located in Pensacola, FL and can be reached via phone at DSN: 922-7723; COM: (850) 452-7723 or

email at [mllstaff@.med.navy.mil](mailto:mllstaff@.med.navy.mil). On the website use 'EMAIL US' link.

**Website:** <https://www.mccll.usmc.mil/nomi/index.cfm> or simply go to Google and type in medical lessons learned!

#### References

- a. BUMEDINST 3500.3 series "Naval Operational Medical Lessons Learned System"

## NAVAL MESSAGES

Naval messages are an essential part of everyday communication with other commands, especially your administrative and operational Chain-of-Command (COC) or your Immediate Superior-in-Command (ISIC). Although communication nowadays is mainly accomplished by email (Non-secure Internet Protocol Router Network (NIPERNET), or Secret Internet Protocol Router Network (SIPERNET), most official tasks and official requests are conveyed via Naval Message System. Aboard ship, Naval Messages are released by the CO or in his/her absence, the XO or CDO may release messages. Every naval message that leaves the ship is from the CO and represents that particular command, thus accuracy and precision are paramount.

**See naval message below and follow line descriptions.**

**Line #1** - Type of message in this case "Administrative".

**Line #2** - This line shows the priority classification of the message. A message has a priority which determines how fast the message will be sent/released. Flash" – 15 minutes, "Immediate" – 30 minutes, "Priority" – 3 hours, and ""Routine" – 6 hours. Most messages drafted by the Medical Department are routine. Do not draft other than "Routine" messages unless directed to do so by CDO/XO/CO or higher authority.

**Line #3** - This is the date-time grouping. The first two numbers are the date; the next four correspond to Zulu time (Greenwich Mean Time) that the message was sent. The month and year are next. For example the below message was sent R 062313Z APR 04

means it was sent/released "Routine" priority on 6 April 2004 @ 2313 Zulu time.

**Line #4** - FM means "from"; the originator.

**Line #5** - TO the recipient of the message. Also called action addressee. If your ship's name is here then you are required to do something and/or send a response. In some cases an AIG (Addressee Indicator Group) is used. In this case PACADMIN is a whole chain of addressees.

**Line #6** – INFO those who receive a copy of your message. This is "For Your Info" (FYI) only. No action is required on their part.

**Line #7** - BT means "Begin Transmission". Read everything between the BTs.

**Line #8** – This message is UNCLAS (unclassified). This is the security classification of the message. Message folders with the correct designation of the Naval Messages are required at all times to carry correspondence. Also, the Standard Subject Identification Code (SSIC) number is required in this line to let the reader know what the broad category of the message is. In this case, this message addresses N06300 - General Medicine Records.

**Line #9** – MSGID means the Message Identifier. This message is General Administration, released by COMPACFLT (Commander, Pacific Fleet) drafted by N01M (Medical).

**Line #10** - Subject line; what the message is about.

**Line #11** – References used to write the message. In this case, General Administration message, from the CNO with the date-time-group of the message.

**Line #12** – AMPN/NARR amplification or narrative. This is where the reference(s) is (are) cited with a brief description of the main concept. If you have one reference use NARR. If you have more than one reference, use for amplification. Use one or the other not both.

**Line #13** - Point of contact of person drafting message. Also, Email, telephone number, etc.

**Line #14** - Body of message. Be brief, but concise. First paragraph should be the reason why the message was written. Last paragraph should be the POC and how to reach the writer of the message. Many messages begin with "IAW REF A." This translates, "in accordance with reference A." If you don't have reference "A"- get it. A reference may be a conversation, phone call, email, manual, etc. You'll look silly if it contains critical info and you act without all that you need.

**Line #15** – This is a very important. This represents the Admiral signing the message.

**Line #16** - BT means, "Break transmission." End of the message.

## SAMPLE MESSAGE

ATTENTION INVITED TO ADMINISTRATIVE MESSAGE	#1
ROUTINE .....	#2
R 062313Z APR 04 ZYB PSN 224249S23	#3
FM COMPACFLT PEARL HARBOR HI	#4
TO PACADMIN .....	#5
INFO CNO WASHINGTON DC//N931//	#6
BUMED WASHINGTON DC//M3F3/M3M//	
TRICARE SAN DIEGO CA//01//	
COMPACFLT PEARL HARBOR HI	
BT.....	#7
UNCLAS //N06300// .....	#8
PACADMIN 010/04	
MSGID/GENADMIN/COMPACFLT/N01M//	#9
SUBJ/PATIENT CARE IN REMOTE OVERSEAS LOCATIONS//	#10
REF/A/GENADMIN/CNO WASHINGTON DC/140100ZNOV03//	#11
NARR/REF A IDENTIFIES INTERNATIONAL GLOBAL POC'S FOR PATIENT CARE.//	#12
POC/CORY SANT/HMC(SW)/COMPACFLT/TEL: (808)474-8862/E-MAIL: CORY.SANT@ (SIGN)NAVY.MIL//	#13
RMKS/1. THE PURPOSE OF THIS MESSAGE IS TO PROVIDE INFORMATION REGARDING ISOS PROCE TO SWMI STUDENTS REGARDING PATIENT CARE IN REMOTE OVERSEAS LOCATIONS.	#14
2. RADM J. N. H. COSTAS, USNR, SENDS.//	#15
BT.....	#16
#0082	
NNNN	

## PORT VISITS MEDICAL PLANNING

An effective port visit requires detailed planning. Early staff work and frequent verification of the schedule with OPS and SUPPO of the ship and ARG/ESG will make the visit a success and more enjoyable for the crew as well as the Medical Team. The following information should be obtained and arrangements made prior to deployment and verified prior to port visits.

- Medical intelligence (threats) on the port and locale from AFMIC and NEPMU.
- Review applicable message traffic from prior visits, Medical Lessons Learned and Cruise Reports.
- Obtain OPORD (Classified document) for AOR from OPS Department.
- Internet search for local information. (NIPRNET & SIPRNET)
- Plan for rabies prophylaxis, malaria prophylaxis, snake bites (check with local facilities before). Double check your anti-malarials, RIG and HDCV.
- If you carry blood, a written plan for transfusion requirements. If you do not have blood, is local blood safe?
- Plan a Medical Brief for the ESG/ATF with honest assessment of the threat and risk of STD, infectious diseases, animal bites, and environmental risks, (heat, UV, local food). Mention the policy for getting medical care – Routine and Emergent. Get this on Site TV. Don't be shy!
- Coordination with ship's SUPPO:
  - ☑ Transportation/driver for MEDEVAC, medical visits and Medical supply runs . See MEDEVAC section of this guide.
  - ☑ Communication for key medical personnel (pagers, cell phones, etc.) - order early via SUPPO)
  - ☑ Meet early with Husbanding Agent. A local asset arranged through Defense Attaché Officer, DAO of US Embassy. A good relationship with this key person is essential.
  - ☑ Clarify with SUPPO and Husbanding Agent the local policy regarding the payment of Civilian Medical bills.

ISOS should be the default when a local policy is not contradictory and U.S. facilities are not available.

- Plan ESG/ATF medical support. ESG/ATF Surgeon writes and disseminates Medical SOP, and medical watch bill for Medical Guard Ship. The medical watch bill should include at least two experts, one a medical provider and the other should be an administrator. Plan for Emergency Recall of key personnel. List of key personnel with every possible contact phone number in event of significant medical event. Plan (in excruciating detail) for management of intoxicated patients – poor planning here will burn you!
- Arrange with Husbanding Agent for hospital visits by key medical personnel. This person should be the first off the brow and their liberty should not start until a report is submitted and details included in the Medical Watch Officer's Log. Each ship should report to the ESG/ATF duty Medical Officer prior to 12 O'clock report. Write SOP for hospitalized service members. Is 24-hr watch by an HM or a person from the individual's unit necessary?
- Coordinate plans for efficient MEDEVAC from foreign civilian medical facility. If ISOS is involved, they can arrange MEDEVAC to the U.S. Ensure funded TAD orders, uniforms, toiletries, pay advance, passport / VISA or military ID requirements, security of personal items, notification of next of kin (NOK), list of key telephone numbers (ship, ISIC, embassy, etc), chaperone or medical escort requirements.
- Write detailed notification (include criteria for notification) for MO of the Watch to include squadron SDO, CDO of patient's unit or ship, ESG/ATF Surgeon or representative. Be ready to discuss cases with NOK.

## **PRE-POST DEPLOYMENT CHECKLIST**

As the Senior Medical Department Representative (SMDR) you are charged with countless duties and responsibilities. The following list, although not all inclusive, it is designed to make you aware of some of the specific tasks that are required before during and after deployment. You may use this list to assist you in planning, coordinating and executing some of your duties.

## **OPLAN / OPORD**

- ☑ Draft/Review specific numbered fleet OPLAN / OPORD (CATF)
- ☑ Review POA&M in COMNAVSURFOR 6000.1 (CATF/MO/IDC)
- ☑ Review medical orders, Appendix Q (CATF/SMO/IDC)
- ☑ Review medical joining report, Appendix Q (CATF/SMO/IDC)
- ☑ Review medical officer watch bill (CATF/SMO/IDC)
- ☑ Medical guard ship policy established (CATF/SMO/IDC)

## **OPERATIONS**

- ☑ Review deployment operations (CATF/CLF/MO/SMDR)
- ☑ Non-combatant evacuation operations (NEO) (CATF/MO/SMDR)
- ☑ Humanitarian Assistance (HA) (CATF/MO/SMDR)
- ☑ Medical Civic Action Program (MEDCAP) (CATF/CLF/MO/SMDR)

## **CATF ASSETS**

- ☑ Identify all Deploying ships/units SMOs / IDCs (CATF)
- ☑ Identify the MEU medical staff assets (CATF)
- ☑ Set policy for integrating MEU medical assets into ESG/ATFs (CATF/SMO/CLF)
- ☑ Set Pre-deployment meeting with all SMO/IDC/CLF of deploying units (CATF)
- ☑ Meet with all unit's CO's if possible (CATF/CO)
- ☑ Personnel deficiencies identified / corrected (CATF/SMO/IDC)
- ☑ Establish PCRTS and SCRTS (CATF)

## **INSPECTIONS**

- ☑ Industrial hygiene and environmental health survey completed (SMO/IDC)
- ☑ TAV/MRE satisfactory completed (SMO/IDC/Ship's ISIC)
- ☑ Training Cycle satisfactory completed (SMO/IDC/Ship's ISIC)
- ☑ DERAT certificate current (SMO/IDC)
- ☑ Obtain another DERAT a week prior to deployment (SMO/IDC)
- ☑ Radiation health survey completed (SMO/IDC)

## **SUPPLIES / EQUIPMENT**

- ☑ AMAL and ADAL updated (SMO/IDC)
- ☑ AMAL and ADAL at 90 - 100 percent (SMO/IDC)

- ☑ Operating rooms and ICU and recovery rooms inspected by FST/HSAP members and deficiencies identified and corrected (CATF/SMO)
- ☑ All equipment deficiencies identified and corrected (CATF/SMO/IDC)

### **BIOMEDICAL EQUIPMENT TECHNICIAN SUPPORT**

- ☑ All medical equipment checked before deployment (BMET)
- ☑ Determined underway support (BMET)
- ☑ Method of obtaining emergency replacement gear (CASREP)

### **TRAINING**

- ☑ All medical FSOs current including Mass casualty (SMO/IDC)
- ☑ Conduct MedReg drill with all units (blue and green) (CATF)
- ☑ Exercise scenarios with all units (blue and green) (CATF)
- ☑ Plan, brief, debrief, scenarios with all units (SMO/IDC)
- ☑ Incorporate medical scenarios with line operations/training (SMO/IDC)
- ☑ Special training requirements identified (Cold Weather, Tropical Medicine, MedReg. (CATF/CLF/SMO/IDC)
- ☑ Helicopter Dunker for personnel that may be involved in AIREVAC (SMO)

### **CREDENTIALING**

- ☑ All personnel certified at the appropriate level (SMO/IDC)
  - BLS (All)
  - ACLS (MOs, NCs)
  - ATLS (MOs)
  - IDC Annual Certification from ISIC (IDC/ISIC)
  - SMDR current in (IDC) refresher training (IDC/ISIC)
- ☑ All embarked providers' credentials by appropriate TYCOM (CATF/SMO)
- ☑ Special privileges (vasectomy, etc) applied for and verified with TYCOM (CATF/SMO)
- ☑ Review elective surgery policy (CATF/SMO)

### **PROCESS ASSESSMENT AND IMPROVEMENT**

- ☑ Obtain provider latest PA&I report from unit's ISIC (CATF)
- ☑ Establish/review policy for PA&I (CATF/SMO/IDC)
- ☑ Establish PA&I review schedule (CATF/SMO/IDC)
- ☑ Conduct PA&I reviews (CATF/SMO/IDC)

## **PREVENTIVE MEDICINE / FORCE PROTECTION**

- ☑ Set-up EMPU Pre-deployment brief for all units (CATF)
- ☑ Review: (CATF/SMO/IDC)
  - Quarantine regulations
  - Medical intelligence (AFMIC)
  - Post-deployment critiques
  - Medical Lessons Learned
- ☑ Review medical policy / requirements for: (CATF/SMO/IDC)
  - Antivenin
  - Rabies
  - JEV
  - Anti-malarial prophylaxis/treatment
- ☑ Ensure all personnel are immunized (especially personnel going ashore) (CATF/SMO/IDC)
- ☑ Ensure OPLAN / OPORD requirements are met: (CATF/SMO/IDC)
  - Anthrax
  - Small Pox
  - CBR required AMAL / Medication available

## **BLOOD BANKING**

- ☑ Determine ESG/ATF capabilities (CATF/SMO)
- ☑ Blood program officer assigned (CATF/SMO)
- ☑ Whole blood program requirements verified (CATF/SMO)
- ☑ Blood volume expansion products policy determined (CATF/SMO)
- ☑ Walking blood bank policy established (CATF/SMO/IDC)

## **MRCO / ALTERNATE MRCO**

- ☑ MRCO appointed and security clearance verified (CATF)
- ☑ Medical regulating channels and procedures confirmed (CATF)
- ☑ Review NTTP 4-02.2 for patient evacuation (MEDEVAC) procedures (CATF/SMO/IDC)
- ☑ Casualty evacuation points determined (CATF/SMO/IDC)
- ☑ Port directory (ensure medical support contacts are valid) (CATF/SMO/IDC)
- ☑ Review host nation medical support (if any) (CATF/SMO/IDC)
- ☑ Set evacuation methods and policies for emergent, routine, and lateral transfers within ESG/ ESF / ATF (CATF)
- ☑ International SOS (ISOS) POCs and procedures in place (CATF/SMO/IDC)

## **SPECIAL MEDICAL CIRCUMSTANCES**

- ☑ Policy for pregnant personnel (CATF/SMO/IDC)
- ☑ Policy for sexual assault (CATF/SMO/IDC)
- ☑ Policy for alcohol intoxication (CATF/SMO/IDC)

## **TIGER / DEPENDENT CRUISE**

- ☑ Medical policy for Tigers approved by CATF, ISIC and TYCOM (CATF/SMO/IDC)
- ☑ Medical questionnaire completed by each Tiger. (SMO/IDC)
- ☑ Who will screen Tigers with potential / considerable risk (CATF/SMO/IDC)
- ☑ CATF and commanding officers notified of specific Tigers with potential medical risks. (CATF/SMO/IDC)

## **POST-DEPLOYMENT**

- ☑ Ensure all Post-deployment Health Assessments (PDHAs) are completed on every deployment (CATF/SMO/IDC)
- ☑ Provide feedback via MLL (CATF/SMO/IDC)
- ☑ Provide debrief to EPMU (CATF/SMO/IDC)
- ☑ Provide debrief to ISIC / TYCOM (CATF/SMO/IDC)
- ☑ PA&I report to provider's ISIC and TYCOM (CATF/SMO)

### References

- a. *COMNAVUSRFORINST 6000.1 dtd 20 AUG 03, "Shipboard Medical Procedures Manual"*

# **PREVENTIVE MEDICINE**

## **MISSION REQUIREMENTS**

- **First** - Maintain the readiness of United States and Coalition Forces
- **Second** - Humanitarian Assistance as directed by the JTF Commander
- **Best source** - NWP 4-02 (Operational Health Service Support)

## **JOINT PM OFFICER (JPMO)**

- A physician who is residency-trained in epidemiology. Best to be integrated EARLY into the JTF planning process (Security clearance, review OPLAN, coordinate with logistics, civil affairs, engineering, veterinarians, entomologists, and myriad

- of other players).
- Writing the OPOD, Annex Q (Prev Med Section).
  - Obtain and filter medical information (AFMIC, PAHO, Embassies, State Dept, tourists, recent visitors, etc.).
  - Advise on immunizations, malaria chemoprophylaxis, and personal vector protective measures, prepare educational efforts for pre-deployment, deployment, & post-deployment phases of operation.
  - Raise PM specific questions: Isolation of suspected tuberculosis cases on ship, vaccinations of refugees, waste treatment, etc.
  - Advantageous to have worked with the JTF Surgeon and other J staffers.

### **DEPLOYED FIELD RESPONSIBILITIES**

- Oversight over all aspects of PM including DNBI surveillance, camp placement, outbreak response, redeployment PM guidance, food service and campsite inspections, contract advice.
- Late arrival means playing "Catch-up;" missed opportunities to meet / plan with staff and executors.
- Need to be an advisor, perhaps a goader, especially to the "Willfully Clueless."

### **REASONS PM MAY NOT BE INVITED**

- Senior's lack of experience and consequent lack of knowledge.
- PM requires transport and support logistics.
- PM might be perceived as "research," not organic garrison staffing.
- Site Commander may think the PM issues can be dealt with "on the fly."
- PM is considered an "outsider," more on the Commander's operations.

### **BENEFICIAL EFFECTS OF PM IN MOOTW**

- Establish supports to minimize DNBI, maintain readiness.
- Assist in keeping migrants and refugees healthy.
- Avoid embarrassment on the world stage - Media & VIPs.
- Provide military counterparts who can see the merits & limitations of NGOs in disaster assistance & refugee care.

- Place experts on site before problem grows out of control.

### **FIELD EXAMPLES SINCE 1994 WHERE PM WAS CONSULTED**

- Malaria cases in US Marines in Guantanamo Bay
- Varicella in Caribbean
- MNF in Haiti
- Meningitis in refugees
- TB cases repatriated to Haiti needing follow-up
- Air crewman coming down with P. falciparum malaria after serving in Sierra Leone

### **PM RESOURCES**

- Navy Environmental and Preventive Medicine Units and Forward Deployable Preventive Medicine Unit (FDPMU). FDPMU is composed of highly trained personnel (PMO, Microbiologist, Entomologist, Industrial Hygiene Officer, Environmental Health Officer, and PMTs) to provide specialized preventive medicine support to forward deployed US Forces and JTF Commanders.
- Navy Disease Vector and Ecology Control Units
- Naval Medical Research and Development Detachments and Commands
- Marine Corps; PMT at Battalion / Environmental Health Officer at Wing, FSSG (Division level) EHO, Entomologist and 10 PMTs / MEF with PM Officer
- Army; Field Sanitation Team in Company with short course training, a Division has 2 PMTs, a Main Support Battalion with ESO, Senior NCO, PMTs, and, when augmenting with Professional Fill, a PMO
- Army Problem Definition Assessment Teams (staff, equipment, and supplies may vary with operation requirements)

### **ORGANIC PM SUPPLIES AND EQUIPMENT**

- Potable Water - Chlorine Level (Any PMT) / Fecal Coliforms tested at Division level
- Vector Control
- Sprayers – Backpack
- (Battalion) / Truck-mounted
- (Division) / C-130 Aircraft (not organic)
- Heat Stress WBGT - (Battalion) & Flag System (Navy/USMC)

Army use categories

### **TEAM PERSONNEL COMPONENTS**

- PMO / Infectious Disease Specialist to work with MTF / Entomologist(s) / Sanitarian (EHOs/ESOs) / Veterinarians (Army)

### **MOST COMMON COMMUNICABLE DISEASE THREATS**

- Tuberculosis, upper respiratory infection, dermatology
- Malaria, Dengue, Leishmaniasis (vector-borne)
- Diarrheal diseases (mild viral to life-threatening)
- Meningococcal meningitis

### **SURVEILLANCE**

- DNBI Weekly Reports from local shore units or fleet assets in the AOR
  - To the JTF Surgeon if in CENTCOM
  - To the cognizant EPMU when in their AOR
- Standardized, consistent SYSTEM from the start of the operation.
- Regular, all-encompassing data collection, analysis, and feedback to the JTF Commander, Surgeon, and the medical chain of command.
- Determine where action(s) must be taken (e.g., outbreak investigations).

### **PM LABORATORY CAPABILITIES (FORWARD DEPLOYED LAB, FDPMU, TAML)**

- Deploying with a laboratory is a public health and readiness standard of care.
- Lab technician +/- Microbiologist and Virologist.
- Requirements: Malaria detection & speciation, microbial culture & sensitivity (resistance), TB smears, identification of parasites, sexually transmitted diseases, +/- Chem Bio.

### **SURVEILLANCE ESSENTIALS**

- Encompassing every MTF (Special Forces, "Aid Bag" medical care, hand-carried meds may slip through).
- Centralized database tallies from Sunday through Saturday using syndromic categories ONLY.

- What will you actually DO with the data?
- Rapid Notifications (Dog bites, Varicella, Measles).
- Report and debrief rates, calibrate goals, forward data to Surgeon, JTF staff, COMPAC/LANTFLT, AFMIC, NEPMU, NEHC, CHPPM.
- Tool to show compliance with prevention efforts (e.g. food service sanitation, latrine maintenance maps).

### **GLOBAL SURVEILLANCE INITIATIVE**

- Bosnia deployment includes more comprehensive screening of personnel (most routinely done for deployable Navy and Marine Corps), serology sampling, established pre-deployment and post-deployment evaluations, and extensive environmental sampling.

### **HUMANITARIAN ASSISTANCE**

- Not what the US military does every day. It is what NGOs do for a living.
- Personal risks for NGOs perceived as being "close" to the military.
- "Suprajoint" coalition with JTF, GOs, NGOs, all under the potential, continuous scrutiny of the world's media.
- Military most valued by NGOs for security, logistics, and communications capabilities, vice clinical care resources.
- No military "specialty" in humanitarian assistance, civil affairs; therefore, staff are mostly reservists.

### **MIGRANT AND REFUGEE HEALTH ISSUES**

- Single most important immunization is measles, and the vaccine requires a well-monitored cold chain.
- Keeping refugees healthy helps protect the JTF.
- Think: "Keep INPUTS away from the OUTPUTS."
- Potable water / waste disposal / vector control / immunizations and prophylaxis / simple shelter / medical waste / outbreak control / primary care / health screening.
- How will you handle: the disabled and chronic disease patients, HIV, HIV screening, cancer cases, tobacco policy, EPWs, medical providers from the refugee population, medical standard(s) of care, and...?

## **RAPID DISASTER ASSESSMENT**

- Who has information on the population (pre-disaster)?
- Where are they from, composition by age/sex, religious practices, health indices, immunization coverage, etc.?
- "Presidential" overfly (Defense Mapping Agency maps).
- Divide disaster area into 30 grids.
- Select household in each grid and sample it and six adjacent households.
- Establish brief questionnaire for each head-of-household and conduct interviews with the assistance of community health workers.
- Pilot test questionnaire on several households to work out glitches.
- Establish measure of effectiveness.
- Provide feedback and monitoring.

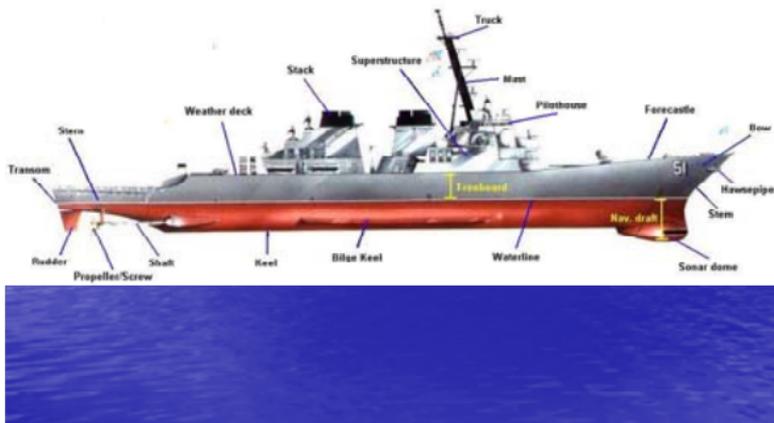
## **TURNOVER**

All information obtained, including lessons learned (JULLs, MCLLs), surveillance data, points of contact, strip maps, methods of conducting theater surveillance, etc., should be pass-down items for the incoming team. Gitmo I was followed by Gitmo II...give your colleagues a break.

### References

- a. *Armed Forces Medical Intelligence Center (AFMIC) CD*
- b. *Navmed P-5010, Manual of Preventive Medicine*
- c. *EPMUs and Navy and Marine Corps Public Health Center websites*

# Shipboard Familiarization



**ATHWARTSHIP:** a line across the ship from side to side

**AMIDSHIP(S):** half way between bow and stern

**BEAM:** width of the ship

**BELL:** A half hour period of a watch on board ship.

**BOW:** the forward part of a ship. To go in that direction is to go forward

**BILGE:** rounded portion that connects bottom with sides

**BULKHEAD:** the wall

**BULLSEYE:** photo-luminescent sign for each compartment

**BRIDGE:** the pilothouse

**CENTERLINE:** an imaginary line running full length down the middle of the ship.

**DECK:** the floor

**FANTAIL:** the after part of the main deck.

**FORECASTLE:** the forward part of the main deck, "Foc'sle"

**FREEBOARD:** the area between the waterline and gunwale

**GO BELOW:** to move from the main deck to a lower deck

**GUNWALE:** the upper edge of the side of a ship or boat

**HEAD:** the bathroom

**INBOARD:** toward the centerline

**LADDER:** the stairs

**LEVELS:** decks above the main deck

**MAIN DECK:** uppermost deck running the length of the ship from bow to stern

**OUTBOARD:** away from centerline

**OVERHEAD:** the ceiling

**PORT:** the left side, facing forward.

**QUARTERDECK:** a ceremonial place designated by the CO

**RACK:** a bed

**STARBOARD:** as you face forward on a ship, the right side

**STERN:** after part of a ship. To go that direction is to go aft

**SUPERSTRUCTURE:** all ship parts above the main deck

**SWAB:** a mop

**TOPSIDE:** going up from below decks to the main deck

**TRANSOM:** the transverse after-most part of any ship

**TRUNK:** the part of a cabin above the upper deck

Number of Bells	Hour (am or pm)		
1	12:30	04:30	08:30
2	01:00	05:00	09:00
3	01:30	05:30	09:30
4	02:00	06:00	10:00
5	02:30	06:30	10:30
6	03:00	07:00	11:00
7	03:30	07:30	11:30
8	04:00	08:00	12:00

## COMPARTMENT NUMBERING

### **Example: 3 - 127 - 2 - F**

Every space on the ship is numbered to indicate its position in three dimensions and its primary use. The hyphens are stated as “tack”. This location would be described as “three tack one-twenty-seven tack two tack foxtrot.”

### **Deck Number: 3**

The first part of the compartment designation is the deck number. When a compartment extends to the bottom of the ship, the number assigned to the bottom compartment is used thus the entrance to an engineering space in the 7 deck may be located in the second or main deck. When the deck is above the main deck the prefix letter “O” is used; e.g., O3 level. This is three levels above the main deck.

### **Frame Number: 127**

The second part is the frame number, working from bow to stern. A frame is a “rib” of a ship, standing athwartships. The frame number indicates how far back in the ship the compartment is from the bow. Frame 127 is 127 ribs aft of the bow. Additionally, Frame 127 is the forward-most frame but the compartment may extend many frames aft.

### **Relation to the Centerline: 2**

The third part shows the relation to the centerline. Compartments on the centerline carry the number 0; those to **starboard** have **odd** numbers, and those to **port** have **even** numbers. The first compartment outboard of the centerline to starboard is 1, the second 3, and so on. (2, 4, etc., are used for the port side).

### **Type of Compartment: F**

The last part is the letter for the compartment’s primary use. In this example, “F” indicates a fuel or oil storage space. H is medical.

Compartment Type Codes examples:

A	Storage Space	L	Living Space
AA	Cargo Holds	M	Ammunition
C	Control	Q	Miscellaneous (galley, wiring trunks)
E	Engineering	T	Trunks and Passages
F	Oil Stowage	V	Voids
J	Jet Fuel	W	Water
K	Chemicals and Dangerous Materials		

## **SHIPBOARD PROTOCOLS**

### **Reporting aboard the Ship**

Walk up the Officer’s Brow, salute the National Ensign, then the Officer of the Deck, and state “Request permission to come aboard.” Show the OOD your Military ID and orders if first reporting aboard. The Ship’s OOD will then grant you permission to come aboard. Note: In port, the National Ensign is flown from the stern of the ship from 0800 until sunset. When the Ensign is not flying, salute the OOD and request permission to come aboard.

### **Departing the Ship**

Go to the Officer's Brow and salute the OOD, showing your ID Card, and state "I have permission to leave the ship" (for Officers). Enlisted personnel would request permission. Step onto the brow and salute the National Ensign at the stern (0800 to sunset).

### **Colors**

Colors are observed at 0800 and at sunset. Colors start with a single whistle. At the sound of a single whistle blow you will face the National Ensign and stand at attention. If you are not in uniform remove your cover and continue to stand at attention. If in uniform, salute as soon as the music starts playing. At the end of the music, drop your salute, but remain at attention until you hear two whistle blows (indicates carry-on). When in formation, only the person in charge of the formation salutes all others stand at attention. When other Navies are present our National Anthem will play first followed by other nation's anthem. Maintain your salute until all the anthems have ended.

### **Rendering Honors to Other Naval Vessel**

Honors are rendered when passing ships at sea or memorials (Arizona Memorial). If you are topside you are required to salute if not in formation or stand at attention if in formation. One whistle blow means attention to Starboard. Two blows means attention to Port. A pause will follow and then one whistle blow means hand salute. Maintain the salute until you hear two blows. There will be another pause. Remain at attention until you heard three blows in a row (carry-on).

### **Covered or not Covered**

When import, you are required to wear a cover if you are topside. When out to sea, you are not required to wear a cover, exception, when Special Sea and Anchor Detail is set (this is set when transiting from the pier to the open seas). Do not wear a cover during Flight Quarters or launching LCAC vehicles. Covers are worn during formation and awards ceremonies.

### **Bridge**

Ask permission from the OOD underway to enter the Bridge – "Request permission to enter the bridge"

## **Tobacco**

Smoking, chewing or dipping is never permitted in the Wardroom or the Medical Department. It is only allowed in designated areas assigned by the CO and when the smoking lamp is lit.

## **Wardroom Etiquette**

Each wardroom has its own dynamics, customs, and written and unwritten rules. It is important to become familiar with these rules to avoid confusion and embarrassment. Specifics:

- Don't loiter in the Wardroom in civilian clothes.
- When joining a group of officers for dinner, it is customary to request permission to join them by asking the senior person present (e.g. "Good evening/Sir/Ma'am, May I join you?").
- Visiting VIPs will be served either in the Flag Mess or in the Ship's Wardroom during the formal sitting. You may receive a formal invitation to dine at the formal sitting. It is customary to accept, unless you are on watch. Ensure that you respond to their invitation.
- The Ship's Commanding Officer normally dines within the CO's mess. You may receive a formal invitation to join the CO for dinner from time to time. Accept the invitation even if you have more important matters to attend.
- Don't hesitate to ask your Line shipmates if you're unsure how to act. They'll help you learn, since they take the protocol and tradition quite seriously. If only out of courtesy, so should we.

## **Mess Bills**

All officers must buy into the mess when reporting aboard. This is called your "Mess Share," but not all ships have this. The mess share is determined by the prorated cost of the mess inventory. The mess share changes monthly; however, it is often around \$100-\$150 per officer per month. When you report aboard, the Supply Officer will explain when mess bills are due, usually between the 10th and 15th of the month. Mess bills must be paid promptly. The FST Medical Administrative Officer should work with the Wardroom Officer to ensure that all mess bills are paid smartly. At the end of

the deployment, you must pay your final mess bill and will be rebated your current “mess share”. Remember that your mess share differs in port from at sea.

### **Chief Petty Officer’s (CPO) mess**

The CPO Mess is similar to the wardroom except that it is for the Senior Enlisted Leaders who hold the rank of Chief Petty Officers (E-7 and above). The mess serves as the Chief’s meeting room for all matters related to day-to-day operation of the ship to the Sailor of Year, Awards, & Disciplinary Review Boards, etc. Normally, access to the CPO mess is by invitation from the CPO president (Command Master Chief).

## **CONDITIONS OF READINESS**

### **Material Conditions**

Degree of access into an area and system by closing hatches/doors to limit damage. Once a condition is set you must ask permission from Damage Control Central to open a fitting. There are three types:

- **Condition X-ray (X):** Least protection. Set when no danger of attack or damage (well-protected harbor). All fittings marked with “X” are closed at all times and require permission from Damage Control Central to open.
- **Condition Yoke (Y):** Set and maintained at sea or inport after working hours. During Yoke, all fittings marked with “Y” or “X” are closed. “X” and “Y” fittings that must remain open after working hours must be logged open in the damage control closure log by the Duty Department Head.
- **Condition Zebra (Z):** Provides maximum protection. Set during wartime when going to sea. Automatically set during General Quarters. All fittings with “Z”, “Y”, and “X” are closed and those that are remain open must reported open to the Damage Control Central.

### **Special Classifications or Modified Conditions**

Conditions above that have been modified to carry-out certain tasks.

- **Circle X and Y:** Letter within black circle. May be opened without permission, but must be closed after use. May be opened when going to or from GQ station, to transfer ammunitions, and to operate vital ship systems (i.e., firemain).
- **Circle Z:** Letter within red circle. May be opened during GQ for comfort of the crew with CO permission. Guarded while open so they can be shut immediately.
- **William (W):** Sea suction valves which serve vital systems cooling water. Closed only to prevent further damage.
- **Circle W:** Letter within black circle. Ventilation fittings, which are normally open, are closed when NBC attack is imminent.
- **Dog Z:** Letter within black 'D'. Closed during darken ship as well as General Quarters.

### **Watch Conditions**

There are various conditions of readiness regarding the ship's fighting capabilities.

- **Condition I - General Quarters:** Maximum state of readiness. Battle stations fully manned. Weapons systems at 100%. Damage control Parties and Battle Dressing Stations are fully manned. Ship can steam in this condition for a short period of time (4-6 hours).
- **Condition II –Special:** Watch for gunfire support, boat, or amphibious operations.
- **Condition III - Wartime Steaming:** Watch stations limited to 3 watch sections. Weapons systems at 1/3 readiness. Damage control parties not manned. Full steaming and fighting capability.
- **Condition IV - Normal Peacetime Steaming:** Only essential watch stations manned. Weapons systems in standby. Gun mounts unloaded/unmanned. Damage Control Parties not manned.

- **Condition V- Peacetime Watch Inport:** – Enough personnel onboard to cover emergencies and get underway.

## **SPECIAL EVOLUTIONS AND EMERGENCY CONDITIONS** **Assumed to be real unless “this is a drill” is announced**

**General Quarters (GQ):** Ship is in imminent danger. Material condition Z set. Repair Parties, Battle Dressing Stations (BDS) and watch stations manned and ready.

**Man Overboard:** A person is missing or evidence of someone falling over the side. All personnel muster with their respective divisions. After mustering, assigned personnel will go their stations and assist with recovery. At least one hospital corpsman is assigned to this station. The rest of the medical department prepares to render treatment to casualty.

**Underway Replenishment:** At sea transfer of fuel stores or personnel. Key personnel are assigned replenishment at sea stations. A hospital corpsman is required at each replenishment station to be used. The rest of the medical department carries out the daily routine.

**Flight Quarters:** An evolution to land helicopters on helicopter-capable ships. A hospital corpsman is required with the flight deck party and at the boat launching station.

**Abandon Ship:** Each crew member has an assigned abandon ship station. When abandon ship order is given, all members muster at their abandon ship station. Do not muster with your division.

**Fire/Flooding at Sea:** The “Flying Squad” is a group of highly trained personnel in all aspects of damage control. Their job is to be the first responders, 24/7, to fire/flooding emergencies. When fire or flooding are too big to handle, the Damage Control Assistant (DCA) will request permission from the CO to go to GQ. At least one hospital corpsman is a member of this party.

**Fire/Flooding Inport:** Inport, the duty section responds to any fire/flooding condition. Outside assistance can be obtained from other ships or the local authorities (911).

**Security Alert:** A situation where someone is trying to gain access or has accessed the ship or a specific location without proper authorization. All hands will stand fast (stay at your current location) except for those members of the Security Alert Force and the Back-up Alert Force.

**Man Down:** This is a condition that involves members of the medical department and stretcher bearers. Each member of the team has a specific assignment and responsibility.

**Mass Casualty:** This is a ship-wide evolution but the main players are members of the medical department. This would be a situation where the medical department assets are overwhelmed and assistance is needed from the crew. Key team members are:

- **The Senior Medical Department Member:** The SMDR mans the most capable BDS or sickbay. This member is in charge of the mass casualty. Briefs the CO on the status of mass casualty.
- **Other Medical personnel:** Man BDS, sickbay and assist with medical treatment as assigned. Watch Quarter and Station Bill.
- **Stretcher Bearers:** Transport personnel and assist as necessary. (Some medical training)
- **Triage Officer:** Normally, the dental officer is in charge of the triage area.
- **DCA:** Responsible for setting-up communications between the mass casualty location, BDS' and or Main Sickbay.
- **Master at Arms (MAA):** The master at arms force will assist the medical with crowd control and clearing passageways to get personnel to the BDS', sickbay or a designated location for evacuation.

#### References

- The Bluejackets Manual, 22<sup>nd</sup> Edition*
- Watch Officer's Guide, 13<sup>th</sup> Edition*
- The Naval Officer's Guide, 11<sup>th</sup> Edition*
- Naval Ceremonies, Customs, and Traditions, 5<sup>th</sup> Edition*

## SPECIAL CIRCUMSTANCES

### PREGNANCY

The overriding concern of the navy's pregnancy policy is safeguarding the health of the pregnant servicewoman and that of her unborn child while maintaining optimum job performance. Commanding officers, supervisors, health care providers must work together to achieve this goal. Pregnancy must be reported to the service member's CO, while ensuring privacy. In addition to providing appropriate medical care, the medical department must assist the COC with the following:

- Provide written notification. Upon confirmation of pregnancy, by a positive pregnancy test in your medical department or by the MTF, the provider must provide written notification of the servicewoman's condition to the commanding officer ASAP but no later than 2 weeks from confirmation.
- Assist the administrative department with command reporting requirements regarding the pregnant service member. **The service member must not remain aboard past the 20<sup>th</sup> week of pregnancy. The service member shall not remain onboard ship if definitive care for obstetric emergencies is not available within 6 hours.**
- Provide timely guidance on work restriction to supervisors and the COC. Refer the servicewoman to occupational health if exposure to chemical, toxic agents or environmental hazards is a concern.
- Recommend light duty as appropriate. Pregnancy does not remove a servicewoman from watch-standing responsibilities, but all hours shall count as part of the 40 hour per week limitation.

#### References

- a. *OPNAVINST 6000.1b. Guidelines Concerning Service Pregnant Women*

### ABORTION

The Navy does not perform or pay for abortion unless the woman's life is at risk. If a service member chooses to have an abortion, civilian facilities may be used at the service member's expense. She is encouraged to follow up with a Navy HCP following the procedure for after-care, medications and duty restrictions.

#### References

- a. *Title 10, U.S. Code, Section 1093*
- b. *SECNAVINST 6300.4, Abortion Policy*
- c. *BUMEDINST 6300.16, Abortion Policy*

### **MENTAL HEALTH/SUICIDE**

Service members determined to be imminently or potentially dangerous pose a heightened risk to themselves and to others. Commanding officers and medical providers must recognize this risk and take appropriate action to ensure the safety of the service members and others. However, service members should not be subjected to unwarranted mental health evaluations or involuntary hospitalization. The reason for referral or hospitalization must be based upon objective standards. See references for legal procedures for referrals when a service member opts not to participate in the referral / evaluation process.

#### References

- a. *SECNAVINST 6320.24A, Mental Health Evaluations of Members of the Armed Forces.*
- b. *MILPERSMAN.*
- c. *OPNAVINST 1720.4A Suicide Prevention Program*

### **SEXUAL ASSAULT**

When in port stateside, all active duty victims and alleged perpetrators will be examined and treated IAW federal or military treatment facility policies, regardless of the place of occurrence of the alleged incident. When underway, deployed, pierside at a foreign port or otherwise impractical, the examination will be conducted by the most experienced health care provider available, which may include a civilian health care facility.

Whether rape has occurred is a legal, not a medical determination. The role of the health care provider is to examine, meet the needs of the victim and to observe, describe, collect and record findings.

The observation of signs of penetration or force, the record of the patient's account of the incident, evaluation of the patient's mental status, and collection/safeguarding of laboratory results are critical elements of the legal portion of case management. Early involvement of Security, Legal, NCIS and Sexual Assault Victim Intervention (SAVI) is required. Mental assessment may be necessary to determine whether victim was mentally impaired (and therefore unable to give informed consent) by drugs, alcohol, etc. during sexual intercourse. The use of the Authorized Minimal Medical Allowance List (AMAL) Navy Sexual Assault Determination Kit is required for protection of the evidence collected in all medical examinations of sexual assault cases. In the absence of a search authorization or warrant, written permission from the patient or guardian is required to examine the patient.

**The new role of medical, as per reference b, provides an option for victims of sexual assault to report assaults to specified individuals without triggering an investigation of the incident (Restricted Reporting). This option affords a victim access to medical care, counseling, and victim advocacy without initiating an investigation.**

#### *References*

- a. BUMED message, R 010043Z NOV 05. *New Role of Medical Department Personnel in Restricted Reporting for Alleged Sexual Assault Victims.*
- b. COMNAVSURFORINST 6300.1a, *Medical Investigation of Alleged Sexual Assault/Rape Cases.*

## **DRUG AND ALCOHOL**

Frequently, service members will be referred by their COC to the MTF for Competency for Duty examinations because of signs or suspicion of being under the influence of alcohol or drugs. The determination of incompetence is primarily a safety issue. If the results of such an examination are intended to be used at Non-Judicial Punishment or Court Martial proceeding, then this gives rise to a number of medico-legal issues:

- Does the member consent (if able)
- If not, the commanding officer or the command duty officer in his absence must sign the request
- Custody of body fluids collected
- The medical department may be called to testify about the patient's condition

See references for more details regarding medico-legal questions.

Whether, the examination is used for medico-legal purposes or not, the medical department must not lose sight that the safety of the patient is still the highest priority. This may require the member to be referred to a facility with more capabilities and/or to institute an admission or close observation to protect the member.

*References*

- a. *BUMEDINST 6120.20B, Competence for Duty Examinations, Evaluations of Sobriety, and Other Bodily Views and Intrusion Performed by Medical Personnel.*

### **FAMILY ADVOCACY-VIOLENCE AND ABUSE**

Spouse and child abuse have a negative effect on military readiness, effectiveness, and good order and discipline. All military personnel and units shall undertake a cooperative effort to reduce and eliminate child and spouse abuse at every command level. Medical department personnel must ensure the safety of the victim of family abuse/neglect is given the highest priority. This may include:

- Temporary admission of a victim to the MTF to prevent further abuse. In the absence of state law, the admission may be up to 48 hours for a minor without parental consent.
- Reporting all known or suspected incidents to the Family Advocacy Program (FAP) representative at the Fleet Family Support Center, Family Advocacy Department and appropriate civilian authorities to include Child Protective Services, NCIS, Police and victim and/or perpetrator's COC as appropriate.
- Ensure medical assessment, evaluation, and treatment is completed in child and spouse abuse incidents when injury occurs, to include photographing of injuries. Ensure this information is available for the FAP representative.

*References*

- a. *BUMEDINST 6320.70, Family Advocacy Program*
- b. *SECNAVINST 1752.3B, Family Advocacy Program*
- c. *OPNAVINST 1752.2A, Family Advocacy Program*
- d. *OPNAVINST 1754.1A, Family Service Center Program*

# **SURFACE WARFARE MEDICAL DEPARTMENT (SWMDO) QUALIFICATION**

## **INTRODUCTION**

Per OPNAVINST 1412.8C, the Surface Warfare Medical Department Officer (SWMDO) designator is an additional qualification which medical department officers assigned to ships can voluntarily attain by demonstrating a broad-based level of shipboard knowledge and experience. The program is not mandatory and must not interfere with the medical department officer's primary duties. The OPNAVINST 1412.8C describes the standard requirements for all officers seeking the SWMDO qualification.

## **ELIGIBILITY**

- Commissioned medical department officers assigned (PCS) or TAD to a commissioned US Navy or Military Sealift Command (MSC) surface ship or afloat staff (FST) for a minimum of 6 months cumulative duty (need not be consecutive).
- Ready Reserve Officers assigned to afloat units for a minimum of 96 drill periods within a 3-yr period with a minimum of 3 2-wk AT periods.

## **REQUIREMENTS**

Graduate from one of the following courses of instruction:

- Surface Warfare Medical Department Officer Indoctrination Course (SWMDOIC)
- Surface Warfare Medical Officer Indoctrination Course (SWMOIC)
- Commander Amphibious Task Force (CATF) Surgeon Course

Note: If an officer has been onboard for six months continuous duty, that officer is eligible to earn SWMDO qualification prior to completing one of the above medical courses, but is strongly encouraged to attend the next available course of instruction.

For the above courses, contact the Surface Warfare Medical Institute (SWMI) for further information and enrollment at: 619-532-6195.

- Complete Shipboard Fire Fighting School
- Complete Basic Damage Control (NAVEDTRA 43119-G) Watch stations 301-306
- Complete the Surface Warfare Officer Division Officer Course (SWOSDOC) At-Sea Curriculum including all Interactive Courseware (ICW), practical problems, and case studies.
  - \*\*Same SWMOSDOC that line officers complete except medical department officers are NOT required to qualify as OOD underway or attend the resident course.
  - To obtain the SWOSDOC 5 CD-set contact SWMI at the above phone number.
  
- Demonstrate a working knowledge of :
  - Shipboard organization and COC
  - Shipboard Training and deployment cycles
  - Naval correspondence, message traffic
  - Afloat medical Supply operations
  - Shipboard Preventive Medicine, Occupational Health, Safety, and Sanitation requirements and programs
  - Shipboard wellness and health promotion programs
  - MEDEVAC procedures
  - Mass casualty plan, GQ medical support/response
  - Medical aspects of CBRNE
  
- Demonstrate effective medical/clinical/leadership performance
- Satisfactorily demonstrate professional knowledge of all aspects of the systems, interrelations, capabilities, and mission of own ship as well as ships in one's battle group during an oral board
  - The multi-member board is chaired by the CO or designated senior SWO (O4 or above) and includes ship's senior SWMDO (SMO, SDO, CATF Surgeon, etc), and other surface warfare officers.

### **DESIGNATION**

Once all requirements are met, the CO presents the SWMDO insignia at an appropriate ceremony. You will need to ensure notification is forwarded to CHNAVPERS (PERS-44), with a copy to the TYCOM and ISIC. PERS-44 will then assign the AQD (additional qualification designator) of LA7.

## **DISCUSSION**

There are several reasons to try to earn the SWMDO pin. Not only does it make you better at your job, it also increases your credibility among other medical and non-medical shipboard officers. It gets you out of the medical department and helps you meet other officers on the ship. By earning your pin, you can feel like a real part of the crew and be a role model for the enlisted in your department who are earning their ESWS and EAWS designations. Finally, you can learn all the amazing capabilities of the ship and its crew. Make sure you see the different ship evolutions, especially flight ops, underway replenishments, anchoring. Go to all the spaces on the ship, including engineering spaces, the bridge, the CIC, etc.

## **TIPS**

Team up with other medical department (or supply department) officers who are also going for their pin. Quiz the enlisted on their ESWS study guides to help them and you learn more. Get to know the other officers on the ship (they may be on your board!) and have them explain what they do. It's much more fun to have informal conversations than try to sit through formal lectures. Visit the different spaces on the ship. Try to find out who will be sitting on your board and learn their background/specialties. They will likely ask you what they know best. Bringing refreshments to the oral board is suggested but not required. Some favorite questions: draw the steam cycle and explain, trace a drop of water from the ocean to the drinking water on the ship, damage control questions, defensive/offensive/medical capabilities of each ship in the CATF/ESG, color of the deck in aft steering. Have fun!!

### References

- a. *Opanavinst 1412.8C series, "Surface Warfare Medical Department Officer Designation"*

## TASK FORCE SURGEON DUTIES

The Joint Task Force (JTF), Amphibious Task (AT) and Landing Force (LF) Surgeons are charged with countless duties and responsibilities. As the TF Surgeon, you must be able to think both as a medical clinician as well as a line officer (blue, green, etc). You must be able to see beyond the day-to-day operations, that is, plan and train for the unforeseen and what ifs. You have to be able to communicate the concerns and issues of all the medical departments to the line in a manner that makes sense and produces the desired results. Although not all inclusive, the list below may be used to assist you in performing some of your duties and help you in the planning and execution of a successful deployment / tour.

### **JOINT TASK FORCE (JTF) SURGEON**

The responsibilities of the JTF surgeon are as follows:

- Advise the CJTF and staff on the health of JTF forces, the conservation of fighting strength, and the application of the Geneva Conventions and law-of-land warfare on HSS.
- Determine requirements, establish, and organize the JTF surgeon's office, and prepare to deploy the unit to conduct continuous 24-hour operations.
- Determine requirements to establish, at a minimum, an area joint blood program office (AJBPO) and a JPMRC. If a JPMRC is not established to provide management for regulating and patient evacuation, the JTF surgeon must establish direct liaison between the theater patient movement requirements center (TPMRC) or global patient movement requirements center (GPMRC) and the service patient movement components.
- Establish the JTF operational area HSS and patient evacuation plan and ensure efficient and effective interface of the theater and strategic AE systems through the JPMRC.
- Monitor medical regulating and patient movement activities of the JPMRC and ensure that procedures are established to provide patient in-transit visibility information to the J-1.
- Advise the CJTF of comparison results between the medical proposed course of action and available medical capabilities.
- Establish and maintain liaison with component surgeons.

- Set priorities for actions within the surgeon's staff and assign responsibilities to specific units and individuals.
- Provide limited patient status and clinical information on selected patients to commanders and authorized representatives, as requested, based on the level of capability for patient in-transit visibility.
- Establish HSS procedures for operations in a CBRN-contaminated environment.
- Provide preventive medicine support and participate in selection of bed-down locations.

### **COMMANDER AMPHIBIOUS TASK FORCE (CATF) SURGEON.**

The duties and responsibilities of the CATF surgeon are as follows:

- Advise the CATF/CESG and staff, ESG units, and the numbered fleet surgeon on HSS matters.
- Optimize HSS readiness of all CATF/ATG units.
- Coordinate OPLANs and OPORDs with the CLF surgeon in preparing medical units.
- Ensure that LF HSS personnel augment the CATF/ATG medical and dental departments.
- Ensure appropriate HSS to all embarked personnel using the ATG medical and dental departments and medical supplies, reserving the LF HSS supplies for ultimate use ashore.
- Monitor and coordinate ATF quality assurance, risk management, credentials, and privileging issues.
- Ensure optimal use of all embarked HSS personnel and material throughout the CATF/ATG.
- Implement and manage CATF/ATG medical regulating.
- Implement preventive medicine measures throughout the CATF/ATG.
- Submit post-deployment lessons learned reports through the appropriate chain of command.
- Coordinate with the State Department Office of Military Cooperation to establish and maintain medical liaison with U.S. and foreign medical facilities ashore.
- Advise the CATF/CESG in designating [CRTS](#) and [CRTS](#), and request required HSS augmentation.
- Implement, coordinate, and oversee medical exercises, training, and education throughout the CATF/ATG to include

- afloat continuing medical education (CME) and continuing education unit (CEU) documentation and PQS training.
- In coordination with the CLF surgeon and other staff officers, plan for transporting casualties, including mass casualties, to the CRTS.
  - Request and disseminate MEDINTEL.
  - Maintain liaison with other CATF/CESG staff officers on issues and actions related to the health care of the CATF/ATG.
  - Plan and provide for medical support of NEO.
  - Coordinate communications support to complete the HSS mission.
  - Manage the whole blood program.
  - Provide projected HSS supply and re-supply needs to cognizant supply system planners.
  - Represent the amphibious task force in all matters pertaining to HSS for an operational mission.
  - Advise as to the status and capabilities of HSS elements supporting the mission.

### **COMMANDER LANDING FORCE (CLF) SURGEON**

The duties and responsibilities of the CLF surgeon are as follows:

- Ensure HSS provision for the LF before embarkation.
- Assist the ships' medical and dental departments in providing HSS for embarked LF personnel.
- Support the evacuation of casualties from the LF area to BESS during and after the assault phase.
- Provide HSS for personnel ashore in the objective area.
- Make evacuation policy recommendations to the CESG and CLF for the operation.
- ID and request external HSS to fulfill requirements beyond the capability of LF HSS elements.
- Determine req. for HSS supply/sustainment for LF HSS units.
- Establish emergency surgical treatment facilities ashore.
- Ensure continuity and interoperability of the MRN to coordinate the movement of casualties to appropriate treatment facilities ashore or afloat after control passes to the CLF.

#### References

- a *U.S. Navy NTTP 4-02.2 "Navy Tactics, Techniques, and Procedures". (draft) dtd Nov 2006*

# TRIAGE

## INTRODUCTION

The military medical treatment facility, either afloat or ashore, can be overwhelmed during a mass casualty creating a sense of chaos and disorder. Consequently, a method of dealing with the conflicting factors of severity of injury, the tactical situation, the mission, and the resources available for treatment and evacuation is essential. Triage is an attempt to impose order during chaos and make an initially overwhelming situation manageable. It is one of the most important tasks in casualty care. Casualty triage is the dynamic process of sorting patients to identify the priority of treatment and evacuation of the wounded, given the limitations of the current situation, the mission, and available resources (time, equipment, supplies, personnel, and evacuation capabilities). It ensures that those who need treatment sooner receive it and that limited resources are not depleted on those who can be delayed with little harm or, more depressingly, who are certain to die. Triage occurs at every level of care starting with buddy-aid and hospital corpsman care, extending through the OR, the ICU and the evacuation system.

## TRIAGE CATEGORY

The below categories are the most familiar to us and are fully described in the NATO Emergency War Surgery Handbook.

- Immediate
- Delayed
- Minimal
- Expectant
- Urgent

- **IMMEDIATE (RED TAG)**

This group includes those sailors requiring urgent life-saving surgery. Often these are victims with a compromise to their ABC's. The surgical procedures in this category should not be time consuming and should concern only those patients with high chances of survival (i.e., respiratory obstruction, unstable casualties with chest or abdominal injuries, or emergency amputation. Often these casualties represent short operative procedures with a good quality of life if successfully performed.

- Unstable chest and abdominal wounds
- Inaccessible vascular wounds with uncontrollable limb ischemia
- Mechanical airway obstruction
- Sucking chest wounds
- Tension pneumothorax
- Maxillofacial wounds with actual or potential airway compromise
- Internal hemorrhage unresponsive to large volume replacement
- Cardiac injuries
- Deteriorating CNS injuries
- Incomplete amputations
- Open fractures of long bones
- White phosphorus burns
- 2<sup>nd</sup> or 3<sup>rd</sup> degree burns of 15-40% (may be moved to "delayed" depending on scope of mass casualty situation)

- **DELAYED (YELLOW TAG)**

This group includes those wounded who are badly in need of time-consuming surgery, but whose general condition permits delay by several hours in surgical treatment without unduly endangering life. Sustaining treatment will be required (i.e., stabilizing IV fluids, splinting, administration of antibiotics, catheterization, gastric decompression, and relief of pain). The type of injuries include large muscle wounds, fractures of major bones, intra-abdominal and/or thoracic wounds, and potentially burns less than 50% of total body surface area (TBSA).

- Stable abdominal wounds, no hemorrhage
- Soft tissue wounds requiring extensive debridement
- Maxillofacial wounds without airway problems
- Vascular injuries with adequate collateral circulation
- Genitourinary disruptions
- Fractures requiring operative manipulation, debridement, and external fixation, without circulatory compromise
- Most eye and CNS injuries, except rapidly changing and deteriorating head injuries
- Time-consuming surgery
- Effects of delay minimized by stabilization

- **MINIMAL (GREEN TAG)**

These casualties have relatively minor injuries (i.e., minor lacerations, abrasions, fractures of small bones, and minor burns) and can effectively care for themselves or can be helped by non-medical personnel. This group has been commonly referred to as the "walking wounded".

- Superficial wounds requiring little more than cleaning and minimal debridement
- Burns < 15% (except face, hands, genitalia)
- Upper extremity fractures
- Sprains
- Abrasions
- Radiation injuries
- Blast injuries without obvious problems
- Psychiatric disturbances

- **EXPECTANT (BLACK TAG)**

Casualties in this category have wounds that are so extensive that, even if they were the sole casualty and had the benefit of optimal medical resource application, their survival would be unlikely. The expectant casualty should not be abandoned, but should be separated from the view of other casualties.<sup>6</sup> When all “Immediate” and “Delayed” cases are completed, or when an “Expectant’s” condition improves, the “Expectants” can be re-triaged, moved up to a higher category, and taken to the operating room. It is essential to provide comfort for these patients.

- Wounds so extensive that, even if they were the only casualty in a stateside trauma hospital, survival would be unlikely.
- Treatment of complex or time-consuming cases, unless all other operative cases are completed and supplies are not a problem.
- An unjustifiable use of the limited assets or supplies that might be applied to several less severely injured individuals.

- **URGENT**

Surgical patients who need an operation but can wait a few hours.

## **DISCUSSION**

Triage begins in the triage area with the triage officer in charge of all major decisions. The casualty is brought into the well-lighted, spacious triage area, without weapons or friends. The weapons are collected outside by the security force. The walking-wounded are escorted to a separate “Minimal” casualty area; if serious injuries are found on examination there, they are moved back into the triage system. Each patient will have a clipboard with a casualty record sheet or medical form attached to it. The treating physician can decide whether chest tubes are needed, tracheotomies required, and large bore IVs or subclavian lines are placed. Uniforms are removed, and the casualty is thoroughly examined, front and back,

top to bottom, and this primary examination will likely be finished before the triage officer comes to the patient.

### **TRIAGE OFFICER**

The triage officer must see all casualties as quickly as possible to size up the situation. To make correct decisions, the triage officer must maintain a global view (internal and external assets) by continually moving and updating perspective on the entire changing situation. If the focus narrows to specific treatment rather than prioritizing, the triage officer is likely to lose the wider perspective of the situation and the ultimate goal of combat medicine - return of the greatest possible number of sailors and marines to combat and the preservation of life, limb, and eyesight in those who must be evacuated.

It is unlikely that a medical officer will be at each litter. The triage officer with a "scribe" at his side taking notes will quickly visit each casualty, receive vitals and the preliminary assessments from the corpsman / nurse / MO, and then do another exam, deciding which patients go to radiology (if there are x-ray capabilities) and which go immediately to surgery. With advice from the team, the triage officer determines those patients to be removed to the expectant area and those to go to the pre-op holding area. If there are a large number of casualties, the triage officer may be better off not making any decisions except the very obvious ones (immediate category) before seeing all the casualties once.

The senior OR administration person (possibly an HM1), the radiologist (if you have one), and the anesthesiologists should be fed information from the circulating triage officer, returning information on problems they have observed or feel should be dealt with before surgery. The triage officer theoretically does not actively treat patients but merely sorts. After reviewing all new arrivals, the triage officer revisits the expectant patients to make sure none have changed status. The triage officer may change the status of any patient as OR rooms open or their condition changes.

Regardless of the opinions and ideas of others, the triage officer determines the priority of operative intervention. To avoid confusion and the "free-for-all" syndrome, it is key that one individual be in total command. As in all areas of combat casualty care, patients

are re-triaged at each echelon of care. Ensure that minimal and expectant casualties do not enter the assessment and stabilization area, unless there is a change in their status.

Consideration must be given to the myriad of problems brought on by nuclear, biological, and chemical weapons attacks. The most critical for triage is the proper decontamination of chemical casualties. With FMF units, this is a Marine Corps task. Aboard ship, the ship's company would activate one or more of the Decon treatment stations for appropriate decontamination of casualties. Obviously, contamination of medical personnel, particularly those in key positions, could render medical units totally inoperable, so it is imperative that decontamination be properly done. Nuclear and biological warfare will not be dealt with here.

As CATF surgeons, consider setting up triage on the hanger deck prior to going into the "good" triage area. Hanger deck triage could be divided into three major categories:

- The dead
- Walking-wounded
- Those patients requiring physician-directed triage

Another problem you may encounter as a CATF/ESG Surgeon is the inability of some physicians to quickly adapt to less-than-ideal surroundings and equipment.

As CATF Surgeons, it is your duty and privilege to establish your authority. Obviously you must establish rapport with your Green Side counterpart, who may be a Lieutenant. Sometimes this can be a problem. The following few points are things you might want to establish as a CATF Surgeon.

- Insist on staff meetings integrating Blue and Green, which will foster a congenial atmosphere.
- As senior medical authority afloat, it is your privilege to set policy, assign triage officers, and establish on-deck, well deck, and triage area policies.
- Mass casualty plans are drawn up and carried out by the CATF Surgeon, unless ashore, where the CLF Surgeon may take over.

- Coordinate Fleet Surgical Teams, other Health Service Augmentees personnel, individual augments (IAs) and Ship's Company.
- Shipboard Medical is owned by SMO and responsible to the vessel's Commanding Officer.

#### References

- Emergency War Surgery, NATO Handbook, Second United States Edition. 1988.*
- Swan KG, Swan KG Jr. Triage: the past revisited. Military Medicine. 1996; 161:448-52.*

## GLOSSARY

**AEROMEDICAL EVACUATION (AE).** The movement of patients under medical supervision to and between medical treatment facilities by air transportation.

**AMPHIBIOUS OPERATION.** A military operation launched from the sea by an amphibious force, embarked on ships or craft with the primary purpose of introducing a landing force ashore to accomplish the assigned mission.

**AREA OF OPERATIONS (AO).** An operational area defined by the joint force commander for land and naval forces. Areas of operation do not typically encompass the entire operational area of the joint force commander, but should be large enough for component commanders to accomplish their missions and protect their forces.

**AREA OF RESPONSIBILITY (AOR).** The geographical area associated with a combatant command within which a combatant commander has authority to plan and conduct operations.

**BATTLE INJURY (BI).** Damage or harm sustained by personnel during or as a result of battle conditions.

**BUDDY AID.** Acute medical care (first aid) provided by a non-medical Service member to another person.

**CASUALTY.** Any person who is lost to the organization by reason of having been declared dead, change in duty status – whereabouts unknown, missing, ill, or injured.

**CASUALTY EVACUATION (CASEVAC).** The unregulated movement of casualties that can include movement both to and between medical treatment facilities.

**CASUALTY RECEIVING AND TREATMENT SHIP (CRTS).** In amphibious operations, a ship designated to receive, provide treatment for, and transfer casualties.

**CASUALTY STATUS.** A term used to classify a casualty for reporting purposes. There are seven casualty statuses: (1) deceased; (2) duty status - whereabouts unknown; (3) missing; (4) very seriously ill or injured; (5) seriously ill or injured; (6) incapacitating illness or injury; and (7) not seriously injured.

**CHEMICAL AGENT.** Any toxic chemical intended for use in military operations.

**COALITION.** An ad hoc arrangement between two or more nations for common action.

**COMBATANT COMMAND.** A unified or specified command with a broad continuing mission under a single commander established and so designated by the President, through the Secretary of Defense and with the advice and assistance of the CJCS. Combatant commands typically have geographic or functional responsibilities.

**COMBATANT COMMAND (COMMAND AUTHORITY) (COCOM).** Command authority over assigned forces vested only in the commanders of combatant commands by Title 10, USC, Section 164, or as directed by the President in the Unified Command Plan, which cannot be delegated or transferred. Combatant commanders exercise COCOM authority over assigned forces and are directly responsible to the national command authority for the performance of assigned missions and the preparedness of their commands to perform assigned missions.

**COMBAT ZONE (CBTZ).** That area required by combat forces for the conduct of operations.

**COMMANDER, EXPEDITIONARY STRIKE GROUP (CESG).** The USN officer designated in the initiating directive as commander of the expeditionary strike group.

**COMMANDER, LANDING FORCE (CLF).** The officer designated in the order initiating the amphibious operation as the commander of the landing force for an amphibious operation.

**COMMUNICATIONS ZONE.** Rear part of a theater of operations (behind but contiguous to the combat zone) that contains the lines of communication, establishments for supply and evacuation, and other agencies required for the immediate support and maintenance of the field forces.

**COMPONENT.** One of the subordinate organizations that constitute a joint force. Normally, a joint force is organized with a combination of Service and functional components.

**CONTAMINATION.** 1. The deposit, absorption, or adsorption of radioactive material, or of biological or chemical agents on or by structures, area, personnel, or objects. 2. Food and / or water made unfit for consumption by humans or animals because of the presence of environmental chemicals, radioactive elements, bacteria, or organisms, the byproduct of the growth of bacteria or organisms, the decomposing material (including the food substance itself), or waste in the food or water.

**CRISIS ACTION PLANNING.** 1. The Joint Operation Planning and Execution System process involving the time-sensitive development of joint operation plans and orders in response to an imminent crisis. Crisis action planning follows prescribed crisis action procedures to formulate and implement an effective response within the time frame permitted by the crisis. 2. The time-sensitive planning for the deployment, employment, and sustainment of assigned and allocated forces and resources that occurs in response to a situation that may result in actual military operations. Crisis action planners base their plan on the circumstances that exist at the time planning occurs.

**DEFINITIVE CARE.** Care rendered to conclusively manage a patient's condition. It includes the full range of preventive, curative acute, convalescent, restorative, and rehabilitative medical care. This normally leads to rehabilitation, return to duty, or discharge from the Service.

**DISEASE AND NONBATTLE INJURY (DNBI).** All illnesses and injuries not resulting from enemy or terrorist action or caused by conflict. Indigenous disease pathogens, biological warfare agents, heat and cold, hazardous noise, altitude, environmental, occupational, and industrial exposures, and other naturally occurring disease agents may cause disease and nonbattle injury. Disease and nonbattle injuries include injuries and illnesses resulting from training or from occupational, environmental, or recreational activities, and may result in short- or long-term, acute, or delayed illness, injury, disability, or death.

**ECHELON.** 1. A subdivision of a headquarters; i.e., forward echelon or rear echelon. 2. A separate level of command. As compared to a regiment, a division is a higher echelon; a battalion is a lower echelon. 3. A fraction of a command in the direction of depth, to which a principal combat mission is assigned; i.e., attack, support, or reserve echelon. 4. A formation in which its subdivisions are placed one behind another, with a lateral and even spacing to the same side.

**EN ROUTE CARE.** Continuation of the provision of care during movement (evacuation) between the health service support capabilities in the continuum of care, without clinically compromising the patient's condition.

**EVACUATION.** Removal of a patient by any of a variety of transport means (air, ground, rail, or sea) from a theater of military operation, or between health service support capabilities, for the purpose of preventing further illness or injury, providing additional care, or providing disposition of patients from the military health care system.

**EVACUATION POLICY.** Command decision establishing the maximum number of days that patients may be held within the command for treatment. Patients that, in the opinion of responsible medical officers, cannot be returned to duty status within the period prescribed are evacuated by the first available means, provided the travel involved will not aggravate their disabilities.

**EXPEDITIONARY STRIKE GROUP (ESG).** The Navy task organization formed to conduct amphibious operations. The expeditionary strike group, together with the landing force and other forces constitute the amphibious force.

**FIRST RESPONDER.** The primary health care providers whose responsibility is the provision of immediate clinical care and stabilization in preparation for evacuation to the next health service support capability in the continuum of care. In addition to treating injuries, they treat Service members for common acute minor illnesses.

**FLEET MARINE FORCE (FMF).** A balanced force of combined arms comprised of land, air, and service elements of the USMC. An integral part of a US fleet with the status of a type command.

**FORCE HEALTH PROTECTION (FHP).** Measures to promote, improve, or conserve the mental and physical wellbeing of Service members. These measures enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards.

**FOREIGN HUMANITARIAN ASSISTANCE (FHA).** Programs conducted to relieve or reduce the results of natural or manmade disasters or other endemic conditions such as human pain, disease, hunger, or privation that might present a serious threat to life or that can result in great damage to or loss of property.

**FORWARD RESUSCITATIVE SURGERY SYSTEM (FRSS).** A highly mobile, rapidly deployable, trauma surgical unit that provides emergency surgical interventions required to

stabilize casualties who might otherwise die or lose limbs before reaching treatment. It is the lightest and most mobile of the Marine Corps health service support elements capable of providing trauma surgical care.

**GLOBAL PATIENT MOVEMENT REQUIREMENTS CENTER (GPMRC).** A joint activity reporting directly to the Commander, US Transportation Command, the Department of Defense single manager for the strategic and continental United States regulation and movement of uniformed services and other authorized patients.

**HEALTH SERVICE SUPPORT (HSS).** All services performed, provided, or arranged to promote, improve, conserve, or restore the mental or physical well-being of personnel. These services include, but are not limited to, the management of health services resources, such as manpower, monies, and facilities; preventive and curative health measures; evacuation of the wounded, injured, or sick; selection of the medically fit and disposition of the medically unfit; blood management; medical supply, equipment, and maintenance thereof; combat stress control; and medical, dental, veterinary, laboratory, optometric, nutrition therapy, and medical intelligence services.

**HEALTH SURVEILLANCE.** The regular or repeated collection, analysis, and interpretation of health related data and the dissemination of information to monitor the health of a population and to identify potential health risks, thereby enabling timely interventions to prevent, treat, reduce, or control disease and injury. It includes occupational and environmental health surveillance and medical surveillance subcomponents.

**HEALTH THREAT.** A composite of ongoing or potential enemy actions; adverse environmental, occupational, and geographic and meteorological conditions; endemic diseases; and employment of nuclear, biological, and chemical weapons (to include weapons of mass destruction) that have the potential to affect the short- or long-term health (including psychological impact) of personnel.

**HOSPITAL.** A medical treatment facility capable of providing inpatient care. It is appropriately staffed and equipped to provide diagnostic and therapeutic services, as well as the necessary supporting services required to perform its assigned mission and functions. In addition, a hospital may perform the functions of a clinic.

**HOST NATION (HN).** A nation that receives the forces and / or supplies of allied nations, coalition partners, and / or NATO organizations to be located on, to operate in, or to transit through its territory.

**INITIAL RESUSCITATIVE CARE.** This level of treatment is provided by a forward resuscitative surgery system, surgical company, or casualty receiving and treatment ship. Additionally, a medical team supported by the necessary staff, equipment, and supplies, including whole blood and blood products, distinguishes this level of care. The initial resuscitative treatment phase is distinguished by the application of clinical judgment and skill by a team of physicians and nurses, supported by a medical staff. This treatment includes medical and surgical capabilities, basic laboratory, pharmacy, and, except in the case of forward resuscitative surgery systems, holding ward facilities. During initial resuscitative care, necessary examinations and observations can be accomplished in a deliberate manner. The objective of this phase of treatment is the aggressive management of life- and limb- threatening injuries that, in themselves, constitute resuscitation and without which death or serious loss of limb or body function is likely to occur. For those patients who require a more comprehensive scope of treatment, arrangements are made for surface or air evacuation to a facility that can provide the required treatment.

**JOINT STAFF (JF).** The staff of a commander of a unified or specified command, subordinate unified command, joint task force, or subordinate functional component (when a functional component will employ forces from more than one Military Department), that includes members from the several Services comprising the force. These members should be assigned in such a manner as to ensure that the commander understands the tactics, techniques, capabilities, needs, and limitations of the component parts of the force. Positions on the staff should be divided so that Service representation and influence generally reflect the Service composition of the force.

**JOINT TASK FORCE (JTF).** A joint force that is constituted and so designated by the Secretary of Defense, a combatant commander, a subunified commander, or an existing joint task force commander.

**LANDING FORCE (LF).** A task organization of troop units, aviation and ground, assigned to an amphibious assault. It is the highest troop echelon in the amphibious operation.

**LOGISTICS.** The science of planning and carrying out the movement and maintenance of forces.

**MARINE AIR-GROUND TASK FORCE (MAGTF).** The Marine Corps principal organization for all missions across the range of military operations composed of forces that are task organized under a single commander, and capable of responding rapidly to a contingency anywhere in the world.

**MARINE EXPEDITIONARY FORCE (MEF).** The largest MAGTF and the Marine Corps principal warfighting organization, particularly for larger crises or contingencies. It is task organized around a permanent command element and normally contains one or more Marine divisions, Marine aircraft wings, and Marine force service support groups. The MEF is capable of missions across the range of military operations including amphibious assault and sustained operations ashore in any environment. It can operate either from a sea base or a land base. It may also contain other Service or foreign military forces assigned or attached to the MAGTF.

**MARINE EXPEDITIONARY UNIT (MEU).** A MAGTF that is constructed around an infantry battalion reinforced, a helicopter squadron reinforced, and a task-organized combat service support element. It normally fulfills the Marine Corps forward sea-based deployment requirements. The MEU provides an immediate reaction capability for crisis response and is capable of limited combat operations.

**MARITIME INTERCEPTION OPERATIONS (MIO).** The legitimate action of denying merchant vessels access to specific ports for the import / export of prohibited goods to or from a specified nation or nations for the temporary purpose of peacekeeping or enforcing imposed sanctions.

**MASS CASUALTY.** Any large number of casualties produced in a relatively short period of time, usually as the result of a single incident such as a military aircraft accident, hurricane, flood, earthquake, or armed attack that exceeds local logistic support capabilities.

**MEDICAL INTELLIGENCE.** That category of intelligence resulting from collection, evaluation, analysis, and interpretation of foreign medical, bio-scientific, and environmental information that is of interest to strategic planning and to military medical planning and operations for the conservation of the fighting strength of friendly forces and the formation of assessments of foreign medical capabilities in both military and civilian sectors.

**MEDICAL REGULATING.** The actions and coordination necessary to arrange for the movement of patients through the levels of care. The process matches patients with a medical treatment facility that has the necessary health service support capabilities, and ensures available bed space.

**MEDICAL REGULATING NETWORK (MRN).** The formal radio communications network for the medical regulating system.

**MEDICAL SURVEILLANCE.** The ongoing, systematic collection, analysis, and interpretation of data derived from instances of medical care or medical evaluation, and the reporting of population-based information for characterizing and countering threats to a population's health, well-being and performance.

**MEDICAL TREATMENT FACILITY (MTF).** A facility established for the purpose of furnishing medical and / or dental care to eligible individuals.

**NONCOMBATANT EVACUATION OPERATIONS (NEO).** Operations directed by the DOS, DOD, or other appropriate authority whereby noncombatants are evacuated from foreign countries when their lives are endangered by war, civil unrest, or natural disaster to safe havens or to the United States.

**OPERATIONS CONTROL (OPCON).** Command authority that may be exercised by commanders at any echelon at or below the level of combatant command.

**OPERATION ORDER (OPORD).** A directive issued by a commander to subordinate commanders to effect the coordinated execution of an operation.

**OPERATION PLAN (OPLAN).** Any plan, except for the Single Integrated Operational Plan, for the conduct of military operations. Combatant commanders prepare plans in response to requirements established by the CJCS and by commanders of subordinate commands in response to requirements tasked by the establishing unified commander.

**PATIENT MOVEMENT.** The act or process of moving a sick, injured, wounded, or other person to obtain medical and / or dental care or treatment. Functions include medical regulating, patient evacuation, and en route medical care.

**PATIENT MOVEMENT REQUIREMENTS CENTER (PMRC).** Term used to represent any theater, joint or the Global Patient Movement Requirements Center function. A joint activity that coordinates patient movement. It is the functional merging of joint medical regulating processes, Services' medical regulating processes, and patient movement evacuation requirements planning (transport to bed plan).

**PLANS, OPERATIONS, AND MEDICAL INTELLIGENCE OFFICER (POMI).** The selected Medical Service Corps officer responsible for the analyses, planning, and execution of mobilization and peacetime plans for both Navy and Marine Corps health service support activities and staff assignments at the joint, combined, and Service levels.

**PREVENTIVE MEDICINE.** The anticipation, communication, prediction, identification, prevention, education, risk assessment, and control of communicable diseases, illnesses, and exposure to endemic, occupational, and environmental threats. These threats include nonbattle injuries, combat stress responses, weapons of mass destruction, and other threats to the health and readiness of military personnel. Communicable diseases include arthropod-, vector-, food-, waste-, and waterborne diseases. Preventive medicine measures include field sanitation, medical surveillance, pest and vector control, disease

risk assessment, environmental and occupational health surveillance, waste (human, hazardous, and medical) disposal, food safety inspection, and potable water surveillance.

**REHABILITATIVE CARE.** Therapy that provides evaluations and treatment programs using exercises, massage, or electrical therapeutic treatment to restore, reinforce, or enhance motor performance and restores patients to functional health allowing for their return to duty or discharge from the Service. Also called restorative care.

**RESUSCITATIVE CARE.** Advanced emergency medical treatment required to prevent immediate loss of life or limb and to attain stabilization to ensure the patient could tolerate evacuation.

**SAFE HAVEN.** Designated area(s) to which noncombatants of the US Government's responsibility and commercial vehicles and material may be evacuated during a domestic or other valid emergency.

**SPECIFIED COMMAND.** A command that has a broad, continuing mission, normally functional, and is established by the President through the Secretary of Defense with the advice and assistance of the CJCS. It normally is comprised of forces from a single Military Department, but may include units and staff representation from other Services.

**SERIOUSLY ILL OR INJURED.** The casualty status of a person whose illness or injury is classified by medical authority to be of such severity that there is cause for immediate concern, but there is not imminent danger to life.

**STABILIZED PATIENT.** A patient whose airway is secured, hemorrhage is controlled, shock treated, and fractures are immobilized.

**SUSTAINMENT.** The provision of personnel, logistic, and other support required to maintain and prolong operations or combat until successful accomplishment or revision of the mission or of the national objective.

**TASK FORCE.** 1. A temporary grouping of units, under one commander, formed for the purpose of carrying out a specific operation or mission. 2. A semi-permanent organization of units, under one commander, formed for the purpose of carrying out a continuing specific task. 3. A component of a fleet organized by the commander of a fleet or higher authority for the accomplishment of a specific task or tasks.

**THEATER.** The geographic area outside CONUS for which a commander of a combatant command has been assigned military responsibility.

**THEATER PATIENT MOVEMENT REQUIREMENTS CENTER (TPMRC).** The activity responsible for intratheater patient movement management (medical regulating and aeromedical evacuation scheduling), the development of theater-level patient movement plans and schedules, the monitoring end execution in concert with the Global Patient Movement Requirements Center.

**UNIFIED COMMAND.** A command with a broad continuing mission under a single commander and composed of significant assigned components of two or more Military Departments, that is established and so designated by the President through the Secretary of Defense with the advice and assistance of the CJCS.

**VERY SERIOUSLY ILL OR INJURED (VSI).** The casualty status of a person whose illness or injury is classified by medical authority to be of such severity that life is imminently endangered.

**WOUNDED IN ACTION (WIA).** A casualty category applicable to a hostile casualty, other than the victim of a terrorist activity, who has incurred an injury due to an external agent or cause. The term encompasses all kinds of wounds and other injuries incurred in action, whether there is a piercing of the body, as in a penetration or perforated wound, or none, as in the contused wound. These include fractures, burns, blast concussions, all effects of biological and chemical warfare agents, and the effects of an exposure to ionizing radiation or any other destructive weapon or agent. The hostile casualty's status may be categorized as "very seriously ill or injured," "seriously ill or injured," "incapacitating illness or injury," or "not seriously injured."

#### References

- a *U.S. Navy NTTP 4-02.2 "Navy Tactics, Techniques, and Procedures" (draft dtd Nov 2006)*

## PRISONERS OF WAR

Combatants cease to be subject to attack when they have individually laid down their arms to surrender, when they are no longer capable of resistance, or when the unit in which they are serving or embarked has surrendered or been captured. However, the law of armed conflict does not precisely define when surrender takes effect or how it may be accomplished in practical terms. Surrender involves an offer by the surrendering party (a unit or individual combatant) and an ability to accept on the part of the opponent. The latter may not refuse an offer of surrender when communicated, but that communication must be made at a time when it can be received and properly acted upon--an attempt to surrender in the midst of a hard-fought battle is neither easily communicated nor received. The issue is one of reasonableness.

Combatants that have surrendered or otherwise fallen into enemy hands are entitled to prisoner-of-war status and, as such, must be treated humanely and protected against violence, intimidation, insult, and public curiosity. When prisoners of war are given medical treatment, no distinction among them will be based on any grounds other than medical ones. (See paragraph 11.4 for further discussion of the medical treatment to be accorded captured enemy wounded and sick personnel.) Prisoners of war may be interrogated upon capture but are required to disclose only their name, rank, date of birth, and military serial number. Torture, threats, or other coercive acts are prohibited.

Persons entitled to prisoner-of-war status upon capture include members of the regular armed forces, the militia and volunteer units fighting with the regular armed forces, and civilians accompanying the armed forces. Militia, volunteers, guerrillas, and other partisans not fighting in association with the regular armed forces qualify for prisoner-of-war status upon capture, provided they are commanded by a person responsible for their conduct, are uniformed or bear a fixed distinctive sign recognizable at a distance, carry their arms openly, and conduct their operations in accordance with the law of armed conflict.

Should a question arise regarding a captive's entitlement to prisoner-of-war status, that individual should be accorded prisoner-of-war treatment until a competent tribunal convened by the captor determines the status to which that individual is properly entitled. Individuals captured as spies or as illegal combatants have the right to assert their claim of entitlement to prisoner-of-war status before a judicial tribunal and to have the question adjudicated. Such persons have a right to be fairly tried for violations of the law of armed conflict and may not be summarily executed.

References

*Naval Warfare Publication NWP 1-14M, "The Commander's Handbook on the Law of Naval Operations"*

# **SAILOR'S CREED**

**I am a United States Sailor.**

**I will support and defend the Constitution of the United States of America and I will obey the orders of those appointed over me.**

**I represent the fighting spirit of the Navy and all who have gone before me to defend freedom and democracy around the world.**

**I proudly serve my country's Navy combat team with Honor, Courage and Commitment.**

**I am committed to excellence and the fair treatment of all.**