

FM 4-02.24 (FM 8-10-24)

AREA SUPPORT MEDICAL BATTALION

TACTICS, TECHNIQUES, AND PROCEDURES

HEADQUARTERS, DEPARTMENT OF THE ARMY

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AREA SUPPORT MEDICAL BATTALION TACTICS, TECHNIQUES, AND PROCEDURES

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PREFACE

This field manual (FM) provides information on the mission, organization, and operation of the area support medical battalion (ASMB). This manual sets forth tactics, techniques, and procedures (TTP) for providing area medical support in the corps and echelons above corps (EAC). It is intended to assist the commanders and staffs of the ASMB headquarters and headquarters detachment (HHD); it is also designed to be used by subordinate area support medical company (ASMC) commanders and their staffs. Information provided in this manual is based on doctrine found in FMs 8-10, 8-10-6, 8-10-26, 8-10-8, 8-55, 100-5, and 100-10.

This publication outlines the functions and operations of each section within the ASMB and how the ASMB staff integrates its activities. It includes the combat health support (CHS) activities for the corps areas and within the communications zone (COMMZ). This manual describes the many coordination links the ASMB HHD must maintain with supported and supporting units.

The staffing and organizational structure presented in this publication reflect those established under the Medical Reengineering Initiative (MRI) and those approved by the Department of the Army (DA) in Tables of Organization and Equipment (TOE) 08456A000 and 08457A000, dated May 1997. However, staffing is subject to change to comply with manpower requirements criteria outlined in Army Regulation (AR) 71-32 and can be subsequently modified. The staffing and organizational structure for the ASMB and ASMCs, Medical Force 2000, based on the L-series TOEs, is provided at Appendix A for those ASMBs and ASMCs that have not converted to the MRI A-series TOEs.

This publication implements the North Atlantic Treaty Organization (NATO) Standardization Agreement (STANAG) 2931, Orders for the Camouflage of the Red Cross and the Red Crescent on Land in Tactical Operations.

As the Army Medical Department (AMEDD) transitions to the 91W military occupational specialty (MOS), positions for 91B and 91C will be replaced by 91W when new unit modification table(s) of organization and equipment (MTOE) take effect.

Users of this publication are encouraged to submit comments and recommendations to improve the publication. Comments should include the page, paragraph, and line(s) of the text where the change is recommended. The proponent for this publication is the United States (US) Army Medical Department Center and School (AMEDDC&S). Comments and recommendations should be forwarded directly to **Commander, AMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-6175**, or by using the E-mail addresses on the Doctrine Literature website at <http://dcdd.amedd.army.mil/index1.htm> (click on Doctrine Literature).

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

CHAPTER 1

COMBAT HEALTH SUPPORT FOR ARMY OPERATIONS**1-1. Army Operations Doctrine**

The Army's keystone doctrinal manual, FM 100-5, expresses how the Army expects forces to operate while allowing for boldness, creativity, and initiative. It guides the conduct of campaigns, major operations, battles, and engagements, in conjunction with other Services and allied forces. Army forces accomplish missions worldwide by combining and executing offensive, defensive, stability, and support operations. Operations encompass rapid deployment, decisive application of military power, and the staying power necessary to achieve long-term success. This manual provides information on the Army's operational concept and operational guide principles. It explains how concepts, principles, functions, and operating systems combine to enable units to execute categories of operations. The capstone manual for the AMEDD, FM 8-10, explains the purpose of CHS in its support of Army operations. It is the primary guide for obtaining and providing CHS for the theater of operations (TO).

1-2. Combat Health Support Mission

The CHS mission—to conserve the fighting strength—dictates that casualties be collected, sorted (triaged), treated, and identified as return to duty (RTD) or nonreturn to duty (NRTD) patients as far forward as possible. Additionally, CHS resources must be employed to provide the greatest benefit to the maximum number of personnel in support of the combat mission. The accomplishment of this mission is dependent on the CHS plan and the synchronization of CHS. Synchronization means more than just coordinated action. It results from an all-prevailing unity of effort throughout the force. The action of each element within a command must flow from an understanding of the higher commander's concept and intent. The CHS plan is the primary vehicle for providing the CHS operational information required to support the commander's tactical plan.

1-3. Army Medical Department Battlefield Rules

The AMEDD has developed medical battlefield rules to assist leaders, working in a complex environment, to establish priorities for providing CHS. The CHS planner and operator applies the following rules, in order of precedence, when priorities are in conflict:

- Maintain medical presence with the soldier.
- Maintain the health of the command.
- Save lives.
- Clear the battlefield.
- Provide state-of-the-art care.
- Return soldiers to duty as early as possible.

For additional information on the AMEDD's Battlefield Rules, refer to FM 8-55.

1-4. Principles of Combat Health Support

a. Conformity. Conformity with the tactical plan involves determining the requirements and planning the support needed to conform to tactical operations. Conformity with the tactical plan is the most fundamental element for effectively providing CHS. Only by participating in the development of the commander's operation plan (OPLAN) can the CHS planner ensure adequate CHS at the right time and place. For additional information on CHS planning, refer to FM 8-55.

b. Proximity. Proximity involves placing CHS units and personnel in the right place at the right time to provide CHS to sick, injured, or wounded soldiers. The location of CHS assets in support of combat operations is dictated by the—

- Mission, enemy, terrain, troops, time available, and civilian considerations (METT-TC) factors.

- Requirements for far forward stabilization of patients, which help maintain the physiology of the wounded or severely injured soldiers.

- Early identification and forward treatment of RTD category patients.

- Forward orientation of evacuation resources, thereby reducing response time.

- Other logistical units/complexes.

c. Flexibility. Flexibility must be maintained to ensure a continuum of CHS. Medical planners and staffs must be proactive rather than reactive and aggressively coordinate any changes to the CHS plan.

d. Mobility. Mobility must be maintained to ensure CHS assets remain close enough to support maneuvering combat forces. The mobility of medical elements should equate to the force being supported.

e. Continuity. Continuity in care and treatment is achieved by moving the patient through a progressive, phased CHS system. The CHS system is a continuum from the forward line of own troops (FLOT) rearward through the continental United States (CONUS). Medical personnel and units must provide optimum care and treatment to the sick, injured, and wounded in an uninterrupted manner. Each type of CHS element contributes a measured, logical increment appropriate to its location and capabilities. Continuity also requires that a sound preventive medicine (PVNTMED) program be implemented and maintained.

f. Control. This principle ensures that CHS resources are efficiently employed to support the tactical plan and that medical units are under the command and control (C2) of a single medical manager. Control is achieved through planning, coordinating, and monitoring all CHS activities. Control measures include maintaining graphical updates of current routes and boundaries, movement criteria, support priorities, and tactical standing operating procedures (TSOPs). Control also ensures that the scope and quality of medical treatment meets professional standards and policies. For additional information on principles of CHS, refer to FM 8-10.

1-5. Threat

The overt threat to medical units on today's battlefield is virtually no different from that of other types of units. Deploying units are normally provided an overall threat assessment prior to their deployment, depending on the availability of time and intelligence information. This threat assessment may be detailed, or in some cases, there may be numerous unknowns. Commanders and medical personnel must have an awareness of the threat and be proactive with countermeasures to reduce or eliminate it. The overall threat includes—

- Enemy weapons systems (direct and indirect fire).
- Enemy combat operations (ground and air).
- Chemical warfare (CW).
- Biological warfare (BW).
- Nuclear warfare.
- Medical threat.
- Endemic disease.
- Environmental injuries (heat and cold).
- Arthropodborne diseases.
- Diarrheal disease (food and water).
- Occupational injuries (such as those caused by carbon monoxide, noise, and petroleum supplies).
- Combat stress.

The threat to medical units and personnel varies according to the intensity, location, and the operational continuum. Threat assessment begins prior to deployment. Continuous threat analysis is initiated upon deployment of a unit and continues until the mission is completed. See FMs 8-10, 8-10-8, and 8-42 for definitive information pertaining to the overall threat which includes the medical threat.

1-6. Modular Medical Support System (Echelons I and II)

Combat health support (Echelons I and II) is provided by the modular medical support system that standardizes all medical subunits within the division, corps, and EAC. This modular system was derived by recognizing that some common medical functions performed at Echelons I and II were the same through the

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division, corps, and EAC. The modular design enables the CHS resource managers to rapidly tailor, augment, reinforce, or reconstitute the battlefield in areas of most critical need. This system is designed to acquire, receive, and sort casualties; to provide emergency medical treatment (EMT) and advanced trauma management (ATM); and to provide area CHS for personnel in the corps and COMMZ. The modular medical support system is built around six modules. These modules are oriented to casualty assessment/collection, evacuation, treatment, and resuscitative surgery. They provide greater flexibility, mobility, and patient care capabilities than were previously available.

a. Combat Medic. The combat medic module consists of one combat medical specialist and his prescribed load of medical supplies and equipment. Combat medics are organic to medical platoons/sections of combat and selected combat support (CS) battalions. They are normally placed under the operational control (OPCON) of platoons/companies/troops of maneuver battalions and squadrons.

b. Ambulance Squad. An ambulance squad is comprised of four medical specialists and two ambulances (two ambulance teams). Ambulance squads are organic to medical platoons or sections in combat battalions, selected CS units, and to the medical companies of the division support command (DISCOM), medical companies (ground ambulance) of the medical evacuation battalion, and medical companies of the ASMB. The squad provides evacuation of patients and ensures the continuity of care en route. Ambulance squads are located in the brigade support area (BSA), division support area (DSA), corps support area (CSA), and in EAC units. Ambulance squads provide direct support (DS) for medical evacuation or they provide medical evacuation on an area support basis throughout the TO. The ambulance teams of a maneuver battalion's medical platoon are placed either in DS of a company/team or are collocated with the treatment squad (battalion aid station [BAS]). In the DS role, they also perform the duties of a combat medic. When collocated, they are dispatched from the BAS to reinforce a team in DS or to evacuate patients from units on an area support basis.

NOTE

Armored ambulances require a third medic to perform en route care.

c. Treatment Squad. The treatment squad consists of the medical platoon leader (field surgeon), a physician assistant (PA), three noncommissioned officers (NCOs), and three medical specialists. The squad is trained and equipped to provide ATM to the battlefield casualty. Advanced trauma management is emergency care designed to resuscitate and stabilize the patient for evacuation to the next echelon of care. To maintain contact with the combat maneuver element, each squad has two emergency treatment vehicles. Each squad can split into two trauma treatment teams, an A-team (which has the physician) and B-team (which has the PA). These squads are organic to medical platoons/sections in maneuver battalions and designated CS units and medical companies of separate brigades, armored cavalry regiments (ACRs), divisions, and echelons above division ASMCs of the ASMBs. Treatment squads may be employed anywhere on the battlefield. When not engaged in ATM, these elements provide routine sick call services on an area basis.

d. Area Support Squad. The area support squad is comprised of one Dental Corps officer, a dental specialist, two x-ray specialists, and two medical laboratory specialists. The squad is organic to the

medical companies of separate brigades, divisions, and ASMCs in the corps and COMMZ. The dental officer is ATM-trained and provides additional treatment capabilities to the clearing station during peak patient loads.

e. Patient-Holding Squad. The patient-holding squad consists of a medical-surgical nurse, two practical nurses, and two medical specialists. It is capable of holding and providing minimal care for up to 40 RTD patients; however, in the light infantry divisions, this squad can hold and care for only 20 RTD patients. This squad is organic to the medical companies of separate brigades, divisions, ACRs, and in the ASMCs.

NOTE

When a treatment squad, an area support squad, and a patient-holding squad are collocated, they form an area support section (clearing station). This section provides CHS on an area basis to all forces within a geographical area of responsibility. The area support section normally operates in the BSA, the DSA, and areas of high concentrations of troops in the CSA and COMMZ. The area support and patient-holding squads are incapable of independent operations.

f. Forward Surgical Team. The corps forward surgical team (FST) is assigned to the combat support hospital (CSH) when not operationally employed forward. Forward surgical teams are organic to the airborne and air assault divisions and are assigned to the main support medical company (MSMC) of the main support battalion (MSB) for Army of Excellence (AOE) divisions. In the Army XXI concept, the FST is also assigned to the CSHs. In the future Army XXI airborne and air assault divisions, the FST is assigned to the division support medical company (DSMC) of the division support battalion (DSB). In both AOE and Army XXI heavy division, separate brigade or ACR, the FST is deployed from the supporting corps. The mission of the FST is to provide a rapidly deployable immediate surgical capability, enabling patients to withstand further evacuation. It provides surgical support in division, separate brigades, and ACR operational areas. The requirement to project surgery forward increases as a result of the extended battlefield. This small lightweight surgical team is designed to complement and augment emergency treatment capabilities for the brigade-sized task force. The FSTs are clinically standard modules regardless of their assignment. These 20-person units are organized into four functional areas—triage-trauma management (TTM), surgery, recovery, and administration/operations. The team provides initial surgery for those critically injured patients who cannot be transported over great distances without surgical intervention and stabilization. Refer to FM 8-10-25 for definitive information on the FST.

1-7. Echelons of Medical Care

Medical care echelons describe the five levels of treatment within the military system. Each echelon has the same capabilities as the echelon before it, but adds a new treatment capability that distinguishes it from the previous echelon. The five echelons are—

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- *Echelon I*—The first medical care a soldier receives is provided at this level. This care includes immediate lifesaving measures, ATM, disease prevention, combat stress control (CSC), casualty collection, and evacuation from the supported unit to the supporting medical treatment element. Echelon I elements are located throughout the combat zone (CZ) and COMMZ. These elements include the combat lifesaver, combat medic, and BAS. Some or all of these elements are found in maneuver, CS, and combat service support (CSS) units. When Echelon I medical care is not present in a unit, this support is provided to that unit by Echelon II medical units.

- *Echelon II*—This echelon duplicates Echelon I and expands services available by adding dental, laboratory, x-ray, and patient-holding capabilities. Emergency care and ATM, including beginning resuscitation procedures, are continued. (No general anesthesia is available.) If necessary, additional emergency measures are instituted; however, they do not go beyond the measures dictated by the immediate needs. Echelon II units are located in the CZ (BSA and CSA) and the COMMZ. Echelon II medical support may be provided by a clearing station, forward support medical company (FSMC), MSMC, DSMC, ASMC, or a troop medical company. Optometry is located at some Echelon II units; also, PVNTMED and mental health/CSC support are now located in some Echelon II medical units.

- *Echelon III*—This echelon of support expands the support provided at Echelon II (division level). Casualties who are unable to tolerate and survive movement over long distances will receive surgical care in hospitals as close to the division rear boundary as the tactical situation will allow. This may be provided within the division area under certain operational conditions. Echelon III care is provided by an FST or a CSH. Operational conditions may require Echelon III units to locate in offshore support facilities, third country support bases, or in the COMMZ.

- *Echelon IV*—This echelon of care is provided by a CSH, which has increased treatment capabilities that are staffed and equipped for general and specialized medical and surgical treatment. This echelon of care provides further treatment to stabilize those patients requiring evacuation to CONUS. This echelon also provides area CHS for EAC soldiers or those located within the COMMZ.

- *Echelon V (Continental United States Support Base Echelon of Care)*—This definitive echelon of care is provided in the CONUS support base. The patient is treated in hospitals staffed and equipped to provide the most definitive care available. Hospitals used to provide this care are not limited to US Army hospitals. Hospitals from the other military services, the Department of Veterans Affairs, and the civilian health care systems may also be used. Civilian hospitals include those hospitals that are members of the National Disaster Medical System (NDMS).

1-8. Planning for Combat Health Support

Planning for CHS is performed at every command level through the TO. In Army operations, the extended battlefield stretches CHS capabilities to the maximum. It presents an unprecedented challenge to the CHS planner, as well as to the tactical commander. It is imperative that the CHS planner at every echelon be involved in the initial stages of the tactical and logistical planning processes. It is only through understanding the tactical commander's plan that the medical commander can continue to provide sustaining CHS in the absence of orders and communications. Commanders must be able to reallocate CHS resources as tactical

situations change. Effective and timely planning is essential to ensure adequate and employable CHS. For definitive information on CHS planning, see FM 8-55.

a. Army Service Component Command Combat Health Support Plan. The Army CHS plan for the TO is developed by the Army Service Component Command (ASCC) surgeon/medical command (MEDCOM) commander. The ASCC surgeon is on the special staff of the ASCC commander. He is the medical staff adviser to the ASCC commander and is responsible for staff planning and coordinating and developing policies for the CHS of ASCC forces. The ASCC surgeon's section of the MEDCOM assists ASCC surgeon. The MEDCOM may be assigned to the ASCC/Army forces, or a C2 module of the MEDCOM may be assigned to the theater support command at the discretion of the ASCC.

b. Corps Combat Health Support Plan. The CHS portion of the corps OPLAN is developed by the MEDCOM and corps surgeon's section. The corps surgeon is a special staff officer located in the corps headquarters. He has a small staff section to assist in completing his mission. The corps surgeon has direct access to the corps commander on CHS matters. He keeps the commander and his staff informed concerning the health of the command and the CHS aspects of combat operations and effectiveness. As the principal medical staff officer, he advises the corps commander and his staff on all CHS matters related to personnel, intelligence, operations, logistics, and civil-military operations (CMO). The corps surgeon works with the MEDCOM for coordinating and synchronizing CHS for the corps. He provides technical supervision and guidance required to ensure that all CHS activities are accomplished for support of corps operations. The corps surgeon exercises staff supervision over CHS in the corps support command (COSCOM), divisions, and other subordinate corps units. The corps CHS plan that is developed is based on the corps commander's guidance and his intent and on information obtained through mission analysis and staff estimates. The corps surgeon makes long-range plans (96 hours and beyond) for CHS. The commanders of the MEDCOM and medical brigade convert these OPLANs into day-to-day operations to fulfill the CHS mission. The ASMB develops a CHS plan for providing area medical support; this process will be discussed in subsequent chapters of this manual.

CHAPTER 2

AREA SUPPORT MEDICAL BATTALION**Section I. ORGANIZATION AND FUNCTIONS****2-1. Area Medical Support**

Area medical support in the corps and EAC/COMMZ is provided by the ASMB (Figure 2-1). This battalion provides Echelon I and Echelon II CHS and medical staff advice and assistance for all units located in its area of responsibility.

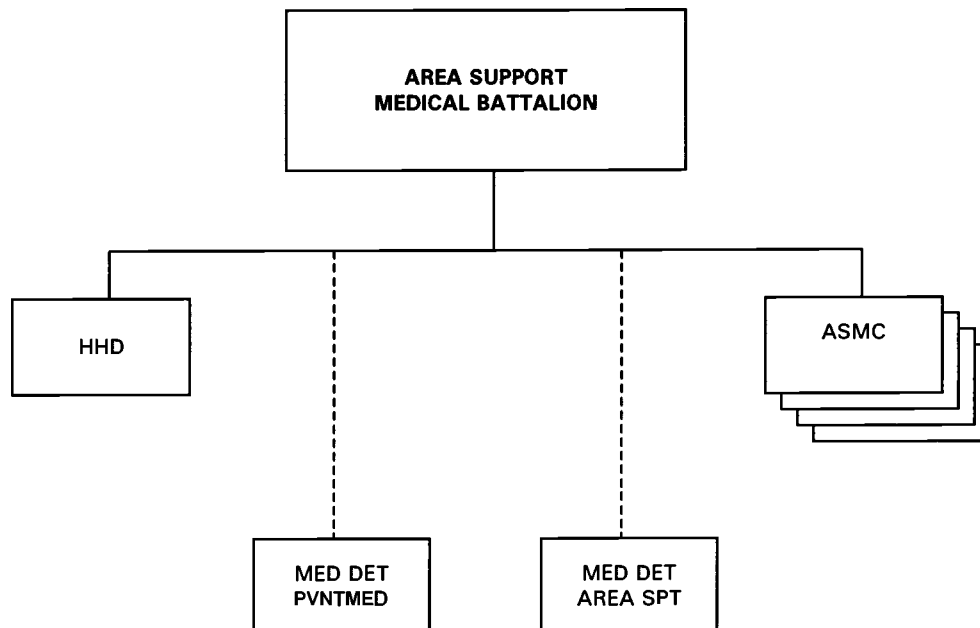


Figure 2-1. Area support medical battalion.

2-2. Organization

The ASMB is organized to provide Echelon II CHS within its assigned area of operations (AO). The ASMB also provides unit-level (Echelon I) CHS on an area support basis for assigned and attached units operating within its assigned AO. The ASMB is modular in design and consists of a battalion HHD (Figure 2-2) and four ASMCs (Figure 2-3). It is normally assigned to a medical brigade or a MEDCOM.

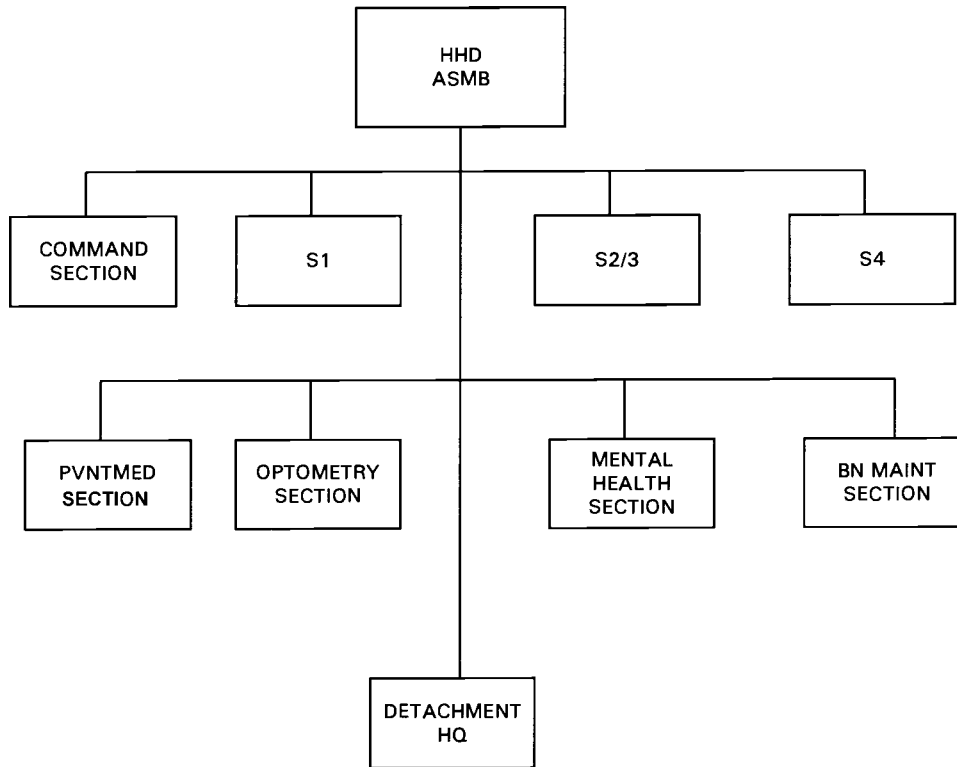


Figure 2-2. Headquarters and headquarters detachment, area support medical battalion.

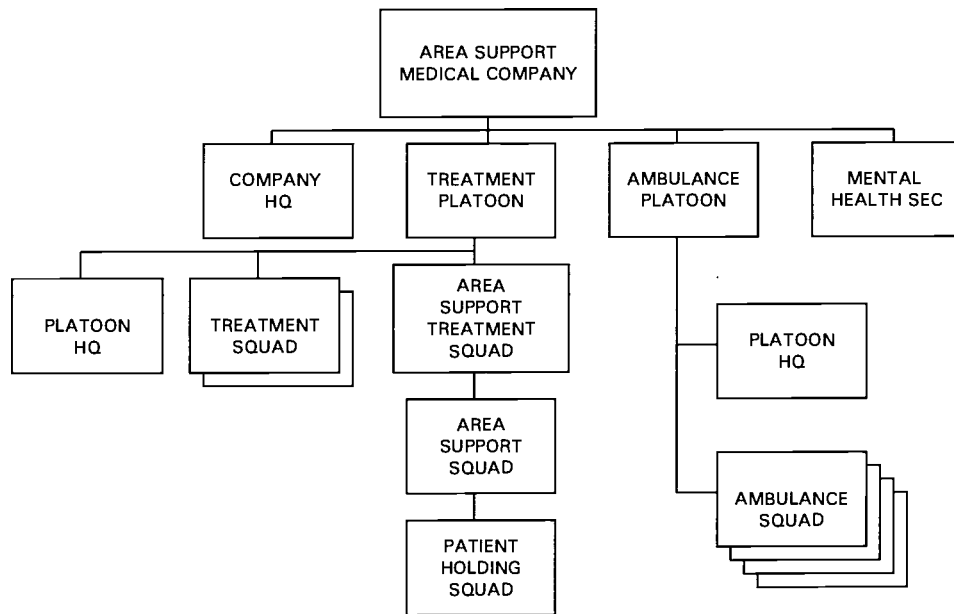


Figure 2-3. Area support medical company.

a. Employment in the Theater. In a mature theater, ASMCs are employed primarily in the corps rear and support areas of the EAC/COMMZ. They are deployed to a geographical area to provide area CHS or may be deployed to provide CHS for designated nondivisional units/troops. The ASMCs also establish clearing stations and provide Echelon I and Echelon II CHS in a wide area (normally, an area or sector of the size established and supported by a corps support group or a corps support battalion). Medical treatment squads/teams of the ASMCs may be deployed to establish treatment stations and provide Echelon I support to given concentrations of nondivisional units that do not have organic CHS. The modular design of the ASMB and its ASMCs permits its employment across the operational continuum. See Chapter 4 and Chapter 5 for additional information pertaining to employment.

b. Mission. The HHD, ASMB provides C2 for assigned and attached units and provides Echelon I and Echelon II CHS to units located in the battalion's AO. It provides medical staff advice and assistance as required. Its functions are centered around three basic principles: treat and RTD; treat and hold (up to 72 hours); and treat and evacuate. Specific functions of the battalion include—

- Command and control and administrative and logistical support for up to seven subordinate units which will be a combination of the ASMCs and area support medical detachments (ASMD), TOE 08753A00. The ASMD is assigned to the medical brigade but will normally be attached to an ASMB.
- Planning and coordinating Echelon I and Echelon II CHS operations, to include staff advice on an area basis for corps and COMMZ units without organic medical assets.
- Advising commanders and staff of supported units on the health of their command and on health aspects affecting their unit's mission or CSS.
- Forwarding information concerning the medical aspects of CSS situations to higher headquarters.
- Allocation of medical resources (personnel and equipment) to ensure adequate medical treatment to all assigned or attached units operating in the battalion's AO in either corps or EAC.
- Mental health consultation/CSC for elements operating in the battalion's AO.
- Optometry support that includes limited eye examination, eyewear frame assembly utilizing presurfaced single-vision lens, and repair service for units assigned to the battalion's AO.
- Preventive medicine consultation and support for units assigned to the battalion's AO, to include planning and coordinating operations of attached PVNTMED detachments. This section is capable of operating as separate teams.
- Unit vehicle maintenance for assigned and attached units.
- Unit administration for assigned and attached units.

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- Combat health logistics, to include Class VIII resupply, medical equipment maintenance support, and blood management.
- Food service support for staff and other medical elements dependent upon the battalion for food service.
- Operating clearing stations (Echelon II) with limited short-term holding capability and limited pharmacy, laboratory, and x-ray services.
 - Providing daily sick call services on an area basis.
 - Providing ground ambulance evacuation of patients.
 - Providing trauma and sick call CHS (Echelon I) on an area basis to units without organic medical elements.
 - Providing emergency, preventive, and general dentistry services.
 - Providing limited neuropsychiatric (NP) services and management of battle fatigue (BF) and stress-related casualties.
 - Providing consultation service for patients referred from unit-level medical treatment elements.
 - Reinforcing or reconstituting unit-level medical elements, to include technical supervision of PAs in units with organic medical platoons without assigned physician(s).

2-3. Command and Technical Relationships

The ASMB commander exercises C2 over the battalion and over medical units/elements attached or assigned to the battalion. He exercises C2 over subordinate elements according to the mission assigned within the framework of the intentions of the next higher command. The ASMB is under the overall command of the MEDCOM/brigade. The ASMB commander, his staff, and subordinate medical commanders employ direct channels of communications on technical and clinical matters. The ASMB commander makes all fundamental decisions in his area of responsibility.

a. Headquarters and Headquarters Detachment Commander. The HHD commander exercises C2 over all elements assigned to his detachment, less OPCON of the battalion headquarters elements.

b. Area Support Medical Company Commander. The ASMC commander exercises C2 over all elements of the ASMC. He serves as the staff surgeon for supported units and provides technical guidance and assistance when required. He provides technical guidance to any Echelon I medical element operating within his AO. He advises commanders of units without organic CHS on the health and welfare of their commands.

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c. *Area Support Medical Battalion Staff.* The ASMB staff provides the commander with factual and timely information. Staff personnel prepare, analyze, estimate, and recommend feasible courses of actions. The staff translates the commander's decisions into instructions and orders, issues those orders, and supervises their execution. Staff members resolve the problems and make decisions within their functional areas based on the commander's intent, guidance, and TSOPs. An efficient, well-organized, and highly motivated staff can accomplish routine things smoothly and effectively. The commander, however, identifies goals and announces what must be done; the staff supports his decisions and ensures they are carried out.

Section II. COMMUNICATIONS

2-4. Battalion Communications

Effective management and control of battalion CHS operations are dependent on the battalion headquarters' ability to communicate with its subordinate ASMCs, ASMDs corps MEDCOM/brigade, corps medical elements, supporting elements, and with the supported units. Communication assets available to the ASMB include radios (amplitude modulation [AM] and frequency modulation [FM]), satellite communications (SATCOM) systems, and mobile subscriber equipment (MSE). Communications support is also provided by the signal unit operating in the area of support.

a. *Staff Responsibilities.* Each staff element of the battalion is responsible for following signal support policies, procedures, and standards in its functional operations. The battalion communications chief and company team chief must coordinate telecommunications interface requirements with the supporting signal unit. The signal unit integrates signal support systems within and between echelons.

b. *Mobile Subscriber Equipment Area Common User System.* The MSE system is the area common user voice communications system for all US Army corps and divisions (Active and Reserve Components). It is the backbone of the corps system and will be deployed from the corps rear boundary forward to the maneuver battalion's main command post (CP). It provides a secure mobile, survivable communications system capable of passing voice, data, and facsimile (FAX) throughout the corps. Additionally, it provides a direct interface to EAC, other Services, NATO, combat net radios, and commercial communications systems. The MSE system is composed of multiple communications nodes with network features that will automatically bypass and reroute communications around damaged or jammed nodes. This system integrates the functions of transmission, switching, control, and terminal equipment (voice and data) into one system; it provides the user with a switched telecommunications system extended by mobile radiotelephones and is integrated within the corps/division force structure. Nodes are deployed from the corps rear boundary forward to the maneuver brigade rear area based on geographical and subscriber density factors. Node centers (NCs) make up the system's backbone, and extension switches let wire line terminal subscribers (telephone, FAX, and data) enter into the total area communications system. Radio access units (RAUs) let mobile radiotelephone users communicate with other mobile and wire telephone users throughout the AO. The system control centers provide the processing capability to assist in overall network management. The MSE system lets subscribers communicate with each other

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using fixed directory numbers, regardless of a subscriber's battlefield location. The MSE system is comprised of the following five functional areas:

- Area coverage.
- Subscriber terminals (fixed).
- Wire subscriber access.
- Mobile subscriber terminal access.
- System control.

The ASMB will participate in the first four of the above functional areas.

(1) *Area coverage.* Area coverage means that the MSE system provides common user support to a geographic area, as opposed to dedicated support to a specific unit or customer. These NCs are under the control of the corps signal officer.

(2) *Subscriber terminal (fixed).* The MSE telephone, mobile radiotelephone, FAX, and data terminal, as part of the area common user system (ACUS), are user-owned and operated. The ASMB is responsible for running wire to the designated junction boxes. These boxes tie the ASMB MSE telephones into the extension switches that access the system. The subscriber terminals used by the unit are digital telephones providing full duplex, four-wire voice, as well as data ports for interfacing the AN/UXC-7 FAX, the Tactical Army Combat Service Support (CSS) Computer System (TACCS), the Army Tactical Command and Control System (ATCCS), and the transportable computer unit as depicted in Figure 2-4.

(3) *Wire subscriber access.* Wire subscriber access points provide the entry points (interface) between fixed subscriber terminal equipment owned and operated by users and the MSE area system operated by the supporting signal unit. Figures 2-5 through 2-7 show the MSE switchboard configurations through which an ASMB may tie into the area system. The two types of interface equipment are the—

- Signal distribution panel (junction box) J-1077. Each panel provides up to 13 subscriber access points.
- Remote multiplexer combiners that provide access for 8 subscriber access points.

Normally the ASMB will interface through the panel. In either case, the ASMB is responsible for installing and operating fixed subscriber terminal instruments. It must also install and maintain the WF-16 field wire from the instruments to the interface points. The WF-16 field wire consists of two pairs of wires. One pair is olive drab and the other pair is brown. The olive drab pair has a ridge along the side for night identification.

(4) *Mobile subscriber terminal access.* The MSE mobile subscriber terminal is the AN/VRC-97 mobile subscriber radiotelephone terminal (MSRT). This MSRT, which consists of a very