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EMPLOYMENT OF THE COMBAT SUPPORT HOSPITAL

TACTICS, TECHNIQUES, AND PROCEDURES

HEADQUARTERS, DEPARTMENT OF THE ARMY

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PREFACE

Throughout history, much has been written on the confrontations and wars between nations. From the beginning, a major concern of the commander has been the health and fitness of his forces. Following all confrontations, an improvement in tactics and techniques has been sought to enhance the force's ability to win the decisive battle. Over the years, advancements in technology have given our commanders weapons with the lethality to destroy or generate casualties once thought to be impossible. These advancements in technology and battlefield strategy have caused support elements to strive to improve the effectiveness of their services. The Army Medical Department (AMEDD) has maintained the pace in the development and employment of battlefield medical techniques to provide responsive, quality combat health support (CHS) for the military forces.

The purpose of this publication is to describe the functions and employment of one of the CHS assets, the combat support hospital (CSH). This publication is designed for the hospital commander, his staff, and assigned personnel. It embodies doctrine based on Medical Force 2000 and the L-edition Table of Organization and Equipment (TOE) 08-705L000. The structural layout of the hospital is flexible and situationally determined (for example, mission requirements, commander's guidance, and terrain features). It requires intensive prior planning and training of all personnel to establish the facility. The staffing and organizational structure presented in this publication reflects those established in the L-edition TOE 08-705L000, effective as of this publication date. However, such staffing is subject to change to comply with Manpower Requirements Criteria outlined in Army Regulation (AR) 570-2 and can be subsequently modified by your modification TOE (MTOE).

This publication is in concert with Field Manual (FM) 8-10, FM 8-55, and Training Circular (TC) 8-13. Other FM 8-Series publications will be referenced in this publication. Users should be familiar with FM 100-5 and FM 100-10.

Echelon is a North Atlantic Treaty Organization (NATO) term used to describe levels of medical care. For the purposes of this publication, the terms "level" and "echelon" are interchangeable.

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This publication implements the following NATO International Standardization Agreements (STANAGs):

STANAG	TITLE
2068 Med	Emergency War Surgery (Edition 4) (Amendment 3)
2931	Orders for the Camouflage of the Red Cross and Red Crescent on Land in Tactical Operations

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

Use of trade or brand names in this publication is for illustrative purposes only and does not imply endorsement by the Department of Defense (DOD).

This chapter implements STANAG 2068 Med.

CHAPTER 1

HOSPITALIZATION SYSTEM IN A THEATER OF OPERATIONS

1-1. Combat Health Support in a Theater of Operations

a. A theater of operations (TO) is that portion of an area of war necessary for military operations and for the administration of such operations. The scenario depicts the size of the TO and the US Forces to be deployed. The theater is normally divided into a combat zone (CZ) and a communications zone (COMMZ). In some instances, the COMMZ may be outside the TO and located in offshore support facilities, Third Country support bases, or in the continental United States (CONUS). The CZ begins at the Army/corps rear boundary and extends forward to the extent of the commander's area of influence. The COMMZ begins at the corps rear boundary and extends rearward to include the area(s) needed to provide support to the forces in the CZ.

b. The mission of the AMEDD is to conserve the fighting strength. This mission of CHS is a continuous and an integrated function throughout the TO. It extends from the CZ back through the COMMZ and ends in CONUS. Combat health support maximizes the system's ability to maintain presence with the supported soldier, return injured, sick, and wounded soldiers to duty, and to clear the battlefield of soldiers who cannot return to duty (RTD). Patients are examined, treated, and identified as RTD or nonreturn to duty (NRTD) as far forward as is medically possible. Early identification is performed by the treating primary care provider and continues in the evacuation chain with constant reassessment. Patients requiring evacuation out of the division who are expected to RTD within the theater evacuation policy are evacuated to a corps and/or COMMZ hospital. Those patients classified as NRTD follow the evacuation chain for trauma care and stabilization for evacuation out of the theater.

1-2. Echelons of Combat Health Support

The CHS system within a TO is organized into four echelons of support which extend rearward throughout the theater (see Figure l-l). The system is tailored and phased to enhance patient identification, evacuation, treatment, and RTD as far forward as the tactical situation will permit. Hospital resources will be employed on an area basis to provide the utmost benefit to the maximum number of personnel in the area of operations (AO). Each echelon reflects an increase in capability, with the function of each lower echelon being contained within the capabilities of the higher echelon. Wounded, sick, or injured soldiers will normally be treated, returned to duty, and/or evacuated to CONUS (Echelon V) through these four echelons:

a. Echelon 1. This echelon is also known as unit level. Care is provided by designated individuals or elements organic to combat and combat support (CS) units and elements of the area support medical battalion (ASMB). Major emphasis is placed on those measures necessary to stabilize the patient (maintain airway, stop bleeding, prevent shock) and allow for evacuation to the next echelon of care.

(1) *Combat medic.* This is the first individual in the CHS chain who makes medically

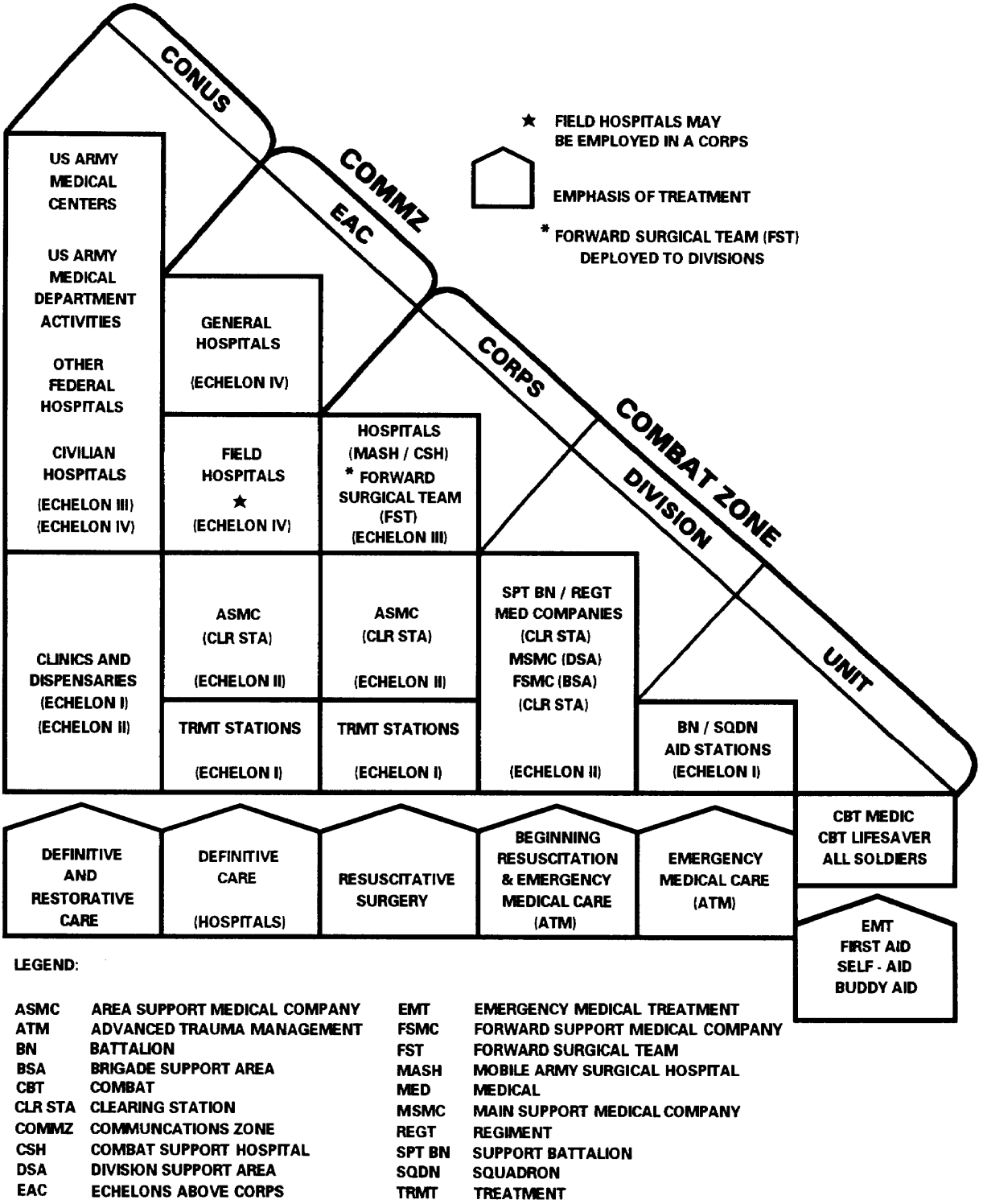


Figure 1-1. Echelons of combat health support.

substantiated decisions based on medical military occupational specialty (MOS)-specific training. The combat medic is supported by first-aid providers in the form of self-aid and buddy aid and the combat lifesaver.

(a) Self-aid and buddy aid. The individual soldier is trained to be proficient in a variety of specific first-aid procedures with particular emphasis on lifesaving tasks. This training enables the soldier, or a buddy, to apply immediate care to alleviate a life-threatening situation.

(b) Combat lifesaver. Enhanced medical training is provided to selected individuals who are called combat lifesavers. These individuals are nonmedical unit members selected by their commander for additional training to be proficient in a variety of first-aid procedures. A minimum of one individual per squad, crew, team, or equivalent-sized unit is trained. All combat units and some CS and combat service support (CSS) units have combat lifesavers. The primary duty of these individuals does not change. The additional duties of combat lifesavers are performed when the tactical situation permits. These individuals provide enhanced first-aid care for injuries prior to treatment by the combat medic. The training is normally provided by medical personnel assigned or attached to the unit. The training program is managed by a senior medical person designated by the commander.

(2) *Treatment squad.* The treatment squad consists of a field surgeon, a physician assistant (PA), two noncommissioned officers (NCOs), and four medical specialists. The personnel are trained and equipped to provide advanced trauma management (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. Each squad can split into two trauma treatment teams. These squads are organic to medical platoons/sections in maneuver battalions and designated CS units and medical companies of separate brigades, divisions, and echelons above division in the ASMB. Treatment squads (treatment teams) may be employed anywhere on the battlefield. When not engaged in ATM, these elements provide routine sick call services on an area basis. Echelon I care for units not having organic Echelon I capability is provided on an area basis by the organization responsible in the sector.

b. Echelon II. This echelon may also be known as division level. Care at this echelon is rendered at the clearing station (division or corps). Here the casualty is examined and his wounds and general status are evaluated to determine his treatment and evacuation precedences, as a single casualty among other casualties. Those patients who can RTD within 1 to 3 days are held for treatment. Emergency medical treatment (EMT) (including beginning resuscitation) is continued and, if necessary, additional emergency measures are instituted; but they do not go beyond the measures dictated by the immediate necessities. The division clearing station has blood replacement capability, limited x-ray and ambulatory services, patient holding capability, and emergency dental care. Clearing stations provide Echelon I CHS functions on an area basis to those units without organic medical elements. Echelon II CHS also includes preventive medicine (PVNTMED) activities and combat stress control (CSC). These functions are performed typically by company-sized medical units organic to brigades, divisions, and ASMBs.

c. Echelon III. The first hospital facilities are located at this echelon. Within the CZ, the mobile army surgical hospital (MASH) and the CSH are staffed and equipped to provide

resuscitation, initial wound surgery, and post-operative treatment. Although the MASH is an Echelon III facility, it is designed to be employed within the division area. At the CSH, patients are stabilized for continued evacuation, or returned to duty. Those patients who are expected to RTD within the theater evacuation policy are regulated to a facility that has the capability for reconditioning and rehabilitating.

d. Echelon IV. At this echelon, the patient may be treated at the general hospital (GH) or the field hospital (FH). The GHs are staffed and equipped for general and specialized medical and surgical care. Those patients not expected to RTD within the theater evacuation policy are stabilized and evacuated to CONUS. At the FH, reconditioning and rehabilitating services are provided for those patients who will be RTD within the theater evacuation policy.

e. Echelon V. This echelon of care is provided in CONUS. Hospitalization is provided by DOD hospitals (military hospitals of the triservices) and Department of Veterans Affairs (DVA) hospitals. Under the National Disaster Medical System, patients overflowing DOD and DVA hospitals will be cared for in designated civilian hospitals.

1-3. Theater Hospital System

a. Medical Force 2000 is the modernization effort to restructure the CHS system including hospitalization in support of a TO. This system consists of four hospitals, a medical company, holding, and six medical/surgical teams. The two corps hospitals are the MASH and the CSH. The two COMMZ hospitals are the FH and the GH. In addition to these hospitals, the medical company, holding, provides a 1,200-cot convalescent capability. For a detailed discussion on the Medical Force 2000 hospital system, refer to FM 8-10.

(1) *Mobile army surgical hospital.* This hospital is a 30-bed facility with the primary mission of providing lifesaving surgical and medical care to stabilize patients for further evacuation, either to the CSH or to COMMZ hospitals. Patients are held approximately 24 to 36 hours until considered stable enough to tolerate a bed-to-bed transfer without incurring further risk to their condition. The MASH will be employed in the corps area or forward in the division rear area. This hospital is not Deployable Medical Systems (DEPMEDS)-equipped. It is 100 percent mobile with organic vehicles.

(2) *Forward surgical team.* A forward surgical team (FST) will replace the two surgical squads in each of the following: the airborne division; the air assault division; and the 2d Armored Cavalry Regiment (ACR). The FSTs will also replace the medical detachment (surgical) and the 30-bed MASH. This team will be a corps augmentation for divisional and nondivisional medical companies. It will provide emergency/urgent initial surgery and nursing care after surgery for the critically wounded/injured patient until sufficiently stable for evacuation to a theater hospital. The FSTs not organic to divisions and the 2d ACR will be assigned to a medical brigade or group and normally attached to a corps hospital when not operationally employed and further attached for support to a divisional/nondivisional medical company.

(3) *Combat support hospital.* This hospital is addressed in detail in the following chapters of this publication.

(4) *Field hospital.* This hospital is a 504-bed facility with the mission of providing hospitalization for patients and for reconditioning and rehabilitating those patients who can RTD

within the theater evacuation policy. The majority of patients within this facility will be in the convalescent care category. The FH is normally located in the COMMZ, but could be used in the corps rear when geographical operational constraints dictate. It is 20 percent mobile with organic vehicles.

(5) *General hospital.* This organization is a 476-bed facility with the mission of providing stabilization and hospitalization for patients who require either further evacuation out of the TO, or who can RTD within the theater evacuation policy. The GH will normally be located in the COMMZ. Its mobility is 10 percent with organic vehicles.

(6) *Medical company, holding.* This unit provides reconditioning and rehabilitation for up to 1,200 convalescent care patients. This unit may be located in the corps or COMMZ. It is used to augment the CSH when operational necessity dictates. It may also be used in the 3-week CSC reconditioning program. This unit is staffed and equipped to provide care for minimal category (self-care) patients.

b. The CSH, FH, and GH are designed using the following four modules:

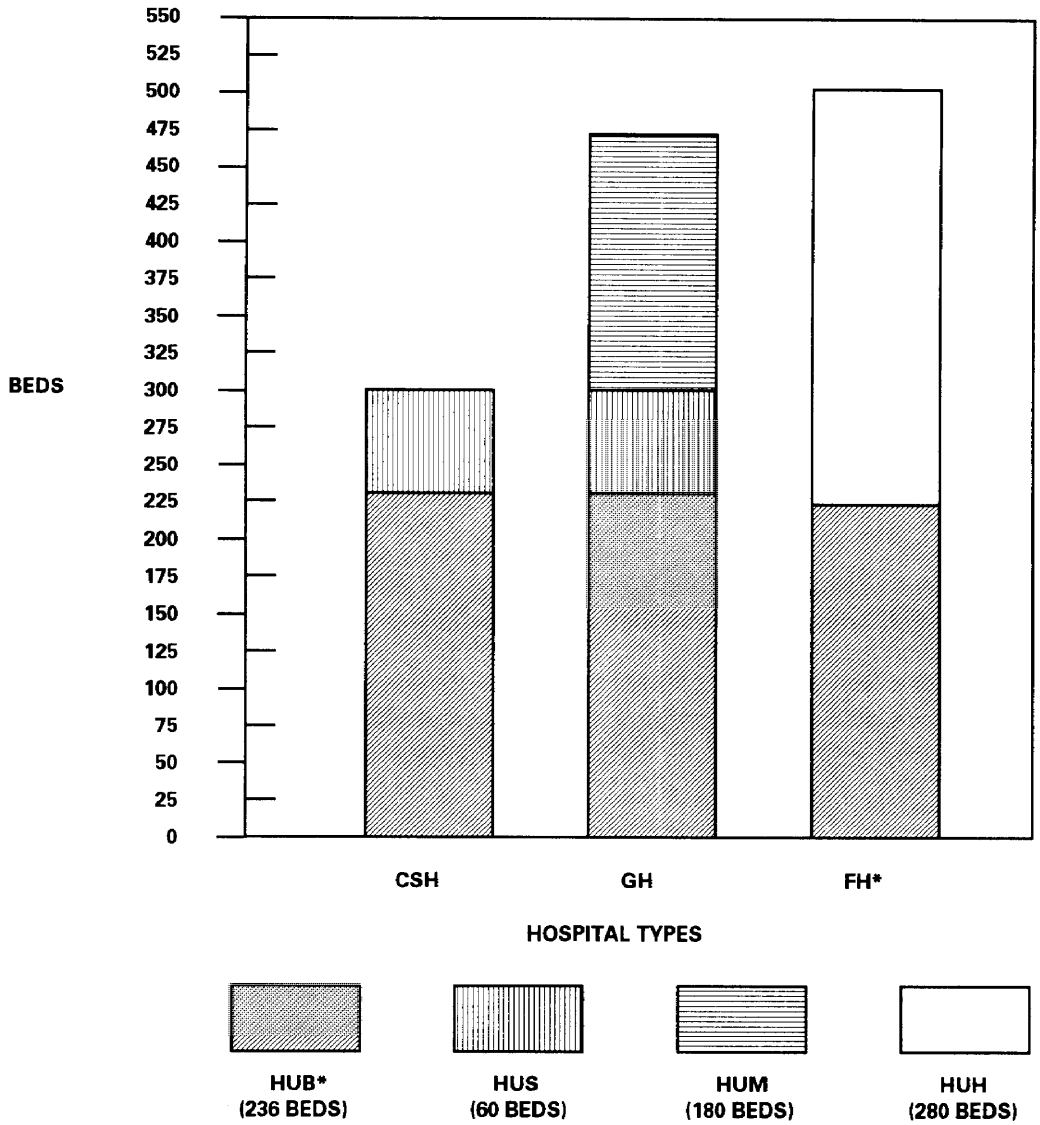
(1) Hospital unit, base (HUB).

(2) Hospital unit, surgical (HUS).

(3) Hospital unit, medical (HUM).

(4) Hospital unit, holding (HUH).

They are configured using the appropriate combination of these modules. The HUB can operate independently, is clinically similar, and is located in each hospital as the initial building block. The other three mission-adaptive modules (HUS, HUM, and HUH) are dependent upon the HUB (see Figure 1-2, page 1-6.



* ALTHOUGH THE HUB HAS 236 BEDS, WHEN IT IS USED AS THE BASE COMPONENT FOR THE FH, IT IS ONLY STAFFED TO PROVIDE HOSPITALIZATION FOR 224 PATIENTS. IN THE FH CONFIGURATION, THE HUB HAS TWO INTENSIVE CARE WARDS THAT PROVIDE CARE FOR UP TO 24 PATIENTS. BY CONTRAST, IN THE CSH AND GH CONFIGURATIONS, THE HUB HAS THREE INTENSIVE CARE WARDS THAT PROVIDE CARE FOR UP TO 36 PATIENTS. THIS IS THE REASON FOR THE 12-PATIENT DIFFERENCE IN THE FH CONFIGURATION.

CHAPTER 2

THE COMBAT SUPPORT HOSPITAL

2-1. Mission and Allocation

The mission of this hospital is to provide resuscitation, initial wound surgery, post-operative treatment, and RTD those soldiers in the CZ who fall within the corps evacuation policy, or to stabilize patients for further evacuation. This hospital is capable of handling all types of patients. It has a basis of allocation of 2.4 hospitals per division.

2-2. Assignment and Capabilities

a. The CSH is assigned to the Headquarters and Headquarters Company (HHC), Medical Brigade, TOE 08-422L100. The hospital may be further attached to the Headquarters and Headquarters Detachment (HHD), Medical Group, TOE 08-432L000.

b. This unit provides hospitalization for up to 296 patients. The hospital has eight wards providing intensive nursing care for up to 96 patients, seven wards providing intermediate nursing care for up to 140 patients, one ward providing neuropsychiatric (NP) care for up to 20 patients, and two wards providing minimal nursing care for up to 40 patients.

c. Surgical capacity is based on eight operating room (OR) tables for a surgical capacity of 144 OR table hours per day.

d. Other capabilities include—

- Consultation services for patients referred from other medical treatment facilities (MTFs).
- Unit-level CHS for organic personnel only.
- Pharmacy, clinical laboratory, blood banking, radiology, physical therapy, and nutrition care services.
- Medical administrative and logistical services to support work loads.
- Dental treatment to staff and patients and oral and maxillofacial surgery support for military personnel in the immediate area plus patients referred by the area CHS units.

2-3. Hospital Support Requirements

In deployment and sustainment of operations, this unit is dependent upon appropriate elements of the corps for—

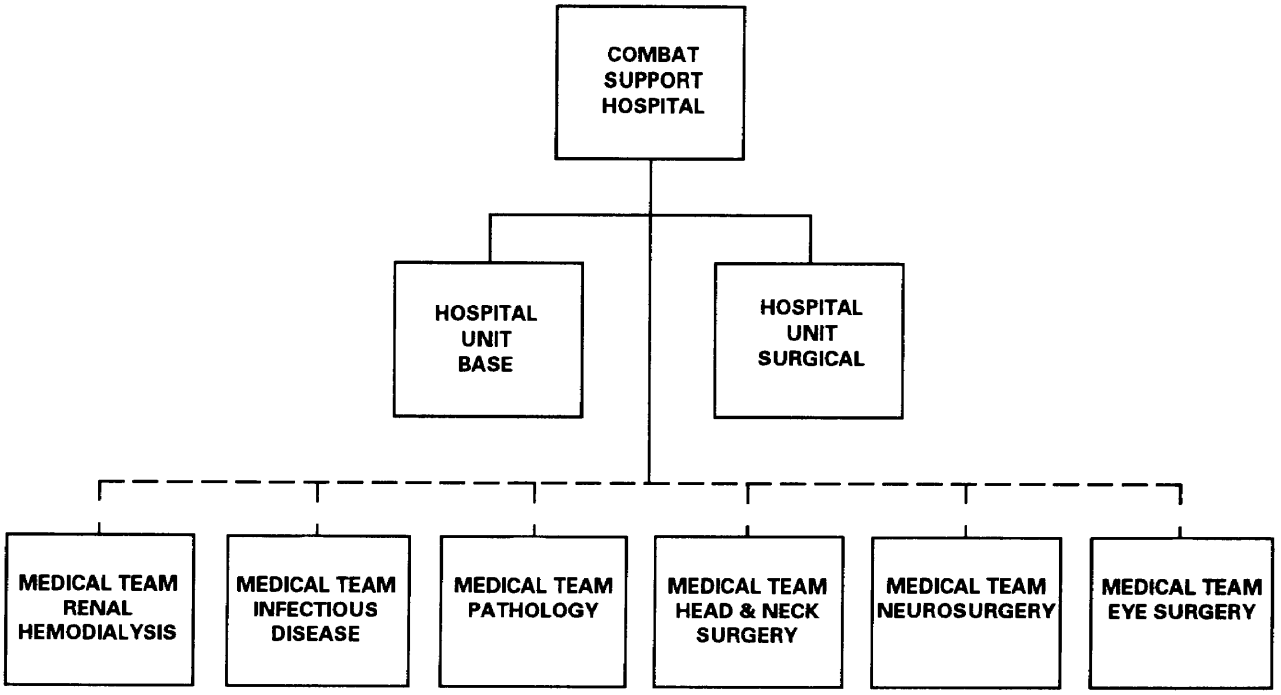
- Personnel administrative services.
- Finance.
- Mortuary affairs and legal services.
- Transportation services (unit is 35 percent mobile with organic assets).
- Laundry services for other than patient-related linen.
- Security and enemy prisoner of war (EPW) security during processing and evacuation.
- Transportation for discharged patients.
- Class I supplies (rations) to include the Medical B Rations required for patient feeding.
- Engineer support for site preparation, waste disposal, and minor construction.

- Veterinary support for zoonotic disease control and investigation; inspection of medical and nonmedical rations, to include suspected contaminated rations and disposition recommendations; and animal bites.

- PVNTMED support for food facility inspection, vector control, and control of medical and nonmedical waste.

2-4. Hospital Organization and Functions

The CSH is a modular-designed facility which consists of a HUB and HUS. It can be further augmented with specialty surgical/medical teams to increase its capabilities. It may become a designated specialty center as the work load or mission dictates (Figure 2-1).



NOTE: DEPENDING UPON OPERATIONAL REQUIREMENTS, THE MEDICAL AND SURGICAL TEAMS MAY OR MAY NOT BE ATTACHED TO THE INDIVIDUAL CLINICAL ELEMENT OF THE CSH.

Figure 2-1. Combat support hospital organization.

a. The HUB is a 236-bed facility which has 36 intensive, 140 intermediate, 40 minimal, and 20 NP care beds. It has two OR modules, one surgical and the other orthopedic, which are staffed to provide a total of 72 OR table hours per day. It also allows for attachment of specialty surgical teams. The HUB is an independent organization which includes all hospital services (Figure 2-2).

b. The HUS is comprised of 60 intensive care beds, two OR modules, one x-ray module, one triage/preoperative/EMT module, and the appropriate staffs (Figure 2-3, page 2-5). The HUS is dependent on the HUB for food service, maintenance, and administration.

c. When the HUB and HUS are employed to form a single hospital, half of the OR tables are staffed for two 12-hour shifts with the other half only staffed for one 12-hour shift per day.

2-5. The Hospital Unit, Base

The HUB provides a solid infrastructure for the CSH operations. The HUB contains the following sections:

a. Hospital Headquarters Section. This section provides internal command and control (C2) and management of all hospital services. Personnel of this section supervise and coordinate the surgical, nursing, medical, pastoral, and administrative services. Stafflng includes the HUB commander, the chiefs of surgery, nursing, and medicine, an executive officer (XO), a chaplain, a command sergeant major (CSM), and an administrative specialist (Table 2-1). When the HUB and the HUS join to function as a CSH, the HUB commander is the CSH commander unless otherwise designated.

Table 2-1. Hospital Headquarters Organization

HOSPITAL HEADQUARTERS			
HOSPITAL COMMANDER	COL	60A00	MC
CHIEF, SURGICAL SERVICE	COL	61J00	MC
CHIEF, NURSING SERVICE	COL	66A00	AN
CHIEF, MEDICAL SERVICE	LTC	61F00	MC
EXECUTIVE OFFICER	LTC	67A00	MS
HOSPITAL CHAPLAIN	MAJ	56A00	CH
COMMAND SERGEANT MAJOR	CSM	00Z50	NC
ADMINISTRATIVE SPECIALIST	SGT	71L20	NC

(1) *Hospital commander (60A00).* Command and control is the process through which the activities of the hospital are directed, coordinated, and controlled to accomplish the mission. This process begins and ends with the commander. An effective commander must have a thorough knowledge and understanding of planning and implementing CHS (FM 8-55). He is decisive and provides specific guidance to his staff in the execution of the mission. The successful commander delegates authority and fosters an organizational climate of mutual trust, cooperation, and teamwork. He has the overall responsibility for coordination of CHS within the hospital's AO. Additionally, he is responsible for the structural layout of the hospital.

(2) *Chief, surgical service (61J00).* The chief surgeon is the principal advisor to the hospital commander for surgical activities. He provides supervision and control over the surgical services to include the ORs. He prescribes courses of treatment and surgery for patients having injuries or disorders with surgical conditions and participates in surgical procedures as required. He coordinates and is responsible for all matters pertaining to the evaluation, management, and disposition of patients received by the section. He is responsible for the evaluation and training programs for his professional staff. He also functions as the Deputy Commander for Professional Services.

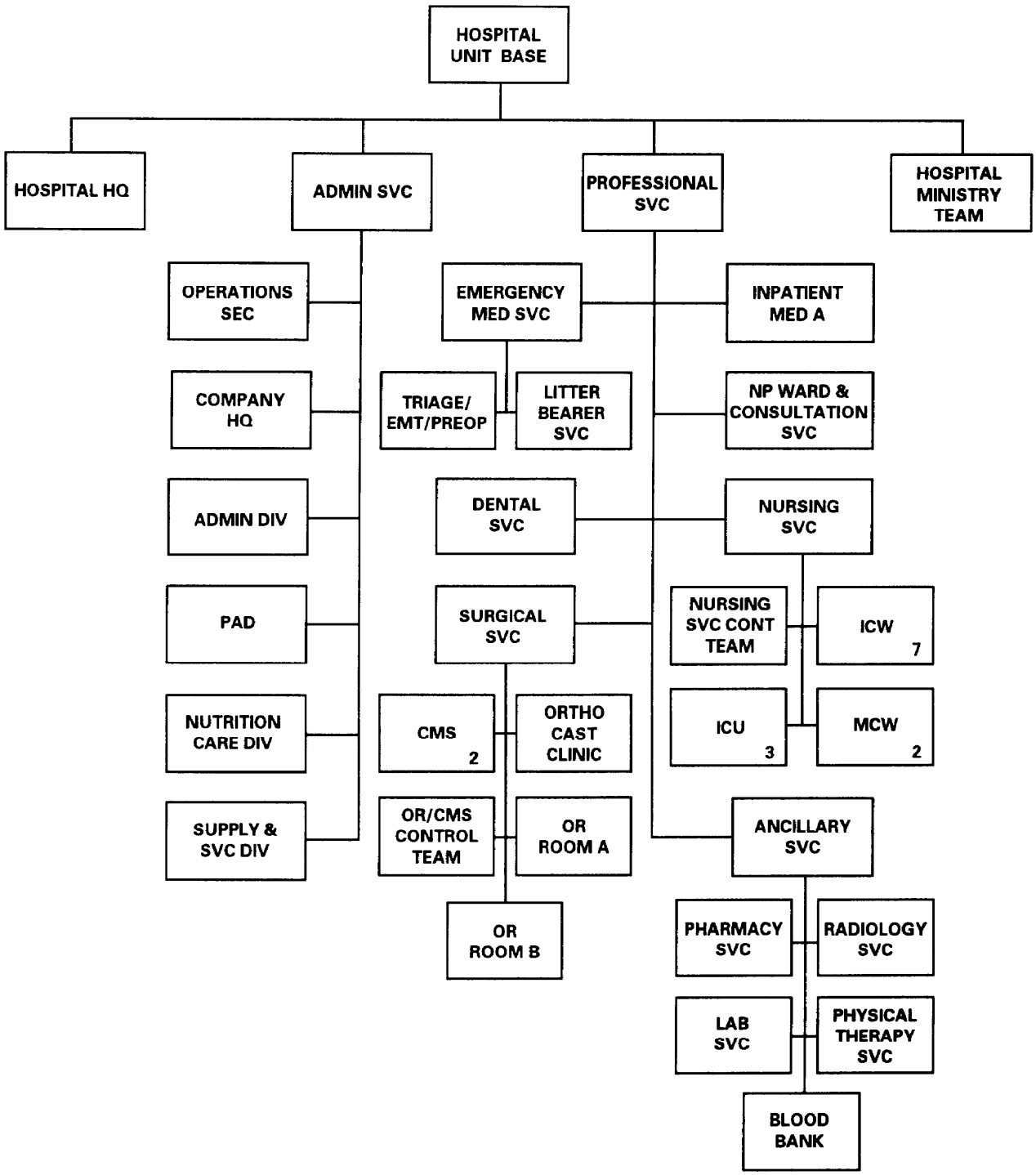


Figure 2-2. Hospital, unit, base.

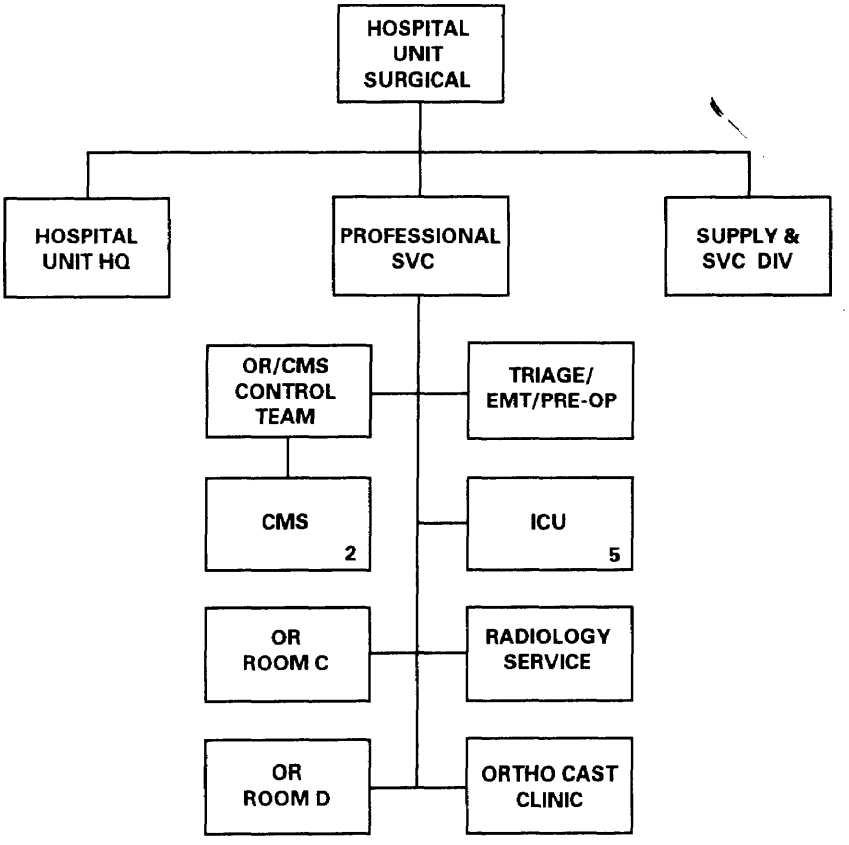


Figure 2-3. Hospital, unit, surgical.

(3) *Chief nurse (66A00).* The chief nurse is the principal advisor to the hospital commander for nursing activities. This officer plans, organizes, supervises, and directs nursing care practices and activities of the hospital. This officer is also responsible for the orientation and professional development programs for the nursing staff.

(4) *Chief, medicine services (61F00).* This officer is responsible for the examination, diagnoses, and treatment, or recommended course of management for patients with medical illnesses. He controls the length of patient stay through continuous patient evaluation, early determination of disposition, or evacuation to the next echelon of care.

(5) *Executive officer (67A00).* The hospital XO advises the commander on matters pertaining to health care delivery. He plans, directs, and coordinates administrative activities for the hospital. He provides guidance to the tactical operations center (TOC) staff in planning for future operations. He also functions as the Chief, Administrative Service.

(6) *Hospital chaplain (56A00).* The chaplain functions as the staff officer for all matters in which religion impacts on command programs, personnel, policy, and procedures. He provides for the spiritual well-being and morale of patients and hospital personnel. He also provides religious services and pastoral counseling to soldiers in the AO.

(7) *Command sergeant major (00Z50).* The CSM is the principal enlisted representative to the commander. He advises the commander and staff on all matters pertaining to welfare and morale of enlisted personnel in terms of assignment, reassignment, promotion, and discipline. He provides counsel and guidance to NCOs and other enlisted personnel of the hospital. He is also responsible for the reception of newly assigned enlisted personnel into the unit. The CSM evaluates the implementation of individual soldier training on common soldier tasks and supervises the hospital's NCO professional development.

(8) *Administrative specialist (71L20).* The administrative specialist performs typing, clerical, and administrative duties for the hospital headquarters. He proofreads correspondence for proper spelling, grammar, punctuation, format, and content accuracy. He establishes and maintains files, logs, and other statistical information for the command. He is the light-vehicle driver and radio operator for the command section.

b. Hospital Operations Section. This section is responsible for communications (internal and external), security, plans and operations, deployment, and relocation of the hospital. The staff is composed of a medical operations officer, a field medical assistant, an operations NCO, a nuclear, biological, and chemical (NBC) NCO, an administrative specialist, and appropriate communications personnel (Table 2-2). The authorization for the field medical assistant is counted in the HUS.

Table 2-2. Hospital Operations Section Organization

HOSPITAL OPERATIONS SECTION			
MEDICAL OPERATIONS OFFICER	MAJ	70H67	MS
FIELD MEDICAL ASSISTANT	CPT	70B67	MS
OPERATIONS SERGEANT	SFC	91B40	NC
SECTION CHIEF	SFC	31U40	NC
NUCLEAR, BIOLOGICAL, AND CHEMICAL NCO	SFC	54B40	NC
ELECTRONIC SWITCH SYSTEMS OPERATOR	SGT	31F20	NC
ELECTRONIC SWITCH SYSTEMS OPERATOR	SPC	31F10	
SIGNAL INFORMATION SERVICE SPECIALIST	SPC	31U10	
ADMINISTRATIVE SPECIALIST	SPC	71L10	
ELECTRONIC SWITCH SYSTEMS OPERATOR	PFC	31F10	
SIGNAL SUPPORT SYSTEMS SPECIALIST	PFC	31U10	

(1) *Medical operations officer (70H67).* This officer is responsible to the XO for the Intelligence Officer/Operations and Training Officer (S2/S3) functions of the hospital. He supervises all tactical operations conducted by the hospital to include planning and relocation. He is responsible for the formulation of the tactical standing operating procedures (TSOP) and hospital planning factors (refer to Appendix A for an example of a TSOP format and Appendix B for an estimate of hospital planning factors).

(2) *Field Medical Assistant (70B67).* This officer is responsible to the medical operations officer for planning and coordinating site selection and convoy operations during hospital deployment and relocation. He also functions as the operations security (OPSEC) and communications security (COMSEC) officer for the hospital. The requirement for this position is counted in the unit headquarters section (HUS). When the HUB and HUS form a CSH, the field medical assistant, HUS becomes the field medical assistant in this section.

(3) *Operations sergeant (91B40).* The operations sergeant is responsible to the medical operations officer for physical security, to include the hospital defense plan; preparation of unit plans, operation orders (OPORDs) and map overlays; and intelligence information and records. He also supervises subordinate staff.

(4) *Section chief (31U40).* This NCO serves as the principal signal advisor to the hospital commander and medical operations officer on all communications matters. He is responsible to the medical operation and plans officers for the planning, supervising, coordinating, and technical assistance in the installation, operation, management, and operator-level maintenance of radio, field wire, and switchboard communications systems. He supervises all subordinate communications personnel.

(5) *Nuclear, biological, and chemical noncommissioned officer (54B40).* This NCO is the technical advisor to the hospital commander and medical operations officer on matters pertaining to NBC operations. He is responsible to the medical operations officer for the planning, training, NBC decontamination (less patient), and other aspects of hospital NBC defensive operations.

(6) *Electronic switch systems operator (31F20).* This operator is responsible to the section chief for the installation, operation, and operator-level maintenance of switchboards and switching systems.

(7) *Electronic switch systems operator (31FI0).* These operators are responsible to the section chief for the installation, operation, and unit-level maintenance on switchboards, switching assemblages, and associated communications equipment.

(8) *Signal information service specialist (31UIO).* This individual is responsible to the section chief for installation and operation of unit wire systems, associated equipment, and frequency modulated (FM) radios.

(9) *Administrative specialist (7L10).* This individual is responsible to the operations sergeant for general typing and administrative functions for the section.

(10) *Signal support systems specialist (31UI0).* This individual is responsible to the section chief for installing wire for field telephones and assisting in the operation of the hospital FM radios.

c. Company Headquarters. This section is responsible for company-level command, duty rosters, weapons control, and mandatory training. Staffing includes the company headquarters commander, the first sergeant, a decontamination specialist, an administrative clerk, and an armorer (Table 2-3).

Table 2-3. Company Headquarters Organization

COMPANY HEADQUARTERS			
COMPANY COMMANDER	CPT	70B67	MS
FIRST SERGEANT	MSG	91B5M	NC
DECONTAMINATION SPECIALIST	SPC	54B10	
ADMINISTRATIVE CLERK	SPC	71L10	
ARMORER	SPC	92Y10	

(1) *Company commander (70B67).* The company commander is responsible to the XO for all activities in the company headquarters. He administers Uniform Code of Military Justice (UCMJ) actions for enlisted personnel; plans and conducts common task training; and functions as the commander of the medical holding detachment, when assigned. When the HUB and HUS are employed to form the CSH, the medical holding detachment is assigned as dictated by the medical mission.

(2) *First sergeant (91B5M).* The first sergeant is responsible to the company commander for enlisted matters. He also assists in supervising company administration and training activities. He provides guidance to the enlisted members of the company and represents them to the company commander. He also functions as the reenlistment NCO.

(3) *Decontamination specialist (54B10).* This specialist is responsible to the first sergeant for training the company's NBC teams on the operation of NBC detection and decontamination equipment and for the operator maintenance on this equipment. He assists the NBC NCO in the establishment, administration, training, and application of NBC defense measures. He also performs NBC reconnaissance and is designated as a light-vehicle operator.

(4) *Administrative clerk (71LI0).* The clerk-typist is responsible to the first sergeant for providing the personnel and unit administration support for the company headquarters. His duties consist of general administration and personnel actions.

(5) *Armorer (92YI0).* The armorer's primary duty is that of maintaining the weapons storage area, small arms, and ammunition and performing small arms unit maintenance. He is designated as the light-vehicle operator for the section.

d. *Administrative Division.* This division provides overall administrative services for the hospital to include personnel administration, mail distribution, awards and decorations, leaves, and typing support. The staff is composed of the hospital adjutant, personnel sergeant, personnel administrative sergeant, an administrative specialist, mail delivery clerks, and an administrative clerk (Table 2-4). This section coordinates with elements of corps support command (COSCOM) for finance, personnel, and administrative services.

Table 2-4. Administrative Division Organization

ADMINISTRATIVE DIVISION			
HOSPITAL ADJUTANT	CPT	70F67	MS
PERSONNEL SERGEANT	SFC	75Z40	NC
PERSONNEL ADMINISTRATIVE SERGEANT	SGT	75B20	NC
ADMINISTRATIVE SPECIALIST	SPC	71L10	
MAIL DELIVERY CLERK	PFC	71L10	(3)
ADMINISTRATIVE CLERK	PFC	71L10	

(1) *Hospital adjutant (70F67).* This officer is responsible to the hospital XO for the adjutant functions within the hospital. He also advises the commander and staff in the area of personnel management for patients and staff.

(2) *Personnel sergeant (75240).* The personnel sergeant is responsible to the adjutant for specific personnel functions which include personnel management, records, actions, and preparation of Standard Installation/Division Personnel System (SIDPERS) changes. He ensures coordination between the medical brigade and/or medical group Personnel and Administration Center (PAC) and the hospital. He advises the hospital commander, adjutant, and other staff members on personnel administrative matters. He also supervises the activities of subordinate personnel.

(3) *Personnel administrative sergeant (75B20).* This individual is responsible to the personnel sergeant for personnel and administrative functions for the hospital.

(4) *Administrative specialists (71L10).* These specialists are responsible to the personnel sergeant for general typing and administrative functions for the division.

(5) *Mail delivery clerks (71L10).* These administrative specialists are responsible