

FM 8-10-9

**COMBAT HEALTH
LOGISTICS
IN A THEATER OF
OPERATIONS**

TACTICS, TECHNIQUES, AND PROCEDURES

HEADQUARTERS, DEPARTMENT OF THE ARMY

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TACTICS, TECHNIQUES, AND PROCEDURES****TABLE OF CONTENTS**

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PREFACE

This publication sets forth tactics, techniques, and procedures for the combat health logistics system (CHLS) in a theater of operations (TO). It embodies doctrine based on Medical Force 2000 (MF2K). It is designed for use by combat health logisticians and medical commanders and staffs; combat service support (CSS) commanders and their staffs; and logisticians of other military Services.

The organizational structures presented in this publication reflect those established in the living table(s) of organization and equipment (LTOE) in effect as of this publication date.

The proponent of this publication is the United States (US) Army Medical Department Center and School (AMEDDC&S). Send comments and recommendations on Department of the Army (DA) Form 2028 (or facsimile) directly to **Commander, AMEDDC&S, ATTN: MCCS-FCD-L, Fort Sam Houston, Texas 78234-6175.**

This publication implements the following North Atlantic Treaty Organization (NATO) International Standardization Agreements (STANAGs) and American, British, Canadian, and Australian (ABCA) Quadripartite Standardization Agreements (QSTAGs):

NATO STANAG	ABCA QSTAG	TITLE
	815	Blood Supply in the Area of Operations
2068 Med	322	Emergency War Surgery (Edition 4) (Amendment 3)
2961		Classes of Supply for NATO Land Forces

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

CHAPTER 1

INTRODUCTION TO COMBAT HEALTH LOGISTICS

1-1. General

This chapter provides an overview of the combat health support (CHS) system and the functional area of combat health logistics. It provides the basis to enhance the understanding of the remaining chapters of this publication which are devoted to the CHLS.

1-2. Scope of Combat Health Support Operations

a. Today's Army must focus on preventing aggression through strength with a smaller force primarily based in the continental United States (CONUS). Future battlefields will be established based upon regional conflicts, most likely in areas where there are not forward deployed US Forces. Combat health support assets of the Army Medical Department (AMEDD) must be tailorable for specific missions to support the Army's role of *force projection* in deterring the threat of global war and future uncertainties.

b. Combat health support will be required for US military forces in three diverse environments—

(1) *Peacetime*. In this environment, the US attempts to influence world events through actions which routinely occur between nations. Use of Army forces in peacetime helps keep the day-to-day tensions between nations below the threshold of conflict. The execution of military operations will be consistent with the peacetime limitations imposed by legislation, departmental policy or regulations, budgetary considerations, local conditions, and other specific conditions prescribed by the Secretary of Defense (SECDEF) or the Chairman of the Joint Chiefs of Staff. Typical peacetime operations include, but are not limited to—

- Disaster relief.
- Nation assistance.
- Security and advisory assistance.
- Counterdrug operations.
- Arms control.
- Support to domestic civil authorities.
- Peacekeeping.
- Humanitarian assistance and disaster relief.
- Noncombatant evacuation.

(2) *Conflict*. This type of environment is characterized by confrontation and the need to engage in hostilities short of war to secure strategic objectives. Operations are normally undertaken to avert crisis after a catastrophic event or in support of diplomatic initiatives.

NOTE

The Army classifies its activities during peacetime and conflict as *operations other than war* (OOTW).

(3) *War*. This is the most violent and high-risk environment with its associated combat operations. This environment may be further referred to as three levels—strategic, operational, and tactical.

For a detailed discussion on military operations, refer to Field Manual (FM) 100-5.

c. Current military operations have the potential to occur in a nuclear, biological, and chemical (NBC) or directed-energy (DE) environment. Although US policy does not condone the use of NBC weaponry, preparedness to operate in this type of environment negates many possible advantages for an enemy to employ those weapons. To be prepared is, in itself, a deterrent to their use. Combat health logisticians must consider and plan for NBC operations. Detailed information on providing NBC protection can be found in FM 3-3, FM 3-4, FM 3-5, and FM 8-10-7.

1-3. Medical Threat and Medical Intelligence

a. A major threat to US Forces deployed outside CONUS (OCONUS) manifests itself in the form of a medical threat. A medical threat is defined as the composite of all ongoing or potential enemy actions and environmental conditions that may render a soldier combat ineffective. The soldier's reduced effectiveness results from sustained wounds, injuries, stress-induced performance deterioration, or diseases. The elements of the medical threat include, but are not limited to—

- Diseases endemic to the area of operations (AO).
- Environmental factors (heat, cold, humidity, and significant elevations above sea level).
- Battle injuries from conventional, NBC, and DE weapons/devices.
- The level of compliance with the law of war and the Geneva Conventions requirements regarding "respect and protection" of medical personnel and medical facilities and transportation means.

1-2

- Physiologic and psychological stressors.

b. Medical intelligence is concerned with one or more of the medical aspects of foreign nations or AO and is significant to medical planning. Developing medical intelligence involves collecting, evaluating, analyzing, and interpreting foreign civilian and military medical, bioscientific, and environmental information. Until medical information is appropriately processed (ordinarily on a national level by the Armed Forces Medical Intelligence Center [AFMIC]), it is not considered to be medical intelligence.

c. For a more detailed discussion of medical threat elements, refer to FM 8-10, FM 8-10-8, and FM 8-42.

Paragraphs 1-4 and 1-5 implement STANAG 2088 Med and QSTAG 322.

1-4. Combat Health Support

a. Combat health support is an integral part of the CSS community. It plays a vital role in the protection of combat troops and enhances combat power. The basic CHS mission is to conserve the fighting strength. The mission objectives are to reduce the incidence of disease and nonbattle injuries (DNBI) through sound preventive medicine (PVNTMED) programs; to provide care and treatment for acute illnesses, injuries, and wounds; to evacuate patients to the appropriate medical treatment facility (MTF) commensurate with the requisite care; and to return soldiers to duty. Combat health support is employed to provide the most benefit to the maximum number of personnel.

b. Combat health support is modular in design and provides a continuum of care, from the point of injury through successive echelons of care, to definitive and rehabilitative hospitals in the CONUS sustaining base (Figure 1-1). It encompasses separate functions integrated into a single system providing CHS throughout the spectrum of military operations. These CHS functions are—

- Patient evacuation and medical regulating.
- Hospitalization.
- Combat health logistics, to include blood management.
- Dental services.
- Veterinary services.
- Preventive medicine services.
- Combat stress control (CSC) services.
- Area medical support.
- Command, control, communications, computers, and intelligence (C4I).
- Medical laboratory services.

c. Combat health support battlefield rules have been established by the AMEDD for use as guidelines in the development of appropriate medical organizations and force structure. These rules are to—

- 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.

1-5. Modular Medical Support

a. Combat health support in the division is provided by a modular medical support system that standardizes all medical subelements. The CHS modular design enables the CHS resources manager to rapidly tailor, augment, reinforce, or reconstitute the CHS units as needed. This system is designed to acquire, receive, and triage patients, and to provide emergency medical treatment (EMT) and advanced trauma management (ATM). Combat health support originates in the forward areas (divisions) with the combat medic (aidman). From this point, the patient is evacuated to the battalion medical platoon or section treatment squad (battalion aid station [BAS]), and then to the medical company treatment platoon (division clearing station).

b. Modular medical support is built around six modules. These modules are oriented to casualty collection, treatment, and return to duty (RTD) or evacuation.

(1) *Combat medic.* The combat medic module consists of one combat medical specialist and the prescribed load of medical supplies and equipment. Combat medics are organic to the medical platoons or sections of combat and combat support (CS) battalions and are attached to the companies of the battalions.

(2) *Ambulance squad.* An ambulance squad is comprised of four medical specialists

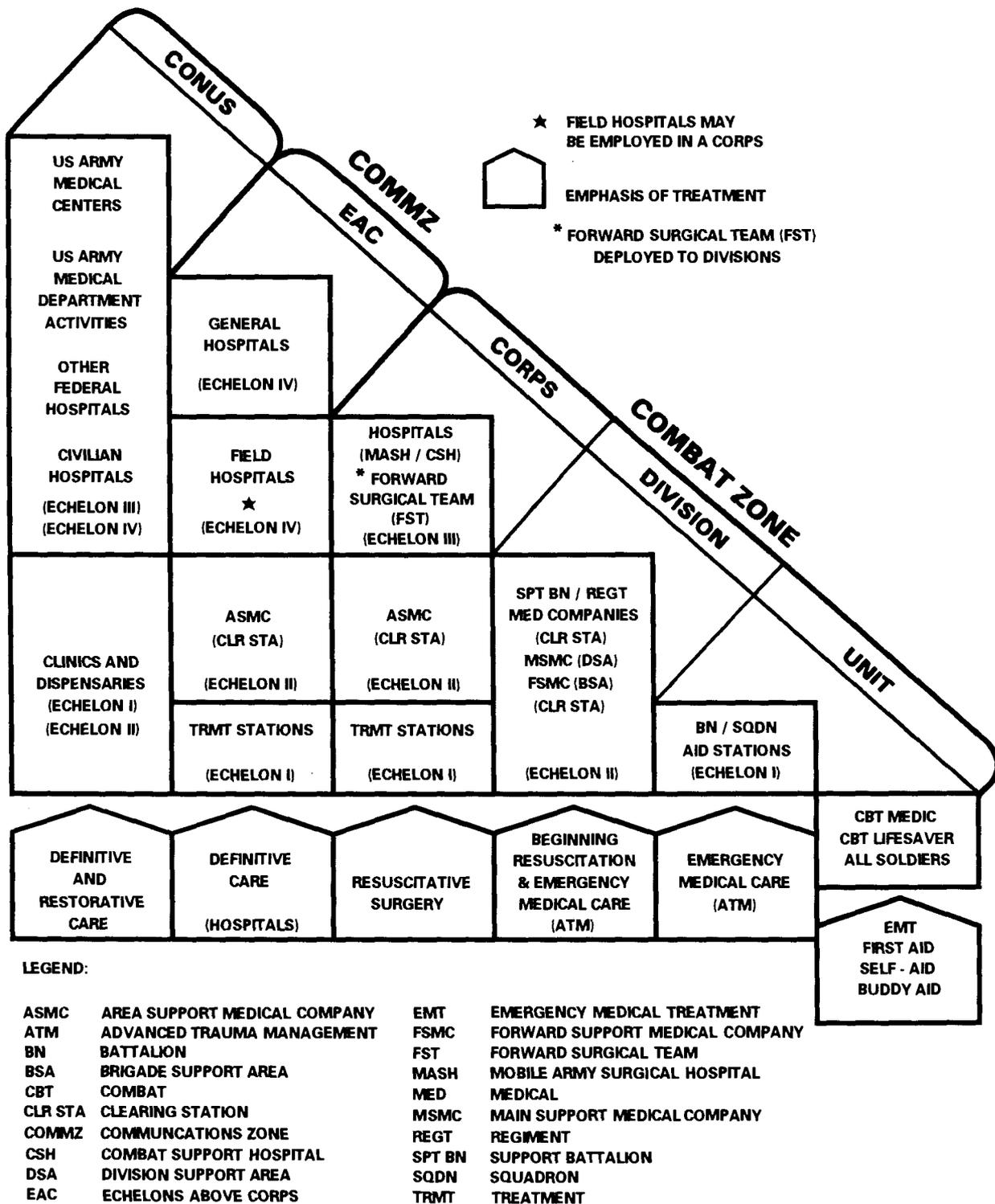


Figure 1-1. Echelons of combat health support.

and two ambulances. This squad provides patient evacuation throughout the division (and/or corps and communications zone [COMMZ]) and en route medical care. Ambulance squads are organic to the medical platoons or sections in maneuver battalions and division/nondivisional medical companies and the area support medical battalions (ASMBs). Medical company ambulance squads are employed in the brigade support area (BSA), division support area (DSA), corps support area (CSA), and in all areas of the COMMZ. The medical platoon's ambulance squads may be collocated with the companies of the maneuver battalions.

(3) *Treatment squad.* This squad consists of a primary care physician, a physician assistant (PA), and six medical specialists. The squad is trained and equipped to provide ATM to the battlefield casualty. Advanced trauma management is physician- or PA-directed emergency medical care designed to resuscitate and stabilize the patient for evacuation to the next echelon of medical care, or to treat and RTD. Advanced trauma management provides maximum benefit if received within 60 minutes of injury. To maintain contact with the combat maneuver elements, each squad has two emergency treatment vehicles equipped with trauma treatment medical equipment sets (MESs). Each squad can split into two treatment teams. These squads are organic to medical platoons or sections in maneuver battalions and designated CS units, as well as being the basic building block of the medical companies.

(4) *Area support squad.* This squad is comprised of one Dental Corps officer, a dental specialist, an x-ray specialist, and a medical laboratory specialist. The squad is organic to the medical companies of separate brigades, divisions, and area support medical companies (ASMCs) in the corps and COMMZ. The dental officer is ATM-trained and provides additional treatment capabilities to the clearing station during heavy patient loads.

(5) *Patient-holding squad.* This squad consists of two practical nurses and two medical specialists. It is capable of holding and providing minimal care for up to 40 (20 in the light infantry division) RTD patients. This squad is organic to the medical companies of separate brigades, divisions, armored cavalry regiments (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(s) of responsibility (AOR). The area support section normally operates in the BSA, DSA, and areas of high troop concentration in the CSA and COMMZ. The area support and patient-holding squads are incapable of independent operations.

(6) *Medical detachment (surgical) and surgical squad.* The medical detachment (surgical) is a corps asset and is an augmentation to Echelon II CHS. It deploys as far forward as necessary to support division/task-force operations. This detachment must collocate with a patient-holding squad for support. Each airborne and air assault division has two surgical squads which are organic to the main support medical company (MSMC) of the main support battalion (MSB). Both the corps medical detachment (surgical) and surgical squads organic to the airborne and air assault divisions have the same basic design. They are comprised of two surgeons, two nurse anesthetists, two operating room specialists, one medical/surgical nurse, and two practical nurses. They are organized to provide early resuscitative surgery for seriously wounded

or injured patients, to save lives, and to preserve physical function. Early surgery is performed whenever a likely delay in the evacuation of a patient threatens life or the quality of recovery. Postsurgical patients awaiting evacuation are held by the patient-holding squad with nursing care provided by the nurses of the surgical module. The task-force medical detachment (surgical) and organic surgical squads will normally be employed in the DSA, but may be employed in the BSA during task-force operations. Normally, the medical detachment (surgical) is attached to a treatment platoon and collocated with the division clearing station or possibly an ASMC.

(7) *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 ACR. The FSTs will also replace the medical detachment (surgical) and the 30-bed mobile army surgical hospital (MASH). This team will be a corps augmentation for divisional and non-divisional medical companies. It will provide emergency/urgent initial surgery and nursing care after surgery for the critically wounded/injured patients until they are 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.

1-6. Combat Health Logistics System

a. The Office of the Deputy Chief of Staff for Logistics (ODCSLOG) is the proponent office for all Army logistics policy. The Office of The Surgeon General (OTSG) and appropriate other medical command authorities manage and

direct combat health logistics (Class VIII). The Logistics Division, OTSG, has primary staff responsibility for developing policies and procedures and providing guidance in the area of medical materiel management. The US Army Medical Materiel Agency (USAMMA) is under control of the US Army Medical Research and Materiel Command. It has the mission of assisting The Surgeon General in the execution of his responsibilities for the management of medical materiel programs in support of Armywide combat health logistics.

b. The Class VIII supply system basically follows the requirements of Army Regulation (AR) 700-Series with exceptions provided in AR 40-61. The policies and procedures covered in AR 40-61 are unique to medical materiel and operations which are subject to regulations and standards of the Food and Drug Administration, the Environmental Protection Agency, the Drug Enforcement Agency, and the Joint Commission on Accreditation of Healthcare Organizations. Additionally, Class VIII supplies and equipment are afforded protective status under the provisions of the Geneva Conventions (see FM 8-10).

c. Logistics support may be executed by strategic, operational, or tactical logistics systems. These three levels of logistics support correlate to the three levels of war (FM 100-5).

(1) The strategic logistics system supports the attainment of broad goals and objectives established by the National Command Authorities in national security policies. It includes special activities under DA control and the national inventory control points (NICPs); national maintenance points; and depots, arsenals, data banks, plants, and factories associated with the US Army Materiel Command. Strategic functions are performed in CONUS and in the rear of the theater. See Appendix A for Class VIII strategic logistics.

(2) Operational logistics support the commander's plan in either a mature or immature theater. Operational logistics link strategic logistics to tactical logistics on the battlefield, ensuring support and success at the tactical level. Operational support attempts to balance the strategic planning requirements with the needs of tactical operations in joint and combined campaigns, major operations, and other military operations within an AO. Operational logistics are conducted by echelons above corps (EAC) and corps and below organizations to support tactical logistics. Chapters 2 through 6 discuss Class VIII support and support organizations at the operational and tactical levels.

(3) Tactical logistics include activities necessary to support military operations. At this level, the essential functions of supply, maintenance, transportation, technical assistance, personnel services support, CHS, and field services are delivered to soldiers to permit them to accomplish their mission. The AMEDD logistician focuses on Class VIII support to sustain the soldier.

d. The CHLS encompasses functional areas which are all tied together as a subsystem of the multifunctional CHS system. Combat health logistics is characterized by goals, policies, procedures, and organizational structures and is directly related to the overall CHS system. It interfaces as a facilitating-type subsystem responsive first and foremost to patient care and secondly to the Army's logistical system. The functional areas include—

- Materiel management (receiving, shipping, storage, and property accounting).
- Medical equipment maintenance and repair support.
- Prescription optical lens fabrication.

- Blood storage and distribution.

e. Basic to any logistical plan are the principles of anticipated user needs and continued support. These principles imply that the individual directing this support have a thorough knowledge of the system being supported, as well as an understanding of how and why the particular item being supplied is used. Combat health logistics cannot operate on the basis of historical data alone. Many external factors—the judgment of the physician, environmental factors, and the peculiarities of the patient's condition—affect the demands for an item. The nonavailability of certain pieces of equipment or supply items can cause an interruption in the CHS being provided.

1-7. General Principles of Combat Health support

There are six general principles of CHS. The logistician needs to understand these principles and apply them in daily operations and planning procedures. The principles are—

a. Conformity. Conformity with the tactical plan is the most basic element for effectively providing CHS. By participating in the development of the commander's plan of operation, the CHS planner can—

- Determine requirements.
- Plan the support needed to conform to tactical operations.

Combat health logistics, as an integral part of CHS, must conform to the tactical plan, and CHS materiel personnel must be an integral part of that planning process.

b. Proximity. Combat health support must be provided to sick, injured, and wounded

soldiers at the right place to keep morbidity and mortality to the minimum. There is a fine line between too close and not close enough. The CHS resources are employed as close to the area of combat operations as the tactical situation will permit. Medical supplies and blood need to be moved as far forward as possible. Patients are evacuated to the MTF, or the MTF is moved to the area where the patient population is the greatest without interfering with combat operations or jeopardizing treatment capability.

c. Flexibility. Combat health support commanders and planners must be prepared to relocate CHS resources to meet changing requirements. All CHS assets are used somewhere within the theater, none are held in reserve. Therefore, the commander has to make alternate plans for redistribution of CHS resources as required. The size and composition of medical units in support of military operations will be tailored based on—

- (1) Mission, enemy, terrain, troops and time available (METT-T).
- (2) Projected patient work loads.
- (3) Anticipated civic action programs.
- (4) Availability of evacuation assets.

(5) Theater evacuation policy.

d. Mobility. The mobility of medical units organic to maneuver elements should be equal to the forces being supported. Medical command and control (C²) headquarters in the TO must continually assess and forecast unit movement and redeployment. With the proper coordination for nonorganic as well as organic transportation resources, commanders can move medical units to best support military operations.

e. Continuity. Optimum care and treatment of the sick, injured, and wounded must be provided in an uninterrupted manner. Each echelon of CHS reflects an increase in capability; however, the function of each lower echelon is contained within the capabilities of all higher echelons. Continuity in care and treatment is achieved by moving the patient through a progressive, phased system, commensurate with the patient's medical requirement. No patient is evacuated any further to the rear than his physical condition or the military situation requires.

f. Control. Combat health support resources must remain under the control and supervision of the medical commander. This also ensures that the scope and quality of medical treatment and care meet professional standards and policies. The medical commander must be able to tailor CHS organizations to best support military operations.

CHAPTER 2

COMBAT HEALTH LOGISTICS

Section I. COMBAT HEALTH LOGISTICS SYSTEM

2-1. General

This chapter introduces the CHLS mission and the combat health logistics organizations to accomplish that mission. It embodies doctrine based on MF2K and the LTOE of each organization.

2-2. Mission

The CHLS mission is to provide—

- Class VIII supplies and equipment (medical materiel, to include medical-peculiar repair parts).
- Optical fabrication.
- Medical equipment maintenance and repair.
- A Single Integrated Medical Logistics Manager (SIMLM) for joint operations (see Appendix B).
- Blood management for Army, joint, or combined operations.
- Contract support.

2-3. Planning Combat Health Logistics

a. To accomplish successful Class VIII support operations, the logistician must continually plan for the transition from OOTW to war. The combat health logisticians must possess a thorough knowledge of the theater environment, command and organizational structures, and the supporting operation plans (OPLANs). During the initial phase of mobilization/deployment, the

deployment of combat health logistics units later in the Time-Phased Force Deployment Data (TPFDD) flow can affect Class VIII support. To enhance combat health logistics, the logistics planner will—

- Identify specified and implied time-phased materiel requirements necessary to support the OPLAN.
- Identify the capabilities, limitations, and requirements of aerial and sea debarkation/embarkation ports.
- Provide coordinating and controlling cell for movement of personnel, supplies, and equipment.
- Identify pre-positioned war reserve stocks in the theater, at ports of embarkation, and pre-positioned stock afloat.
- Identify host-nation (HN) support, if available.
- Identify joint, combined, allied, or coalition logistics support requirements, to include the distribution plan.

b. The structure of a force projection operation may consist of any size force—from a battalion-sized organization to a larger-sized force consisting of multiple corps and a supporting EAC organization. It is imperative that the combat health logistician be involved in CHS planning. See Chapter 6, FM 8-55, for guidance on planning the combat health logistics plan and estimate, and Appendix C, this manual, for a format example of a tactical standing operating procedure (TSOP).

c. Combat health logisticians should anticipate reconstitution. Reconstitution is an extraordinary action used to restore units to a desired level of operational effectiveness commensurate with mission requirements and available resources. During concept development, reconstitution must be an integral part of the planning process. The medical logistics (MEDLOG) battalions will have the responsibility for reconstitution of medical units and medical assemblages with Class VIII materiel and equipment. Under emergency situations, the MEDLOG battalions may be tasked to provide replacement logistics equipment, such as materiel handling equipment and vehicle logistics/maintenance personnel, to forward medical units. It should be noted that this will degrade the mission capability of the MEDLOG battalions and should only be directed under emergency conditions. Nonmedical Class VII items and personnel replacements are provided to medical units requiring reconstitution by the appropriate managers. For more information on reconstitution, see FM 100-9.

2-4. Combat Health Logistics Structure

The CHLS is structured to provide the flexibility, mobility, and capability to support continuous operations and each increment of the deploying forces. It is tailored to support missions throughout the stages of military operations and across the operational continuum. The system is anticipatory and projects its support based on operational objectives. The organizational structure to support a TO consists of four types of units:

- Medical logistics battalions (forward).
- Medical logistics battalions (rear).
- Theater Medical Materiel Management Center (TMMMC).
- Medical logistics support detachments.

Section II. COMBAT HEALTH LOGISTICS ORGANIZATIONS

2-5. General

This section discusses the theater's combat health logistics organizations and their organic elements. It also discusses their assignment, basis of allocation, capabilities, and concept of operations.

2-6. Medical Battalion, Logistics (Forward), Table of Organization and Equipment (TOE) 08485L000

a. *Mission.* The mission of this unit is to provide Class VIII supplies, single-vision optical fabrication, medical equipment maintenance support, and blood storage and distribution to divisional and nondivisional units operating in the supported corps. In selected scenarios,

this unit is augmented to perform Class VIII management functions of the TMMMC and may also assume the role of SIMLM for the theater.

b. *Assignment.* This unit is assigned to the corps under the C2 of the Medical Brigade, TOE 08442L000.

c. *Basis of Allocation.* One MEDLOG battalion (forward) is allocated per corps or three division equivalent-sized force. One additional MEDLOG battalion (forward) is allocated to support each additional increment of 100,000 joint service population.

d. *Capabilities.* This unit—

(1) Provides C2, staff planning, supervision of operations, and administration of

assigned or attached units engaged in providing Class VIII supplies, single-vision optical fabrication, medical equipment maintenance support, and blood processing, storage, and distribution.

(2) Provides Class VIII supplies based on a consumption rate of 1.9 pounds per man per day, a theater stockage objective of 30 days, and 15 days of supplies in each supported corps.

(3) Provides Class VIII supplies, single-vision optical fabrication, medical equipment maintenance support, and blood processing, storage, and distribution to a maximum force of a two to three division equivalent-sized corps.

(4) Receives, classifies, and issues up to 141.5 (maximum) short tons of Class VIII supplies per day. (This organization can support a corps force consisting of 74,470 soldiers based on its processing capability, consumption rate of 1.9 pounds per man per day, and the theater stockage objective. These factors may change based on a number of variables. However, the actual methodology explained in the example will remain the same.)

EXAMPLE

A corps force consisting of 74,470 soldiers to be supported requires 70.75 short tons per day (74,470 troops x 1.9 pounds per man per day / 2000 pounds [to arrive at short tons]) to be issued to the force. The MEDLOG battalion (forward) is required to receive 70.75 short tons per day to replace the stock issued. The MEDLOG battalion (forward) would be at its limit to support the corps.

(5) Provides storage of up to 707.5 short tons of Class VIII supplies based on an average order ship time of 5 days.

NOTE

Based on a 15-day stockage level in a corps with 5 days of that stockage level being order ship time, the operating and safety levels to be stored would be 10 days. Using the data in the note above, the unit stores 707.5 short tons (70.75 short ton per day x 10 days).

(6) Provides unit medical equipment maintenance for units without organic capability and direct support (DS) medical equipment maintenance to corps and division medical units.

(7) Provides for blood processing, storage, and distribution within the corps. Distributes blood products to division medical units.

e. Concept of Operations. This unit is the single point of contact for MEDLOG support for the corps. It should be located near major lines of communication (sea or air) to ease transportation requirements for incoming shipments and facilitate distribution of materiel. The modular nature of this unit allows it to be incrementally introduced in the theater with the supported forces. Forward support platoons (FSPs) of the distribution company should be deployed early to coordinate support to a division medical supply office (DMSO) and prepare to receive Army reserve stocks and resupply from CONUS.

(1) *Supply support.* Levels of supply at the MEDLOG battalion (forward) are kept to a minimum to permit relocation on a rapidly changing battlefield. Request for nonstocked items will be passed to the supporting supply source. This supporting supply source may be a MEDLOG battalion (rear) or the CONUS base. Corps transportation assets will normally be used to move the medical supplies forward to the divisions, separate brigades, ACRs, and Special Forces groups.

(2) *Medical equipment maintenance services.* The MEDLOG battalion (forward) provides medical equipment maintenance services to supported units in the corps. It provides unit-level maintenance to units in the corps without organic medical equipment repairers. It provides DS maintenance to medical units in the corps. This level of maintenance is directed toward repair and return of equipment. Maintenance support teams (MSTs) will provide these services as far forward as the tactical situation permits. The MEDLOG battalion (forward) maintains limited Medical Standby Equipment Program (MEDSTEP) items to support medical equipment maintenance repair programs.

(3) *Optical services.* Optical fabrication requirements beyond the capabilities of the MSMCs and the corps ASMBs are provided by the MEDLOG battalion (forward). This organization provides spectacle frame repair, fabrication of single-vision prescription lenses

and spectacles, and fabrication of protective mask inserts.

(4) *Blood processing, storage, and distribution.* The logistics support company, MEDLOG battalion (forward) receives, stores, packs for distribution, and distributes blood and blood products.

f. Organic Units. This organization has three organic units.

(1) Headquarters and headquarters detachment.

(2) Logistics support company (forward).

(3) Distribution company (forward).

See Figure 2-1 for an organizational diagram of the medical battalion, logistics (forward).

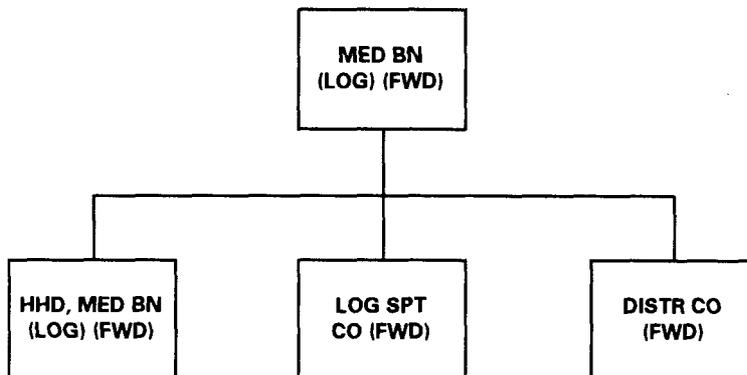


Figure 2-1. Medical battalion, logistics (forward).

2-7. Headquarters and Headquarters Detachment, Medical Battalion, Logistics (Forward), TOE 08486L000

a. Mission. The mission of this unit (Figure 2-2) is to provide C2 and administrative and logistics support to assigned and attached units.

b. Basis of Allocation. One unit is allocated per MEDLOG battalion (forward).

c. Capabilities. This unit—

(1) Provides C2, staff planning, supervision of operations, and administration of assigned or attached units.

(2) Provides unit maintenance for all medical equipment of assigned and attached units.

(3) Maintains a consolidated property book for assigned units.

(4) Coordinates with corps movement control center (MCC) for the routine delivery of Class VIII supplies.

(5) Coordinates with the medical battalion (evacuation) for transportation assets (aeromedical or ground ambulance) for the emergency delivery of Class VIII supplies.

d. Concept of Operations. This unit will normally be employed with the logistics support company to plan and direct the execution of the combat health logistics mission.

e. Dependency. This unit is dependent upon—

(1) Appropriate elements of the corps for unit CHS, supplemental transportation, finance, personnel and administrative services, religious and legal support, and technical intelligence for captured medical materiel.

(2) The Logistics Support Company, TOE 08487L000, for food service.

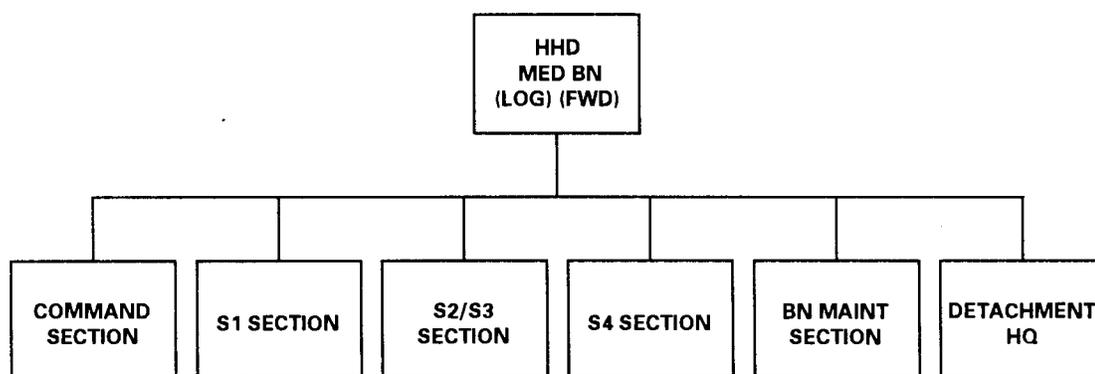


Figure 2-2. Headquarters and headquarters detachment, medical battalion, logistics (forward).

2-8. Logistics Support Company, Medical Battalion, Logistics (Forward), TOE 08487L000

a. *Mission.* The mission of this company (Figure 2-3) is to—

- Execute the planned support of the corps in the areas of Class VIII supplies, single-vision optical fabrication, medical equipment maintenance support, and blood processing, storage, and distribution.

- Be prepared to support medical units of other Services in the corps area, as directed.

b. *Basis of Allocation.* One logistics support company is allocated per MEDLOG battalion (forward).

c. *Capabilities.* This unit—

(1) Receives, classifies, and issues up to 119.5 short tons of Class VIII supplies per day.

(2) Provides storage for up to 1,486 short tons of Class VIII supplies.

(3) Receives and distributes pre-assembled modules (PUSH packages) for re-supply in support of divisional and nondivisional units in the supported corps.

(4) Provides unit medical equipment maintenance for units without organic capability and DS medical equipment maintenance through MSTs.

(5) Provides for blood processing, storage, and distribution within the corps.

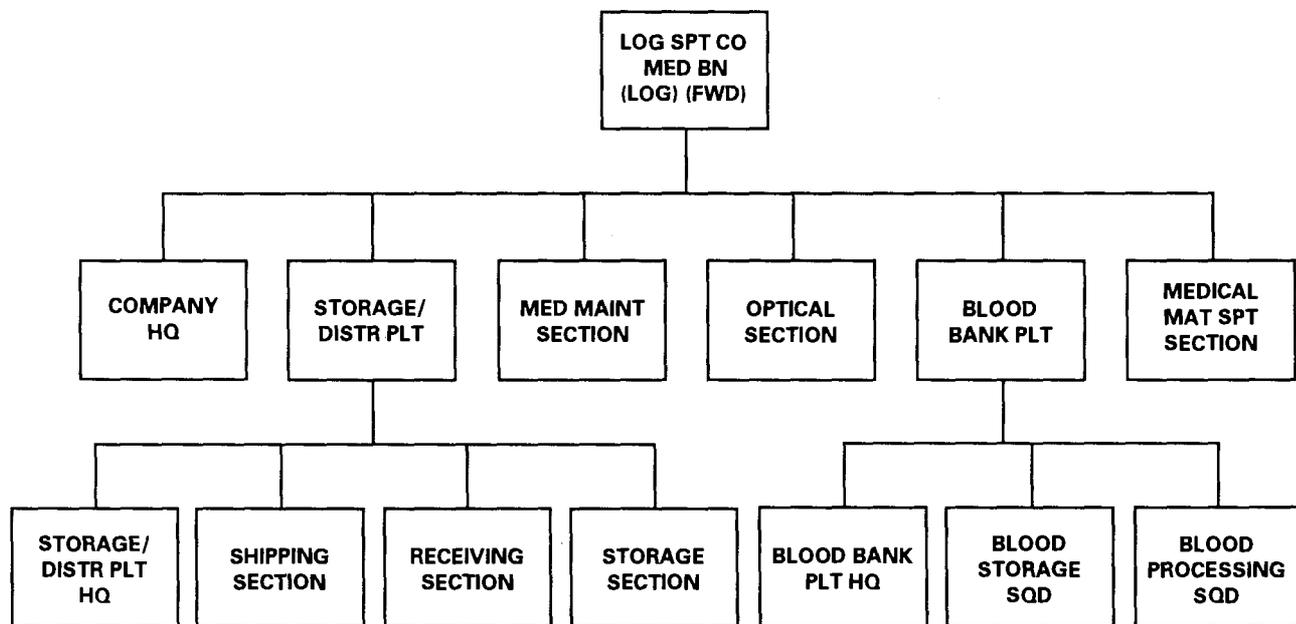


Figure 2-3. Logistics support company, medical battalion, logistics (forward).