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Emergency Employment of Army and Other Resources
U.S. ARMY MEDICAL COMMAND MOBILIZATION PLAN

Supplementation of this regulation and establishment of forms other than MEDCOM forms are prohibited without prior approval from Headquarters, U.S. Army Medical Command, ATTN: MCOP-P.

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*This regulation supersedes HSC Mobilization Plan (HSC-MP), 31 January 1992.

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1. SITUATION.

a. General.

(1) History. This is the first printing of this publication. It incorporates the information in the Health Services Command Mobilization Plan (HSC-MP), 31 Jan 92, that is rescinded.

(2) Purpose. This plan assigns responsibilities and provides policy and guidance for the U.S. Army Medical Command (MEDCOM) during contingency operations or mobilization to include deployment, sustainment, redeployment, and demobilization planning and execution.

(3) General. The focus of the U.S. National Strategy has shifted in response to the dramatic geopolitical changes in Eastern Europe. As the Warsaw Pact threat in Europe receded, defense planning began focusing on regional conflicts in which the U.S. might be involved. Appropriate responses to regional contingencies that affect U.S. interests is an integral part of U.S. military strategy. Such regional conflicts and crises, erupting with little or no warning, are the most likely future threats.

(4) Preconflict Actions. The MEDCOM will prepare to provide immediate and sustainable medical support of approved operations plans, concept plans and no-plan contingencies for any region in the world. The Reserve Components (RC) of the Army will be fully integrated into plans to execute this mission. Graduated mobilization response (GMR) options will be implemented upon order in response to ambiguous or definite warnings of a possible crisis requiring involvement of Army forces (Figure 1).

(5) Post Conflict Actions. The MEDCOM provides medical support to the mobilizing and deploying forces, the active duty population, patients evacuated from the theater(s) of operations, and other eligible beneficiaries (family members and retirees) within the limitations of available resources.

b. Enemy Forces. See Annex N (Operations Security).

c. Friendly Forces. The combined military forces of the United States.

d. Assumptions.

(1) There may or may not be a declaration of national emergency prior to a Presidential Selected Reserve Call-up (PSRC).

(2) Mobilization will progress sequentially from a lower level to a higher level.

(3) Loss of professional filler system (PROFIS) personnel may occur prior to a PSRC.

(4) Deployment operations will begin before or during the PSRC.

(5) Contingencies requiring rapid deployment of U.S. forces will require the activation of RC forces.

(6) Availability of RC units and individuals will be limited due to manpower ceilings.

(7) The Army Individual Mobilization Augmentee (IMA) and Individual Ready Reserve Augmentee (IRR Augmentee) programs will be allocated a slice of the Army manpower allocation approved for involuntary order to active duty.

(8) Mobilization and deployment of units will initially follow schedules in the Global Command and

Control System - A (GCCS-A) Mobilization Planning Application.

(9) Wartime industrial mobilization will not occur prior to full mobilization; however, an industrial surge of selected items under peacetime rules of production may be ordered as early as partial mobilization.

(10) Peacetime funding procedures will remain in effect until full mobilization is declared.

(11) The Surgeon General (TSG) will establish policy for selective continuation of Graduate Medical Education (GME) programs.

(12) There will be an increase in the incidence of disease from overcrowding, lack of adequate sanitary facilities, inadequate utilities, and occupational exposures at mobilization stations and training centers.

(13) Equipment requirements for facility expansion will be available through Prime Vendor or Contingency/Exigency Contracts.

(14) Augmentation personnel may require refresher and orientation training.

(15) The tactical situation in overseas areas during a mobilization or contingency operations will permit the U.S. Air Force (USAF) to evacuate casualties from the theater(s) of operations to the continental United States (CONUS).

(16) The Department of Veterans Affairs (DVA) hospital system and National Disaster Medical System (NDMS), when activated, will provide hospitalization for military patients beyond the capacity of the MEDCOM's medical facilities.

(17) General demobilization will commence as soon as operational

requirements of the supported Commander-in-Chief (CINC) permit.

(18) Demobilization of selected units and individuals may occur at any time during a crisis.

2. MISSION. When directed by Headquarters, Department of the Army (HQDA), the MEDCOM mobilizes to provide health care support for mobilization, deployment, sustainment, redeployment, and demobilization of Army forces. The MEDCOM will simultaneously maintain the capability to provide continuity of patient care while ensuring it retains the capability to care for patients returning from the theater(s) of operations. The MEDCOM also provides individual Army Medical Department (AMEDD) training, medical materiel, and medical research and development to support the Army mobilization force. The mission is further delineated as follows:

a. Deploy AMEDD individuals and teams as directed.

b. Provide direct health care support to the mobilizing, deploying, and sustaining base military forces.

c. Provide health care to beneficiaries within the limitations of available resources.

d. Expand the Army's direct military health care system to provide treatment for patients evacuated from the theater(s) of operations.

e. Provide individual skill training for essential medical skills needed during mobilization and/or contingency operations.

f. Provide medical solutions to protect and sustain the health of the Army forces across the continuum of military operations.

g. Provide for health promotion, preventive medicine, and health care services.

h. Provide dental services.

i. Provide veterinary services.

j. Provide blood and blood products in support of contingency requirements.

k. Provide Class VIII and biomedical repair support to the mobilizing, deploying and sustainment base military forces.

3. EXECUTION.

a. Concept of Operations (Annex A). The MEDCOM conducts mobilization and sustainment operations on a regional basis emphasizing centralized planning and decentralized execution. (MEDCOM Regulation [Reg] 500-5-2, U.S. Army Medical Command Mobilization Concept of Operations.)

(1) The MEDCOM provides mobilization planning directives and guidance to Major Subordinate Commands (MSC), MEDCOM installations, other major Army command (MACOM) installation commanders, and Table of Distribution and Allowances (TDA) U.S. Army Reserve (USAR) WARTRACE aligned medical units. All MEDCOM activities conduct extensive mobilization preplanning in coordination with their installation medical planning activity.

(2) Mobilization execution is decentralized down to the MSCs and further decentralized within each MSC. Selected U.S. Army Medical Centers (MEDCEN) will be designated primary receiving centers (PRC). A PRC is the initial hospital to which patients returning to CONUS from theaters of operations are regulated. The PRCs will provide predominantly intensive and intermediate levels of care.

b. Policy.

(1) Nonactive duty beneficiary care will be continued during and after mobilization to the extent permitted by available resources. Health care, both inpatient and outpatient care, to eligible beneficiaries will not be restricted until it becomes apparent that care of active duty personnel is being compromised due to lack of space and staffing.

(2) Use of existing facilities "within-the-walls" will be made to provide health care including the hospitalization of patients. The MEDCOM maximum bed expansion for mobilization will be limited to "within-the-walls" expansion.

(3) Priority for the allocation of medical equipment and supplies will be established by Headquarters (HQ) MEDCOM and provided to the U.S. Army Medical Research and Materiel Command (MRMC) for implementation.

(4) Contracting for civilian services will be expanded to meet operational requirements.

(5) Maximum use will be made of the Logistics Civil Augmentation Program (LOGCAP) and AR 700-137.

(6) For planning purposes, patients expected to return to duty within 60 days will be hospitalized in the direct military care system.

(7) The DVA hospital system will serve as the initial backup support to the military health care system. In accordance with Public Law 97-174, mobilization is not required for requesting assistance from the DVA.

(8) The National Defense Medical System will be activated by the Assistant Secretary of Defense for Health Affairs (ASD-HA). Prior to NDMS activation, civilian hospitals

may be utilized as required through managed care.

(9) During mobilization, patients requiring hospitalization in CONUS will be regulated by the Global Patient Movement Requirements Center (GPMRC).

(10) The MEDCOM is responsible for base operations (BASOPS) health service support at mobilization. This requirement includes range support, aerial port of embarkation (APOE) and/or seaport of embarkation (SPOE) support, ground and air evacuation, etc.

(11) WARTRACE aligned RC troop program units (TPU) will be used for caretaker hospital backfill, facility expansion to "within-the-walls" hospitalization capacity, BASOPS installation medical support, Korean Professional Filler System, and European Regional Medical Command (RMC) backfill.

c. Tasks.

(1) Major Subordinate Commands. Responsibilities common to all MEDCOM MSCs and MEDCOM installations are covered in this paragraph. Responsibilities unique to specific MSCs and MEDCOM installations are addressed in paragraphs 3c(2) through 3c(8).

(a) Prepare, publish, and maintain an up-to-date mobilization plan in support of assigned missions.

(b) Develop training guidance for WARTRACE aligned RC units, and monitor their unit status reports (USR).

(c) Operate an emergency operations center (EOC), and coordinate taskings.

(d) Direct and coordinate professional cross-leveling, back-

fill, and special medical mission requirements.

(e) Coordinate logistics support requirements for a contingency operation or mobilization.

(f) Establish and maintain links with critical information management systems.

(g) Develop input to personnel distribution plans. Allocate personnel based on manpower documents and established priorities.

(h) Identify personnel to fill mobilization requirements as directed.

(i) Provide Army Medical Department officer and enlisted personnel identified as PROFIS personnel to the deployed and deploying forces as directed by HQ MEDCOM, and provide other personnel fillers as directed.

(j) Establish a mobilization planning committee in accordance with MEDCOM Regulation 500-5, and maintain written records of committee meetings. Ensure mobilization planning procedures and actions are reviewed and approved by the committee.

(2) The RMC commanders will:

(a) Coordinate regional health care planning within their RMC.

(b) Provide command and control, policy, and direction to MEDCEN and medical department activity (MEDDAC) commanders.

(c) Provide operational guidance and assistance regarding health care delivery, education, and training.

(d) Ensure managed care programs support transition to war.

(e) Prepare a health care delivery plan which integrates readiness requirements. The plan will project health care demand across the full spectrum of clinical services.

(f) Advise the command on patient administration mobilization issues and requirements.

(3) Commander, U.S. Army Medical Department Center and School (AMEDDC&S) will:

(a) Continue to administer approved AMEDDC&S directed training, including courses at the U.S. Army School of Aviation Medicine (USASAM). The AMEDDC&S will continue to conduct approved courses for AMEDD personnel, and as required, for other Army personnel, members of other services, and for authorized foreign nationals within policies established by HQDA.

(b) Plan for the training of AMEDD personnel in clinical skills requiring the presence of a special environmental or patient care activity.

(c) Prepare and maintain a current mobilization program of instruction (MOBPOI) for each course to be taught during mobilization.

(d) Expedite the development and fielding of Combat Health Support Systems.

(4) Commander, U.S. Army Center for Health Promotion and Preventive Medicine (CHPPM): Continue to perform peacetime functions including support for other services, investigations, and training for the Army health and environment programs encompassing preventive medicine, occupational health, and environmental sciences.

(5) Commander, U.S. Army Dental Command (DENCOM) will: Provide

dental policy to Regional Dental Commands (RDC).

(6) Commander, U.S. Army Medical Research and Materiel Command.

(a) The MRMC mission will shift from basic research to support of field operations during a contingency operation or mobilization. The geographical area of conflict and Army operations in that area will determine the thrust of the research and development effort after mobilization. Program priorities will be adjusted to meet critical needs.

(b) The MRMC directs and manages Class VIII supply support, and operates as the Army Service Item Control Center (SICC) for medical materiel. These activities are managed through the U.S. Army Medical Materiel Agency (USAMMA), a MRMC subordinate command.

(7) U.S. Army Veterinary Command (VETCOM) will: Provide policy and guidance to the Regional Veterinary Commands (RVC).

(8) Commander, MEDCOM installations will:

(a) Coordinate with installation tenants for support of assigned missions.

(b) Installations will provide mobilization and deployment support to RC units within the AR 5-9 responsibility of the installation.

d. Coordinating Instructions.

(1) This plan is effective for planning upon receipt, and for execution upon receipt of HQDA Mobilization Order.

(2) Specific orders directing expansion of operating beds will be issued through Letter of Instruction from HQ MEDCOM. All other missions

will be executed as directed by Automatic Digital Network (AUTODIN) message.

4. SERVICE SUPPORT.

a. Logistics - See Annex D (Logistics).

b. Personnel - See Annex G (Personnel).

5. COMMAND AND SIGNAL.

a. Command.

(1) Command and control will be exercised through the MEDCOM's Emergency Operations Center, Fort Sam Houston, Texas 78234-6007, Defense Switching Network (DSN) 471-6242; Commercial 210-221-6242.

(2) The MEDCOM will assume command of mobilized WARTRACE aligned USAR TDA units upon their arrival at the mobilization station. The HQ MEDCOM will publish an order assigning the unit to the appropriate MEDCOM MSC.

b. Signal. See Annex Q (Information Management)

T - Not Used
U - Emergency Operations Center
V - Historical Activities
W - Not Used
X - Glossary
Y - References
Z - Distribution

ANNEXES:

A - Concept of Operations
B - Health Care Services
C - Resource Management
D - Logistics
E - Facilities
F - Reserve Components
G - Personnel
H - Preventive Medicine
I - Safety - Accident Prevention
J - Dental Services
K - Veterinary Services
L - Training
M - Security
N - Operations Security (OPSEC)
O - Chaplain
P - Public Affairs
Q - Information Management
R - Demobilization
S - Provost Marshal

MOBILIZATION LEVELS

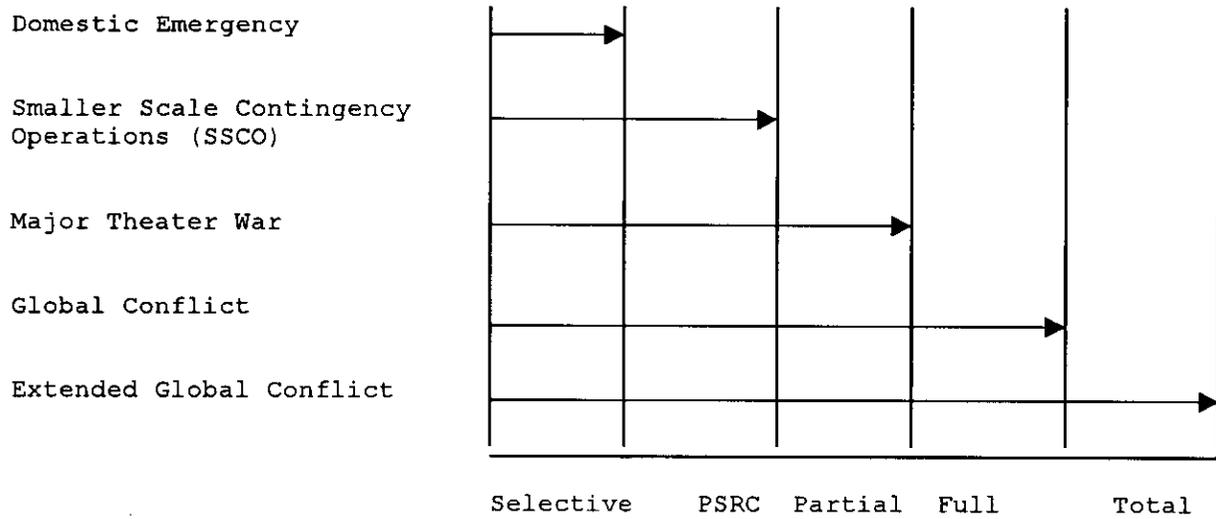


Figure 1 - Mobilization Levels by Contingency Type

- SSCO INCLUDES:**
- Humanitarian Assistance
 - Peacekeeping
 - Disaster Relief
 - No-fly Zones
 - Reinforcing Key Allies

**ANNEX A (Concept of Operations)
to MEDCOM Mobilization Plan
(MEDCOM-MP)**

See MEDCOM Reg 500-5-2, U.S. Army Medical Command Mobilization Concept of Operations.

**ANNEX B (Health Care Services) to
MEDCOM Mobilization Plan (MEDCOM-
MP)**

1. References. See Annex Y.

2. Purpose. This annex describes health care services to be provided by MEDCOM activities to eligible beneficiaries during a contingency operation or mobilization.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. The MEDCOM activities plan for health care services to support a contingency operation or mobilization in accordance with policies and requirements specified in the Army Mobilization and Operations Planning and Execution System (AMOPES).

5. Policy. Not used.

6. Responsibilities. All MEDCOM activities will plan to provide all categories of health care services required to support the expanded Army Forces during a contingency operation or mobilization.

7. Procedures. Not used.

APPENDICES:

- 1 - Hospitalization
- 2 - Ambulatory Care Services
- 3 - Blood Program
- 4 - Clinical Services
- 5 - Contingency Medical
Regulating and
Bed Status Reporting
- 6 - Family Assistance
- 7 - Soldier Readiness Processing
- 8 - Credentialing and Privileging

of Health Care Providers

**APPENDIX 1 (Hospitalization) to
ANNEX B (Health Care Services) to
MEDCOM Mobilization Plan (MEDCOM-
MP)**

1. References. See Annex Y.

2. Purpose. To provide guidance for planning for hospital beds in support of eligible beneficiaries and theaters of operations evacuees during contingency or mobilization operations.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Medical treatment facilities (MTF) will be prepared to provide medical support to the expanded Army in accordance with the MEDCOM Mobilization Concept of Operations, MEDCOM Reg 500-5-2. When directed by MEDCOM, the MTFs will expand their inpatient bed capacity.

5. Policy.

a. Contingency and mobilization plans will include hospital core expansion (within-the-walls) support for mobilization or contingency operations.

b. The MTFs should not plan to operate fewer beds in the intensive and intermediate categories than operated during peacetime.

c. Patient category definitions are provided at TAB B, this Appendix.

6. Responsibilities. All inpatient care in Army hospitals is provided under the jurisdiction of the responsible MEDCEN or MEDDAC commander in accordance with AR 40-4 and MEDCOM Reg 40-21.

7. Procedures.

a. Provide inpatient services to support locally generated

patients during mobilization at active, semi-active, and state-operated installations. Inpatient support at installations without tenant medical treatment facilities will be provided through use of memorandums of understanding (MOU), memorandums of agreement (MOA), or inter-service support agreements (ISSA) with contiguous other Service, Federal, or civilian hospitals. These MOUs, MOAs, and ISSAs will be negotiated during pre-mobilization planning.

b. Medical equipment requirements for ambulatory care patients at active, semi-active, and state-operated mobilization stations will be documented by the responsible medical activity in accordance with MEDCOM Reg 40-21.

c. The mechanism for regulating patients inter- and intra-CONUS is the medical capability report provided by the responsible MTF commander through the Defense Medical Regulating Information System (DMRIS). See Appendix 5, Annex B, this plan.

TABS:

- A - Bed Requirements
- B - Definition of Patient Categories
- C - DVA/Department of Defense (DOD) Contingency Hospital System
- D - National Disaster Medical System (NDMS)

TAB A (Bed Requirements) to Appendix 1 (Hospitalization) to Annex B (Health Care Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide planning guidance for bed expansion in CONUS Level V MTFs during contingency/mobilization operations.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept.

a. Designated MEDCOM MTFs will expand inpatient services to the extent the core facility and staffing level permit.

b. Only the core facility ("within-the-walls") will be considered when determining the MTF's bed expansion capability for inpatient care.

5. Policy. Not used.

6. Responsibilities. Not used.

7. Procedures.

a. Consolidate and maintain inpatient bed expansion capability data within the RMC.

b. Monitor regional MEDCEN and MEDDAC plans for inpatient bed expansion.

TAB B (Definition of Patient Categories) to Appendix 1 (Hospitalization) to Annex B (Health Care Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide patient category definitions.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. All MEDCOM activities plan for support of a contingency/mobilization. The following definitions of patient categories will provide standard definitions to be used for patient care throughout the command.

5. Policy.

a. Intensive Care. That care rendered to patients whose physiological status is so dis-

rupted that they require immediate and continuous nursing care. The care is provided by specially trained personnel who possess the clinical and managerial skills necessary to deliver safe nursing care to patients with complex medical problems. Extensive, highly technical care is required because of the patient's inability to maintain vital functions and communicate needs. Various life support systems, e.g., respirators, monitors, pumps, and/or hypothermia equipment, are standard items used in this setting. Examples of the types of patients requiring intensive care include those with massive hemorrhage, neurosurgical, vascular, or burn injuries; post-surgical patients; and patients with infectious diseases, malaria, fever of unknown origin, or gastrointestinal conditions such as ulcers and dysentery.

b. Intermediate Care. That care rendered to patients whose physiological and psychological status is such that they require observation and nursing care for the presence of real or potential life-threatening diseases/injuries. The acuity of care may range from those requiring constant observation and care to those patients able to ambulate and begin assuming responsibility for their own care. These patients may require monitoring devices, ventilator support, intravenous (IV) therapy, frequent suctioning, dressings, changes, reinforcements, and ambulation.

c. Minimal Care. That care rendered to ambulatory and partially self-sufficient patients who require limited therapeutic and diagnostic services and are in the final stages of recovery. The focus of nursing management is on maintenance of a therapeutic environment which enhances recovery. Complexity of care includes administering medications and treatments which cannot be done by the patients,

and providing instruction in self-care and post-hospitalization health maintenance.

6. Responsibilities. Not used.

7. Procedures. Not used.

TAB C (Department of Veterans Affairs/Department of Defense Contingency Hospital System) to Appendix 1 (Hospitalization) to Annex B (Health Care Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide guidance concerning the coordination and utilization of the DVA/DOD Contingency Hospital System.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. The Department of Veterans Affairs Medical System has a network of hospitals and clinics throughout the United States. These hospitals provide care to eligible veterans on a daily basis. Upon activation of the DVA/DOD Contingency Hospital System, the DVA will make inpatient beds available for the care of casualties returning from the theaters of operations in excess of MEDCOM's bed capacity.

5. Policy. Public Law 97-174, Section 5011A, Department of Veterans Affairs and Department of Defense Health Resource Sharing and Emergency Operations Act, requires the DVA to plan for support of the DOD military medical systems during a military contingency.

6. Responsibilities. The HSC Reg 500-3 designates MEDCOM medical treatment facilities as military coordinating centers, and delineates their responsibilities. Each military coordinating center will act as the conduit to the military for the assigned DVA activity.

7. Procedures.

a. The military coordinating center will coordinate with the assigned DVA activity on issues pertaining to the DVA/DOD Contingency Hospital System.

b. Each MEDCOM activity will prepare appropriate plans, to be included in its mobilization plan, for accomplishing its responsibilities under the DVA/DOD Contingency Hospital System.

TAB D (National Disaster Medical System) to Appendix 1 (Hospitalization) to Annex B (Health Care Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide guidance for the activation and operation of the National Disaster Medical System (NDMS) under contingency or mobilization conditions.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept.

a. The NDMS is a voluntary cooperative effort designed as the backup system for the DVA/DOD Contingency Hospital System. The voluntary effort of NDMS combines the forces of the Department of Defense, Department of Health and Human Services, Department of Veterans Affairs, the Federal Emergency Management Agency, State and local governments, and the private sector.

b. The system provides care for the victims of any incident that exceeds the medical capability of an affected State, Region, or Federal Medical Care System. It may be used in emergency events, such as an earthquake, industrial disaster, or military contingency.

c. In the event of mobilization, all available military medical resources and the DVA/DOD contingency hospital system would be utilized prior to activation of the NDMS system. The military beds, current and planned expansion, would ensure the soldiers rapid return to duty. Once the military direct care system and the DVA/DOD Contingency Hospital System have reached their maximum bed capacity, the NDMS may be activated to provide further support.

d. The medical capability of NDMS does not include any medical capability of the DVA or the military medical systems.

5. Policy. Not used.

6. Responsibilities.

a. The MSCs with military NDMS Federal Coordinating Centers (FCC) within their region will plan and program for funding, cost accounting, and reimbursement in accordance with chapter 5 of AR 500-60.

b. The FCCs will represent the command in NDMS related matters in their designated geographic area.

7. Procedures.

a. The MEDCOM MEDCENs and MEDDACs, designated as FCCs, will prepare and maintain planning documents in support of their NDMS mission.

b. The FCCs will execute NDMS operation plans at the level dictated by the NDMS activation order.

APPENDIX 2 (Ambulatory Care Services) to Annex B (Health Care Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. This appendix provides policy and guidance for ambulatory patient care services under contingency operations or mobilization.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Health care services under contingency operations or mobilization conditions include the requirement to provide primary care services in non-specialized ambulatory care settings. This will include providing health care services by nonspecialized primary care physician providers and non-specialized primary care non-physician health care providers. Specific areas of concern are troop medical clinics (TMC), Army Health Clinics (AHC), patient transportation, and ambulatory care facilities. Primary care services will be provided to uniformed personnel and eligible beneficiaries.

5. Policy.

a. Primary care clinics will be operated at active, Federal semi-active, and state-operated installations in support of the mobilizing and deploying force.

b. Dental services will be planned for by the responsible dental activity (DENTAC) commander.

c. Civilian employee health services. Civilian employees will be provided occupational health services in accordance with AR 40-5 and MEDCOM Reg 10-1.

6. Responsibilities. The MEDCENS and MEDDACs are responsible for coordinating ambulatory care services support for all installations within their Health Service Areas (HSA).

7. Procedures.

a. Troop medical clinic. The installation Director of Health Services (DHS) must evaluate the necessity to operate TMCs. Medical personnel assets must be allocated in such a manner as to provide both hospitalization support and ambulatory care services.

b. Patient transportation. The MTFs must identify vehicle and personnel assets necessary to provide routine and emergency patient transportation.

c. Support for training activities (range firing, etc.) that cannot be met by organic medical resources of the unit conducting the training must be identified and provided by the MTF.

d. Physician extenders. The MTFs must be prepared to provide the necessary assets to staff the TMCs and clinics. Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) should be emphasized during training to allow physician assistants (PA) to be optimally utilized.

TABS:

A - Medical Support to Active, Semi-Active and State Operated Mobilization Stations.

TAB A (Medical Support to Active, Semi-Active, and State-Operated Mobilization Stations) to Appendix 2 (Ambulatory Care Services) to Annex B (Health Care Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance for providing medical support to active, semi-active and state-operated mobilization stations under contingency operations or mobilization.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Active, semi-active, and state-operated installations will be activated to support the mobilizing and deploying force. It will be necessary for the responsible MEDCEN or MEDDAC to provide medical support to these installations. Many of the installations do not have operating medical activities on site, and those that do will require augmentation.

5. Policy.

a. Medical support to active, semi-active, and state-operated installations will be provided by the MEDCEN or MEDDAC responsible for the HSA in which the Installation is located.

b. Patient transportation to the supporting inpatient facility will be provided by the TMC. Patient transportation from training areas, ranges, etc., on the installation to the TMC will be provided by the supported table of organization and equipment (TOE) unit, if possible.

6. Responsibilities. The MEDCEN or MEDDAC with active, semi-active, and state-operated installations within its HSA will provide or coordinate health care services to the installations.

7. Procedures.

a. Ambulatory care services, medical logistics, and preventive medicine services will be provided by personnel from the parent medical treatment facility.

b. Dental services will be provided as planned for by the DENCOM.

c. Veterinary food inspection will be provided by the VETCOM.

APPENDIX 3 (Blood Program) to Annex B (Health Care Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance for the MEDCOM Blood Program under contingency operations or mobilization.

3. Assumptions.

a. All currently required serological tests for infectious disease markers will be performed on collected units of blood in accordance with published Army policy.

b. Shortages in medical stocks needed for the initiation of the MEDCOM mobilization blood program will be acquired through normal supply channels and local purchase mechanisms.

c. Authorization for limited civilian over-hires may be granted by HQ MEDCOM prior to, or during mobilization.

d. Units of blood unavailable for distribution due to positive/reactive infectious disease markers will not exceed five percent.

e. Proportions of random donor populations will approximate the normal distribution of ABO and Rh group/type within the normal U.S. population. Group AB red blood cell units will not be shipped to the Armed Service Whole Blood Processing Laboratories (ASWBPL).

f. See paragraph 1d, basic plan.

4. Concept.

a. The military services operate blood programs under coordination of the Armed Services Blood Program Office (ASBPO). Blood quotas assigned will be based on supported thea-

ter or operations blood requirements.

b. The MEDCOM blood program will begin expansion of its blood program as directed.

c. Selected MEDCOM Blood Donor Centers (BDC) will be tasked to increase blood collection and shipment to a designated ASWBPL.

d. The MEDCOM will provide personnel augmentation to the ASWBPLs at Travis and McGuire Air Force Bases.

5. Policy.

a. The MEDCOM blood program is based on policies established in references at Annex Y and those published on an interim basis from the Office of The Surgeon General. The mobilization blood program may not necessarily conform to that of the peacetime Army Blood Program in that various requirements may be waived in order to accomplish mission requirements.

b. The blood program is restricted in peacetime to blood collections from military personnel, their dependents, and civilian personnel on the installations. These restrictions may be modified during periods of national emergencies, mobilization, or war by the Assistant Secretary of Defense for Health Affairs.

6. Responsibilities. The MEDCOM Blood Program Office has staff responsibility for the command blood program.

7. Procedures.

a. All blood units will be prepared as red blood cells (RBC) unless otherwise directed. Blood shipments will not include fresh frozen plasma, platelets, or group AB red blood cells except as otherwise directed by MEDCOM.

b. Blood will be shipped by the most expeditious means of transportation. Blood should arrive at the designated ASWBPL within 72 hours, but not later than 5 days, after collection.

TABS:

- A - Mobilization Blood Collection Activities
- B - Mobilization Blood Quotas

TAB A (Mobilization Blood Collection Activities) to Appendix 3 (Blood Program) to Annex B (Health Care Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance on the command blood collection activities.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Selected MTFs will expand blood collection activities to support contingency or mobilization operations.

5. Policy. Not used.

6. Responsibilities. The MEDCOM Blood Program Office has staff responsibility for the command blood program.

7. Procedures. The MEDCOM Blood Program Office will publish and distribute the list of mobilization blood collection activities separately from this plan.

TAB B (Mobilization Blood Quotas) to Appendix 3 (Blood Program) to Annex B (Health Care Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide information on the U.S. Army Medical Command Blood Program quotas.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Selected MEDCENS and MEDDACs will be assigned specific daily blood collection quotas to support mobilization and/or contingency operations.

5. Policy. Not Used.

6. Responsibilities. The MEDCOM Blood Program Office will develop and distribute the mobilization blood quotas to support contingency operations or mobilization.

7. Procedures. The MEDCOM will publish and distribute mobilization blood quotas separately from this plan.

APPENDIX 4 (Clinical Services) to Annex B (Health Care Services) to MEDCOM Mobilization Plan (U) (MEDCOM-MP) (U)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance for clinical services support during a contingency operation or mobilization.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept.

a. Clinical Services will continue to provide continuity of care to active duty personnel and authorized beneficiaries.

b. Clinical Services will be returned to base line capability to treat casualties returning from the theater(s) of operations.

5. Policy.

a. Health care services, inpatient and out-patient, to eligible beneficiaries will not be restricted until it becomes apparent that care of active duty personnel is being compromised

due to lack of space and staffing.

b. Prior to a PSRC, Clinical Services will compensate for personnel losses by cross leveling available resources.

6. Responsibilities.

a. Subordinate MEDCOM medical activities will provide health care support to the mobilizing, deploying and sustaining base military forces, while maintaining continuity of care for eligible beneficiaries.

b. The MTFs will deploy PROFIS and CareTaker-PROFIS (CT-PROFIS).

7. Procedures. Procedures will be in accordance with (IAW) AR 601-142.

APPENDIX 5 (Contingency Medical Regulating and Bed Status Reporting) to Annex B (Health Care Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance on patient regulating procedures using contingency medical regulating during a contingency or mobilization operation.

3. Assumption. See paragraph 1d, basic plan.

4. Concept.

a. The primary purpose of contingency medical regulating is to relieve the overseas theater(s) of operations of personnel requiring hospitalization in CONUS, in a manner that will ensure all patients will receive optimal medical care.

b. When implemented, contingency medical regulating procedures discontinue "by name" and

capability reporting. Instead, bed availability is reported in each of 13 medical specialty categories, and patients are regulated as the aggregate number of patients requiring beds.

5. Policy.

a. Patients are regulated and evacuated by standard procedures whenever it is feasible. The provisions of this appendix are invoked only when conditions exist that preclude using standard procedures.

b. It is DOD policy that in both peace and war movement of patients of the Armed Forces will be accomplished by airlift when available, and conditions are suitable for aero-medical evacuation, unless medically contraindicated.

6. Responsibilities. Not used.

7. Procedures.

a. Contingency medical regulating procedures are normally implemented by the GPMRC on the recommendation of a Joint Medical Regulating Officer (JMRO), or the Theater Patient Movement Requirements Center (TPMRC). Conditions may exist that would require the unilateral initiation of these procedures by the GPMRC.

b. On implementation of contingency medical regulating and bed status reporting, CONUS MTFs report the total beds available in each of the 13 contingency specialty categories, as of 2400 local time using the DMRIS or immediate precedence message with appropriate classification. The initial report will include both operating and available beds. Subsequent reports include only available beds unless there has been a change in the number of operating beds.

TABS

A - Patient Movement

Tab A (Patient Movement) to Appendix 5 (Contingency Medical Regulating and Bed Status Reporting) to ANNEX B (Health Care Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide the concept and execution guidance with respect to patient movement within CONUS during a contingency operation or mobilization.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept.

a. A regional concept of patient movement will be used during situations where patients will be returning from an OCONUS theater(s) of operations. Regulating of patients to a PRC will maximize patient care capability during a time of limited specialty staff, and will ensure that patients regulated from OCONUS will arrive at an MTF that is capable of providing the necessary care. Central to this concept is the need to move patients, no longer requiring specialty care, to an MTF with a reduced but adequate capability. If patient movement is not timely, the CONUS PRCs will clog and limit their ability to receive additional patients from the theater(s) of operations.

b. Patients who no longer need specialty care will be transferred to an MTF at their home station as soon as their medical condition and the capability of the home station MTF permit.

5. Policy. The USAF will move patients from the theater(s) of operations to CONUS "hubs" and distribute patients throughout

CONUS to an airfield "cluster" in the proximity of the PRC.

6. Responsibilities.

a. The USAF has the responsibility to move patient from OCONUS to CONUS "hubs" and "cluster."

b. The RMC is responsible for coordinating patient transfers and referrals in and between RMCs with the GPMRC.

7. Procedures.

a. Patient evacuation procedures will follow the concepts outlined in paragraph 4.

b. A regional patient movement plan will be included as a subset of the regional transportation plan. The regional patient movement plan will integrate all Service MTFs, DVA Medical Centers, and participating NDMS hospitals in the RMC.

APPENDIX 6 (Family Assistance) to Annex B (Health Care Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance for Social Work Service's family support during a contingency operation or mobilization.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept.

a. Social Work Services (SWS) has a responsibility to provide responsive, sustained and quality services to soldiers and family members during a contingency operation or mobilization.

b. Social Work Services responsibilities must be fully integrated with the installation mobilization support plan.

5. Policy. The Social Work Services support to family assistance centers must be sustained throughout mobilization.

6. Responsibilities. Social Work Services is responsible for establishing links with other Federal, state, and nonprofit agencies, especially the Army Community Service, Army Emergency Relief, and the American Red Cross.

7. Procedures. Social Work Services will coordinate with the Installation Army Community Service to ensure support to families during a contingency operation or mobilization.

APPENDIX 7 (Soldier Readiness Processing) to Annex B (Health Care Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance for accomplishing the soldier readiness processing (SRP) mission.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept.

a. The SRP will be an ongoing process at the installation during peacetime in preparation for possible overseas movement. Although the installation Director of Personnel and Community Activities (DPCA) has overall responsibility for SRP, the DHS plays an integral role in the process.

b. The SRP is the mission that will affect the MTF early in any contingency operation or mobilization scenario. The MTF may be augmented by a mobilized RC Installation Medical Support Unit (IMSU) to assist with SRP.

5. Policy.

a. Medical support to the SRP is an MTF mission.

b. All PROFIS designees will complete the SRP processing through phase 3 to the maximum extent possible within 30 days of assignment to a PROFIS position.

6. Responsibilities. The MTF Commander has primary responsibility for providing medical support to the SRP at the installation level.

7. Procedures. Procedures will mirror those established during peacetime operations for the SRP site.

APPENDIX 8 (Credentialing and Privileging of Health Care Providers) to Annex B (Health Care Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. This appendix provides policy and guidance on the credentials requirement and privileging process of health care providers during mobilization and deployment.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. The credentials review and privileging of health care providers are integral parts of the MEDCOM Quality Management Program and a cornerstone to quality health care delivery.

5. Policy.

a. The MTF commanders will continue to be responsible for the credentials review and granting of privileges to providers assigned to their activity.

b. All currently required credentials reviews and validations will remain in place.

c. Health care providers requiring supervised practice will not be deployed.

6. Responsibilities.

a. The RMCs have the responsibility to provide assistance with the RC provider Credentialing process. Reference the MOU between the MEDCOM, Office Chief Army Reserve (OCAR), National Guard Bureau (NGB), and the U.S. Army Forces Command (FORSCOM).

b. Commanders of RC medical units mobilized intact are responsible for ensuring all of their providers are appropriately credentialed.

c. Medical treatment facility and medical unit commanders are responsible for monitoring practice patterns to ensure the delivery of competent, safe care.

7. Procedures.

a. The MTFs/DENTACs will forward the appropriate credentials documents to gaining activities. For nonprivileged health care practitioners, the sending facility should provide information on credentials status and life support training as a minimum.

b. Utilization of providers in other than their primary specialty will be in accordance with current Army regulations.

c. Individual RC providers or practitioners who are mobilized will have their credentials reviewed by the MTF Credentials Board.

d. Quality management will be in accordance with published Army guidance.

ANNEX C (Resource Management) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. This annex provides resource management policy and guidance in areas of mobilization table of distribution and allowances (MOBTDA) development and financial management for contingency operations and mobilization.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept.

a. Peacetime resource management guidance and controls will remain in effect in the initial phases of mobilization, and will be lifted only upon directions of HQ MEDCOM.

b. The MOBTDA's prepared by each activity will reflect minimum essential manpower and equipment requirements, and organizational structure to support mobilization.

5. Policy. The MEDCOM installations and activities will follow the procedures in the annual update memorandum published by the MEDCOM Assistant Chief of Staff for Resource Management (ACSRM) in the development of MOBTDA's.

6. Responsibilities.

a. MEDCOM installations. The MTF's on MEDCOM installations will provide information at the installation level for development of the MOBTDA.

b. Other MACOM installations. All MEDCOM activities that are tenants on other MACOM installations will initiate, maintain, and update an ISSA, on an annual basis. The ISSA will provide for facilities, transportation, and other support required for contingency operations and/or mobilization.

7. Procedures. The MEDCOM will publish detailed update guidance

for all MEDCOM activities prior to each MOBTDA update cycle.

APPENDICES:

- 1 - Mobilization TDA (MOBTDA) Developmental Guidance.
- 2 - Financial Management

APPENDIX 1 (Mobilization TDA (MOBTDA) Developmental Guidance) to Annex C (Resource Management) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide general guidance to MEDCOM activities in preparing MOBTDA's to support contingency operations and or mobilization missions.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept.

a. The MOBTDA's will be prepared to reflect minimum essential manpower and equipment requirements, and organizational structure to support all mobilization missions. The MOBTDA's will be reviewed annually and updated as required.

b. The installation mobilization population estimates to be supported by outpatient clinics, and other non-inpatient functions are available at the Installation Directorate of Plans, Operations, Training and Security (DPTMS). Headquarters MEDCOM will provide each activity with detailed MOBTDA update guidance prior to the beginning of each MOBTDA update cycle.

c. Mobilization TDA's will be developed to reflect resource requirements for PSRC and partial mobilization as separate and distinct requirements. The MEDCOM ACSRMs will determine which TDA to use as the base document for MOBTDA expansion.

5. Policy. All MEDCOM activities will use the update guidance provided by HQ MEDCOM ACSRM in the MOBTDA development.

6. Responsibilities. The MEDCOM ACSRM has staff responsibility for providing MOBTDA update guidance to all MEDCOM activities.

7. Procedures. The MEDCOM ACSRM will publish detailed MOBTDA guidance for MEDCOM activities annually following receipt of Department of the Army (DA) guidance.

APPENDIX 2 (Financial Management) to Annex C (Resource Management) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To prescribe policy and guidance for resource management personnel in mobilization and deployment planning.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Peacetime resource management guidance and controls will remain in effect in the initial phases of mobilization and will be lifted only on direction of HQ MEDCOM.

5. Policy.

a. During mobilization, MSCs will use existing funds that MEDCOM and HQDA have not restricted.

b. Funding authority.

(1) Funding authority remains in formal channels and is accounted for under normal reporting procedures unless otherwise directed.

(2) Reserve component units that are activated and attached to a MEDCOM activity will be

funded by the activity to which they are attached.

(3) Temporary tours of active duty (TTAD) may be required for RC members volunteering for active duty. The activity requesting TTAD will be required to provide an operational and maintenance fund cite for travel and per diem.

(4) The U.S. Army Reserve Personnel Command (AR-PERSCOM) will fund travel and per diem from an IMA's and IRR augmentee's home of record to their duty station and return. Pay and allowances will be funded by the Military Pay Account (MPA).

c. Charges to appropriations. All expenses incurred after the unit or individual entered on active duty are chargeable to the applicable project in the MPA or Operations and Maintenance, Army (OMA) appropriations.

6. Responsibilities. Not used.

7. Procedures. Procedures will mirror those established during peacetime unless otherwise directed by HQ MEDCOM.

ANNEX D (Logistics) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance on supporting the expanding Army force under contingency or mobilization conditions.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept.

a. The probable timing sequence of medical requirements dictate readiness priorities. First, in any type of conflict that requires deployment of forces, medical and dental treatment facilities will be con-

fronted with a variety of missions at all installations involving the support of deployment and deployed troops. The magnitude and duration of this effort is directly proportional to the extent of the military effort. Second during a contingency or partial mobilization, MEDCOM may direct a specific or all RMCs within CONUS to expand within the existing physical plant (core) to meet returning casualty requirements. This maximum core expansion is the limit of inpatient capability. Requirements beyond maximum core expansion must be met with resources outside the Department of Defense.

b. The overall concept is to have necessary durable and non-expendable items required to support installation/deployment missions and the core expansion mission available locally. Equipment items that are patient dependent and/or subject to obsolescence (patient monitors, infusion pumps, etc.) must be identified and local coordination made to ensure availability of the items through lease. Items that cannot be provided in this manner must be identified in order for timely procurement action to be taken.

5. Policy. Not used.

6. Responsibilities.

a. Major Subordinate Commands. The MSC Commanders have the responsibility to plan for, coordinate, and oversee the provisions of responsive medical acquisition and logistics support. This support will be provided on a regional basis to maximize the full realm of AMEDD support to deploying Army units.

b. Commanders of MTFs. The MTF commanders are responsible for providing medical logistics materiel management to authorized units/organizations within their area of responsibility. They are

responsible for providing supply and maintenance support, technical assistance and guidance to organizational elements of the MTF, and other units and activities authorized support. They are also responsible to provide direct medical staff support functions and technical advice to supported installations commanders in fulfilling all Class VIII requirements of DA designated deployment platforms.

c. The MSC and MTF Mobilization Planning Committees are responsible for reviewing all mobilization support plans prior to their being submitted to the MSC commander.

7. Procedures. The Chief, Logistics at MEDCOM MSCs and MTFs will:

a. Provide technical and professional advice, guidance, and liaison to ensure that adequate supplies of essential medical and nonmedical material are available to support contingency and deployment missions.

b. Provide guidelines for determination of medical material requirements for contingency operations or mobilization conditions in support of the expanded Army.

c. Establish policies to follow in identifying priorities for acquisition of medical and non-medical material required by units upon activation and for the equipping and expansion of fixed facilities.

d. Provide for medical equipment maintenance and optical fabrication support of Army requirements and those of the other Armed Services in accordance with agreements existing at the time.

APPENDICES:

1 - Supply Management

- 2 - Property Management
- 3 - Transportation
- 4 - Environmental Services
- 5 - Medical Equipment Maintenance
- 6 - Prime Vendor and Contingency/Exigency Contracts.

APPENDIX 1 (Supply Management) to Annex D (Logistics) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. This appendix provides the supply management guidance required to support contingency/mobilization operations.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Supply management operations will continue to follow prescribed regulatory policies and guidelines during contingency or mobilization operations. Adaptation to wartime policies will be at the direction of the Secretary of the Army.

5. Policy.

a. Medical materiel required to support early deploying units will be made available from peacetime stocks. Items not available will be activated or requisitioned from the most appropriate source of supply. The goal is to provide deploying units with the highest fill rate possible prior to departure. When time does not allow for shipment to the Power Projection or Power Support Platforms, coordination will be made to forward late arriving supplies to the deploying unit en route or in the theater of operations.

b. Medical materiel deficiencies from the installation and supported activities will be provided to the installation medical support activity (IMSA), as either a requisition, for immediate processing, or as a

pre-positioned requisition to meet contingency operations or mobilization missions.

c. Requisitions will be prepared in accordance with AR 725-50 and AR 40-61 or applicable automated supply system.

d. Regulated medical materiel (sets, kits, and major medical assemblages coded as acquisition advise code A) turned into the IMSA will be reported immediately to USAMMA.

6. Responsibilities. Not used.

7. Procedures. Procedures will mirror those established during peacetime until otherwise directed.

APPENDIX 2 (Property Management) to Annex D (Logistics) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. This appendix provides guidance for the management, procurement, and accounting of MEDCOM capital equipment during contingency/mobilization conditions.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Property management activities will follow current regulatory policies, procedures, and guidelines for procurement, accounting, and management of capital equipment.

5. Policy.

a. The Army Medical Department Property Accounting System (AMEDDPAS) will continue to be utilized to manage property book equipment.

b. Relief from accountability will be obtained through AR 735-5.

6. Responsibilities. Commanders must ensure:

a. New capital equipment requirements are identified and submitted to the formal Medical Care Support Equipment (MEDCASE) channels in the most expeditious means possible.

b. Equipment cross-leveling is utilized to the extent possible in order to fulfill equipment requirements.

c. Coordination with the MEDCOM Assistant Chief of Staff for Logistics (ACSLOG) to determine what equipment and materiel, if any, may be available for cross-leveling within the command.

d. New equipment requirements are submitted in accordance with established regulations and supply bulletins.

e. Coordination with MEDCOM ACSLOG to develop procedures facilitating the purchase or lease of additional equipment required to support mobilization equipment shortfalls.

7. Procedures.

a. Property managers will continue to maintain strict property accountability in accordance with AR 710-2 and MEDCOM Property Management Bulletins.

b. AMEDDPAS will continue to be used to manage property book equipment.

c. The MEDCASE requirements will be channeled through normal procedures.

d. Relief for accountability will be obtained through AR 735-5.

e. The MSCs will monitor mobilization equipment requirement shortfalls.

APPENDIX 3 (Transportation) to Annex D (Logistics) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance on regional transportation planning.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Regional transportation plans will include essential guidance and policies regarding the movement of staff, patients, and material. Each of these areas will be considered as a major subset of the regional transportation plan.

5. Policy. The Mobilization Planning Committee will review and approve the regional transportation plan prior to forwarding to the commander.

6. Responsibilities.

a. The RMC Chief, Logistics Division has overall responsibility for mobilization transportation requirements within the RMC.

b. The Chief of Readiness at the RMC will ensure requirements for ground evacuation and air evacuation means by Army aircraft are planned for to support mobilization requirements.

c. The RMC Chief, Patient Administration Division (PAD) is responsible for planning of activities concerning the receiving, evacuating, transferring, and referring of patients within the RMC.

d. The Chief, Department of Primary Care and Community Medicine (DPCCM) is responsible for planning for emergency ambulance and local patient transportation services in support of mobilization requirements.

7. Procedures. Each RMC will develop and maintain a Regional Transportation Plan. Regional transportation procedures at MEDCOM installations will differ from those at activities which are tenants on other MACOM installations.

APPENDIX 4 (Environmental Services) to Annex D (Logistics) to MEDCOM Mobilization Plan (U) (MEDCOM-MP) (U)

1. References. See annex Y.

2. Purpose. To provide policy and guidance on implementing Environmental Service requirements under contingency or mobilization conditions.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Existing procedures for Environmental Services will expand to meet contingency operations or mobilization requirements. Mobilization for Environmental Services does not mean implementing new procedures.

5. Policy.

a. Hospital Housekeeping Services. Existing contracts will contain applicable clauses to expand square footage cleaning requirements. Coordinate with the supporting Directorate of Contracting as required for modifications, adding and subtracting facilities as requirements change. Additionally, the contractor will have contingency plans to demonstrate the ability to meet MTF requirements. The facilities which have not contracted housekeeping services will maintain procedures to hire additional personnel to clean the expanded square footage required to support the additional beds.

b. Precious Metals Recovery Management. The Precious Metals Coordinator (PMC) will maintain a working relationship with the

Defense Reutilization and Marketing System regional representative to request, upon expansion, additional recovery equipment to support new requirements. Existing procedures will remain in place to maximize recovery of precious metals and not harm the environment. If silver recovery services are provided by contract, the PMC will maintain a working relationship with the vendor to cover contingencies.

c. Textile Management. Planning will include a 7-day linen stockage for the expanded bed capability. Alternate sources of supply will be maintained to supplement Department of the Army requisitions. A primary and alternate source for laundry operations will be identified to support anticipated expansion requirements. Contracts, if applicable, will contain contingency clauses and requirements.

d. Medical Regulated Waste. Existing procedures will be maintained. Compliance with local, state, and Federal laws will be maintained to minimize the hazard to individuals and the environment. Alternate sources of disposal will be identified to include other Federal Agencies, private commercial vendors, or state agencies. Alternate approved storage sites, alternate approved methods of disposal, and approved collection procedures to minimize waste will be maintained.

6. Responsibilities. The ACSLOG, MEDCOM will issue implementing guidance and resolve environmental service support requirements.

7. Procedures. Existing procedures used to support the operations will be maintained. The Office of the Assistant Chief of Staff for Logistics will issue additional guidance by message, memorandum, or by Environmental Services Bulletins to support

implementation of expanded service management related functions.

APPENDIX 5 (Medical Equipment Maintenance) to Annex D (Logistics) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance for the maintenance of medical equipment under contingency or mobilization conditions.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Medical equipment maintenance activities will continue to follow current regulatory requirements and guidelines for the maintenance of medical equipment.

5. Policy.

a. Medical maintenance support will continue to be provided for within assigned geographical areas as delineated in AR 5-9 and MEDCOM Reg 40-21.

b. Medical equipment repairers will not be utilized in a health care facility's labor pool.

6. Responsibilities. Commanders at all levels will ensure medical equipment is inspected prior to being placed in use.

7. Procedures.

a. All medical equipment will receive a thorough inspection prior to being placed in use. Equipment requiring scheduled services will be included in the AMEDDPAS database.

b. Maintenance support to Military Entrance Processing Stations (MEPS) will continue in accordance with the MOU between MEDCOM and the Military Entrance Processing Command (MEPCOM).

c. Maintenance contracts will be used when qualified medical maintenance personnel are not available.

Appendix 6 (Prime Vendor and Contingency/ Exigency Contracts) to Annex D (Logistics) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide guidance for prime vendor and contingency/exigency contracts to support a contingency operation or mobilization.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. The MEDCOM mission no longer envisions expansion to large trauma and convalescent facilities. This expansion requirement necessitated the storage of large amounts of equipment with which to rapidly expand. The current concept is to expand only to the maximum capacity for which the hospital chassis were designed. This "within-the-walls" expansion reduced the requirement to have large stockpiles of equipment on hand. The MEDCOM has established contingency/exigency contracts in order to meet expansion requirements for non-expendable/durable equipment. The prime vendor initiative has also reduced the requirement to have expansion expendable stocks on hand. Each contract has contingency clauses written into them.

5. Policy. Not used.

6. Responsibilities. The Chief, Logistics Division will develop plans to ensure that equipment requirements have been identified by the Mobilization Planning Committee.

7. Procedures. Not used.

ANNEX E (Facilities) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. **References.** See Annex Y.
2. **Purpose.** To provide policy and guidance on medical facility expansion under contingency operations or mobilization conditions.
3. **Assumptions.** See paragraph 1d, basic plan.
4. **Concept.** Medical Treatment facilities will expand services within the existing medical facility physical plant (within core) only. Buildings of opportunity will not be used to provide hospitalization for inpatients.
5. **Policy.**
 - a. Nonmedical buildings of opportunity will not be used for hospitalization (inpatient) purposes.
 - b. Facility requirements for outpatient troop health, dental or medical clinics will be determined and resolved at the installation level by the responsible MTF through full-time use (multiple shift) of existing clinics.
6. **Responsibilities.** Not used.
7. **Procedures.** Not used.

ANNEX F (Reserve Components) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. **References.** See Annex Y.
2. **Purpose.** To provide information on the RC forces of the U.S. Army that support the MEDCOM during contingency or mobilization operations.
3. **Assumptions.** See paragraph 1d, basic plan.

4. Concept. The USAR has the mission to support the MEDCOM during contingency or mobilization operations. This contingency/mobilization mission includes the three missions of personnel backfill, personnel augmentation, and installation and deployment support. The USAR mobilization assets available to the MEDCOM to accomplish these missions are:

a. U.S. Army Reserve TDA Hospital (Caretaker). A single mission USAR unit that backfills a designated MTF that provides CT-PROFIS personnel to an active component (AC) activity. The USAR caretaker hospital's structure matches that of the AC caretaker hospital, and its authorized personnel mirror, by Area of Concentration (AOC) or Military Occupational Specialty (MOS) and grade, the MTF's CT-PROFIS losses.

b. U.S. Army Reserve TDA Hospital (Backfill). A single mission USAR unit that backfills a designated MTF that provides personnel to forward deployed activities such as the Korean PROFIS requirement and/or Europe. The USAR backfill hospital's structure matches that of the AC hospital's personnel losses or the minimum required backfill.

c. U.S. Army Reserve TDA Hospital (Augmentation). A single mission unit that augments a designated MTF. The USAR hospital is tailored to support the MTF's specific mission.

d. Installation and Deployment Support Unit (IDSU). The IDSU is a multiple mission unit that augments an MTF's capability to provide installation and deployment support. Its structure consists of up to three distinct elements: an Installation Medical Support Unit (IMSU), Veterinary cell, and a Blood Donor Center (BDC). The IDSU's organizational structure may contain

one, two, or all three of these elements. It has a unique unit identification code (UIC) with each element assigned a derivative UIC permitting it to mobilize as a complete unit or each element to mobilize independently.

(1) Whether mobilized with the IDSU or independently, the IMSU comes under the command and control of the MTF responsible for the health service area. The IMSU is not to be assimilated into the MTF, but will remain intact and retain its unit integrity.

(2) The IMSU's primary mission is to augment the MTF responsible for SRP at the Power Projection Platform (PPP) or Power Support Platform (PSP). This support will span the full mobilization spectrum from a PSRC through demobilization.

(3) Depending on the scenario and the level of operational tempo, it may be necessary for either the RMC or the MEDCOM to relocate the IMSU to a different Power Projection Platform or Power Support Platform. The MTFs must prepare to conduct SRP operations without the support of an IMSU.

e. Individual Reserve Component Personnel. In addition to TDA medical units, the USAR provides individuals in the following categories to backfill or augment MEDCOM.

(1) Individual Mobilization Augmentee. Personnel assigned as IMAs are USAR members of the Ready Reserve and fill positions within the MEDCOM and its subordinate activities during a contingency or mobilization. The majority of MEDCOM IMA authorizations are predesignated for backfill of PROFIS losses.

(2) Individual Ready Reserve. The IRR consists of unassigned pretrained individual

soldiers and IRR Augmentation personnel. They provide the majority of fillers required to bring both the AC and RC units up to the wartime required strength in the event of contingency or mobilization.

5. Policy. The RC TDA medical units should perform annual training at the MTF to which they are WARTRACE aligned.

6. Responsibilities.

a. The Chief, Plans Division, Office of the Assistant Chief of Staff for Operations (ACSOPS), MEDCOM is responsible for identifying RC requirements and coordinating with the U.S. Army Reserve Command (USARC) on WARTRACE alignments.

b. The RMCs are responsible for coordinating annual training for WARTRACE aligned USAR units. This coordination is accomplished through the Annual Training Site Scheduling Conferences held annually in each Continental U.S. Army (CONUSA).

c. All MEDCOM activities with assigned IMA and IRR Augmentee personnel are responsible for coordinating their annual training

7. Procedures. The procedures will be as outlined in MEDCOM Reg 500-5-5, Major Subordinate Command (MSC) Commanders' Handbook, of the Mobilization Planning System.

ANNEX G (Personnel) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance to support the MEDCOM personnel mobilization mission.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. The military and civilian work force will be reduced during a contingency operation or mobilization due to active duty deployments and the RC and retiree call-ups. The following measures will be taken to minimize the effect upon the MEDCOM and its subordinate activities.

a. Military personnel.

(1) Priorities for personnel distribution will be in accordance with the current Department of the Army Master Priority Listing (DAMPL) and those determined at the time of mobilization.

(2) Cross-leveling actions will be reported to HQ MEDCOM. MEDCOM personnel will not be cross-leveled to deploying units without the direction and approval of U.S. Army Personnel Command (PERSCOM).

b. Civilian personnel.

(1) The expansion of the civilian workforce is a potential source of personnel to support the MEDCOM mobilization mission.

(2) Planners will develop complementary programs to support the military effort for quick and effective execution to meet mobilization requirements.

5. Policy. Not used.

6. Responsibilities.

a. The Assistant Chief of Staff for Personnel (ACSPER) exercises staff responsibility at HQ MEDCOM for the establishment of the concept and procedures for personnel mobilization planning in support of the MEDCOM mobilization mission.

b. All MEDCOM commanders are responsible for, and will ensure completion of activity level

personnel mobilization requirements.

7. Procedures.

a. MEDCOM MTFs will develop appropriate plans for backfill of civilian losses due to mobilization. Plan for the expansion and management of the civilian workforce to support mobilization.

b. Personnel status will be reported in the Medical Situation Report (MEDSITREP) as required by MEDCOM Reg 525-3.

APPENDICES:

- 1 - Professional Filler System (PROFIS)
- 2 - Cross-Leveling of AMEDD Personnel
- 3 - Civilian Personnel Management in Mobilization

APPENDIX 1 (Professional Filler System (PROFIS)) to Annex G (Personnel) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To establish responsibilities and procedures in implementing AMEDD PROFIS system.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. During contingency operations or mobilization, The Surgeon General is responsible for managing AMEDD personnel, and bringing deploying and deployed OCONUS units up to required AMEDD strength. This responsibility will be met primarily through the designation of AMEDD personnel, within MEDCOM and its subordinate activities, as AMEDD professional fillers.

5. Policy.

a. All PROFIS assignments will be stabilized for a minimum of 18 months.

b. The PROFIS personnel must be prepared for movement and arrival on station in the designated time after initial notification.

6. Responsibilities.

a. The ACSPER MEDCOM will exercise staff supervision of PROFIS at HQ MEDCOM.

b. The MTF Commanders who have been tasked through the MSCs by HQ MEDCOM to provide PROFIS are responsible for ensuring that designated PROFIS requirements placed on their activity are filled.

7. Procedures. Procedures are delineated in AR 601-142.

APPENDIX 2 (Cross-leveling of AMEDD Personnel) to Annex G (Personnel) to MEDCOM Mobilization Plan (U) (MEDCOM-MP) (U)

1. References. See Annex Y.

2. Purpose. This appendix provides policy and guidance on cross-leveling of AMEDD personnel.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. It will be necessary to cross-level AMEDD personnel within and between MACOMs to bring deploying units up to deployable standards. The installation Strength Officer will identify shortfall requirements to DA PERSCOM. PERSCOM will validate the shortfall requirements and coordinate personnel taskings with MEDCOM prior to directing MEDCOM to provide personnel to the deploying unit.

5. Policy.

a. The AMOPES exempts MEDCOM AMEDD personnel from being cross leveled across MACOMs at the installation level. Cross-leveling AMEDD personnel across

MACOMs requires DA PERSCOM approval following coordination with MEDCOM.

b. Personnel losses due to cross-leveling within the command will not be backfilled on a one for one basis. The command's goal for personnel backfill for cross-leveling is 80 percent of losses. Backfill should be requested for essential positions only.

6. Responsibilities. The MEDCOM will monitor the cross-leveling actions within the command.

7. Procedures.

a. Cross-leveling personnel within and between MSCs.

(1) The HQ MEDCOM is the authority for cross-leveling between MSCs.

(2) The RMC Commander is the authority for cross-leveling MTFs within the RMC.

b. Cross-leveling between MACOMs. The exchange of FORSCOM non-deployable Area of Concentration/Military Occupational Specialty (AOC/MOS), to include Specialty Skill Identifier (SSI), qualified medical personnel for deployable MEDCOM MOS/SSI qualified medical personnel to staff deploying FORSCOM units during contingency or mobilization operations will be accomplished only on direction and approval of DA PERSCOM following coordination with MEDCOM.

APPENDIX 3 (Civilian Personnel Management in Mobilization) to Annex G (Personnel) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance for replacement of civilian workforce losses due to contingency or mobilization operations.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Portions of the civilian work force will become losses during contingency or mobilization operations due to membership in the RC or recall to active duty under a retiree recall. These personnel will need to be replaced to provide continuity of care, and additional personnel may need to be hired to support expanded operations.

5. Policy. Expansion under contingency or mobilization operations will be accomplished by expanding the military force. However, planners must establish plans and procedures for expansion of the civilian workforce to augment expansion efforts.

6. Responsibilities. Commanders at all echelons will ensure appropriate planning for hiring to replace losses and possible expansion requirement is accomplished.

7. Procedures. Procedures and emergency authorities are delineated in AR 690-11.

ANNEX H (Preventive Medicine) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. This annex provides policy and guidance for the preventive medicine program support of contingency or mobilization operations.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept.

a. Priorities for the MEDCOM preventive medicine program will be shifted to provide increased support to mobilization and/or deployment operations.

b. The U.S. Army Center for Health Promotion and Preventive Medicine (CHPPM) will provide general preventive medicine and occupational health support to the Army world wide. Specific direction will be provided by this headquarters to include changes in priority, scope and nature of support.

5. Policy. Planning for preventive medicine support must encompass support for all installations, including Federal semi-active and state operated mobilization stations.

6. Responsibilities. Not used.

7. Procedures. Preventive medicine procedures are governed by the references at Annex Y and other applicable regulations, Technical Bulletins-Medical, and field manuals in this functional area. The MTF's plans for the preventive medicine program must be written in the execution format establishing the "how" specific to the installation.

ANNEX I (Safety/Accident Prevention) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance for safety and accident prevention and reporting during contingency or mobilization operations.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept.

a. The safety professional at the RMC provides safety consultant services to all Army health care activities within the RMC.

b. The Safety personnel will provide contact safety services to medical activities within their command. These personnel

may be civilian safety professionals or military personnel trained in safety program management.

5. Policy.

a. The commander's safety policy must be clear and concise and be disseminated to all personnel throughout command channels.

b. A qualified member of each command will be designated by the commander to represent the command on all safety matters during contingency mobilization operations.

6. Responsibilities. Not used.

7. Procedures. Safety and accident prevention procedures are governed by the references at Annex Y and other applicable publications.

ANNEX J (Dental Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance on dental operations within MEDCOM during mobilization/contingency operations.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept.

a. In addition to providing patient care at the dental clinics, the U.S. Army Dental Command (DENCOM), through the RDCs and DENTACs, must also provide personnel to support SRP.

b. All deploying soldiers are required to be at least dental class 2. In peacetime, the DENCOM provides routine, emergency, and preventive dental care to the AC soldiers to maintain their dental health. The RC soldiers, however, will not

arrive with the same level of dental care.

5. Policy.

a. All deploying soldiers will be placed in dental class 2 prior to deployment unless the requirement is waived by proper authority.

b. For planning purposes, dental care should be made available at whatever time the soldiers are available.

6. Responsibilities. The DENCOM is responsible for providing dental care at all Army installations to include, PPPs, PSPs, semi-active and state-operated installations.

7. Procedures. Dental services are governed by the references in Annex Y and other publications.

ANNEX K (Veterinary Services) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. This annex provides policy and guidance on the Veterinary Command's role and responsibilities during contingency/mobilization operations.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept.

a. The Department of the Army's Veterinary Services serves as the DOD executive agent for veterinary medical care and will provide services to ensure the safety and quality assurance of the food supply to all military departments. The mission of the U.S. Army Veterinary Command (VETCOM) will expand significantly to support all military services and other DOD activities in their area of operations during mobilization.

b. Early employment will be required to meet increased decentralized food inspection support, expanded operations from prime vendors, support of deploying government-owned animals and evacuation of privately owned animals. The VETCOM may have to provide augmented support to Federal and state agencies, operational ration plants, water inspection, humanitarian operations, and other veterinary preventive medicine activities.

c. The location and size of the force supported will determine the veterinary support required from the reserve components. Reserve component personnel must be utilized as early as possible to augment the active component for the expanded mission requirements.

5. Policy. Not Used.

6. Responsibilities.

a. The Army Veterinary Service is responsible for DOD veterinary support to all military services and Federal and state agencies on either a task oriented or geographical basis.

b. The VETCOM is responsible for providing the RVCs with overall coordination of the veterinary mission, planning for information management (IM) requirements for the expanding veterinary mission, and providing resourcing and technical guidance under mobilization conditions.

c. The VETCOM is also responsible for zoonotic disease control and medical treatment of government-owned animals.

7. Procedures. The Veterinary Service procedures are governed by the references in Annex Y.

ANNEX L (Training) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance for the expansion of the Army Medical Department training base under contingency or mobilization conditions.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. During a contingency operation or mobilization, the U.S. Army Medical Department Center and School will continue to provide all current peacetime courses while expanding the AMEDD training base as necessary to meet contingency or mobilization requirements.

5. Policy.

a. Refresher training for AMEDD enlisted personnel will be conducted by the AMEDDC&S. The priority for refresher training will be given to enlisted specialists designated as combat replacements.

b. Students in GME programs will be assigned to PROFIS positions only with the approval of The Surgeon General.

6. Responsibilities.

a. The proponent teaching division at the AMEDDC&S is responsible for providing mobilization programs of instruction (MOBPOI), lesson plans, and other supporting materiel to the mobilization teaching location.

b. Commanders at all teaching locations are responsible for ensuring that planning for resourcing of mobilization teaching responsibilities is completed.

7. Procedures.

a. The Mobilization Army Program of Individual Training (MOBARPRINT) for mobilization courses is distributed to the teaching locations by the

AMEDDC&S for use in projecting mobilization teaching loads.

b. The MEDCOM can expect to be tasked to provide refresher training for Recently Trained 18 (RT-18) enlisted AMEDD personnel as early as partial mobilization.

c. Commanders have the discretionary authority to extend the training week and establish training shifts as best meets local conditions.

APPENDIX:

1 - Graduate Medical and Health Education

APPENDIX 1 (Graduate Medical and Health Education) to Annex L (Training) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. **References.** See Annex Y.

2. **Purpose.** The purpose of this appendix is to provide policy and guidance for the conduct of Graduate Medical Education (GME) and Graduate Health Education (GHE) under contingency operations or mobilization conditions.

3. **Assumptions.** See paragraph 1d, basic plan.

4. **Concept.**

a. Graduate Medical Education encompasses the professional (internship, residency, and fellowship) training of physicians to improve readiness and accomplish the Army's health care missions by ensuring the proper balance of physicians specialties are maintained.

b. Graduate Health Education encompasses the professional training of non-physicians to improve readiness and accomplish the Army's health care missions by ensuring the proper balance of specialties are maintained.

5. **Policy.**

a. The GME and GHE programs will function following mobilization as directed by The Surgeon General.

b. Personnel in GME and GHE will fall into the last category of providers used for PROFIS duties. The intent is to minimize the disruption of training to the greatest extent possible.

6. **Responsibilities.** Not used.

7. **Procedures.** The GME program procedures are governed by AR 601-142.

ANNEX M (Security) to MEDCOM Mobilization plan (U) (MEDCOM-MP) (U)

1. **References.** See Annex Y.

2. **Purpose.** This annex provides policy and guidance for the command security program during contingency/mobilization operations.

3. **Assumptions.** See paragraph 1d, basic plan.

4. **Concept.** A contingency operation or mobilization has the potential for an increased threat to the command, not only by opposing forces but also by dissident/disloyal personnel within the military service and civilian population. This increased threat can be countered by an enhanced security posture within the command.

5. **Policy.**

a. The status of foreign nationals in residence at MEDCOM installations and activities for training purposes will not change pending additional guidance from HQDA.

b. Direct release of information to foreign nationals who have requested information will be denied. All such requests

will be forwarded without action to HQ, MEDCOM.

6. Responsibilities. Commanders at all echelons are responsible maintaining an effective security program.

7. Procedures. Security procedures are governed by the references in Annex Y.

ANNEX N (Operations Security (OPSEC)) to MEDCOM Mobilization (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. This annex provides policy and guidance for secure planning, coordination, and conduct of pre-mobilization preparation for contingency operations or mobilization.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Operations security (OPSEC) is a process of analyzing the command's actions by determining indicators that hostile intelligence systems might exploit. Adversaries could interpret or piece together the data, thus deriving critical information. Once these indicators have been identified, measures must be selected and executed that eliminate or reduce these vulnerabilities to an acceptable level.

5. Policy. Operations security must be stressed at all levels of command.

6. Responsibilities.

a. Denying information to an enemy is a command responsibility.

b. The ACSOPS, HQ MEDCOM has staff responsibility for the command operations security program.

7. Procedures. Maintain OPSEC awareness through conducting periodic threat briefings. Ensure an OPSEC awareness briefing is given to all new personnel during their in-processing.

ANNEX O (Staff Chaplain) to MEDCOM Mobilization Plan (U) (MEDCOM-MP) (U)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance for a full program of ministry and pastoral care under contingency/mobilization conditions.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Contingency operations or mobilization conditions create special needs for the mobilizing and deploying forces and their families. These needs must be met by the pastoral community through enhancing the quality of health care by providing comprehensive religious and pastoral ministry to patients, soldiers, staff, and their family members. Planning must always focus on the requirement for pastoral care for the patient and the patient's family.

5. Policy.

a. Cross-leveling of chaplains and Unit Ministry Teams (UMT) within the RMC will be accomplished in coordination with the HQ MEDCOM Staff Chaplain upon recommendation of the RMC Staff Chaplain. Cross-leveling of chaplains and UMTs across RMCs will be as directed by the HQ MEDCOM Staff Chaplain.

b. Based on the contingency or mobilization scenario and level of operational tempo, all MEDCOM Chaplain IMA, regardless of assignment, will be considered resources for the primary receiving centers (PRC).

6. Responsibilities. Not used.

7. Procedures. No change in procedures from peacetime is envisioned. However, several additional actions may be required.

ANNEX P (Public Affairs) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance for the Public Affairs programs during a contingency operation or mobilization.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Public Affairs activities, to include requests for support from local or regional news media, will increase significantly during a contingency operation or mobilization. The activity should be geared toward maximizing the flow of cleared (releasable) information to the Army's internal and external publics.

5. Policy.

a. All subordinate activities of this command will perform a public affairs mission during and subsequent to mobilization.

b. Each subordinate activity will publish a weekly command information product.

c. Unless otherwise notified, the Freedom of Information Act and Privacy Acts will remain in force throughout MEDCOM.

d. Unless otherwise notified, do not invoke field Press Censorship. Forward all media queries to which the local office cannot respond, without comment, to HQ MEDCOM.

6. Responsibilities. The Chief, Public Affairs Office, HQ MEDCOM has overall staff responsibility for all public affairs matters regarding MEDCOM's role and activities.

7. Procedures. Not used.

ANNEX Q (Information Management) to MEDCOM Mobilization Plan (U) (MEDCOM-MP) (U)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance on utilization and expansion of information management services and facilities under contingency operation or mobilization conditions.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. The information management activities will provide required support under contingency operations or mobilization.

5. Policy.

a. Information management functions unchanged by the contingency/mobilization will continue to be subject to regulations in effect during peacetime, and will continue as normal.

b. Initial capabilities to support mobilization come from existing resources.

6. Responsibilities. The Assistant Chief of Staff, Information Management (ACSIM) at HQ MEDCOM has staff responsibility for all information management functions within the command. The MSCs have responsibility for information management within the confines of their command.

7. Procedures. Not used.

APPENDICES:

- 1 - Communications
- 2 - Automation
- 3 - Publications and Printing
- 4 - Records Management

APPENDIX 1 (Communications) to Annex Q (Information Management) to MEDCOM Mobilization Plan (MEDCOM-MP)

- 1. **References.** See Annex Y.
- 2. **Purpose.** This appendix provides policy and guidance for utilization and expansion of communications-electronics (C-E) services and facilities during contingency operations or mobilization.
- 3. **Assumptions.** See paragraph 1d, basic plan.
- 4. **Concept.** Existing common user facilities and services will be used to the maximum extent.
- 5. **Policy.** Not used.
- 6. **Responsibilities.** Not used.
- 7. **Procedures.** Requirements for additional capabilities will be prepared and submitted in the form of capability requirements (CAPR).

APPENDIX 2 (Automation) to Annex Q (Information Management) to MEDCOM Mobilization Plan (MEDCOM-MP)

- 1. **References.** See Annex Y.
- 2. **Purpose.** To provide policy and guidance for automation planning to support the MEDCOM mobilization mission.
- 3. **Assumptions.** See paragraph 1d, basic plan.
- 4. **Concept.** Automation activities will provide all required support under contingency operations or mobilization conditions.

5. **Policy.** Mobilization mission essential applications will have operational priority.

6. **Responsibilities.** Not used.

7. **Procedures.** Automation procedures are governed by the references in Annex Y.

APPENDIX 3 (Publications and Printing) to Annex Q (Information Management) to MEDCOM Mobilization Plan (MEDCOM-MP)

- 1. **References.** See Annex Y.
- 2. **Purpose.** This appendix provides policy and guidance for the publications and printing programs in the command under contingency operations or mobilization conditions.
- 3. **Assumptions.** See paragraph 1d, basic plan.
- 4. **Concept.** The publications and printing program will expand, as necessary, to support the command's mobilization mission.

5. **Policy.** Not used.

6. **Responsibilities.** Not used.

7. **Procedures.** Publications and printing procedures are governed by the references in Annex Y.

APPENDIX 4 (Records Management) to Annex Q (Information Management) to MEDCOM Mobilization Plan (MEDCOM-MP)

- 1. **References.** See Annex Y.
- 2. **Purpose.** To provide policy and guidance for the records management program in the command during contingency operations or mobilization.
- 3. **Assumptions.** See paragraph 1d, basic plan.

4. Concept. The records management program will expand to support the command under mobilization conditions.

5. Policy. Not used.

6. Responsibilities. Not used.

7. Procedures. Records management procedures are governed by the references in Annex Y.

ANNEX R (Demobilization) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance on medical/dental processing and treatment of demobilizing AC and RC soldiers during the demobilization process.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. The MEDCOM activities will support the demobilization process. The MEDCOM activities, both MTFs and DTFs, will provide personnel to conduct medical examination, medical screenings, dental screenings, and counseling regarding latent health risks and health care benefits.

5. Policy. Peacetime health care services will be maintained for eligible beneficiaries while the demobilization process is being executed.

6. Responsibilities. The MEDCOM is responsible for providing medical, dental, and IMSA support for the demobilization process at designated CONUS installations.

7. Procedures. Demobilization procedures are governed by the references in Annex Y, and are described in MEDCOM Regulation 500-5-5, Commanders' and Medical

Mobilization Planners' Handbook, MEDCOM-MPS.

APPENDICES:

- 1 - Medical Examination
- 2 - Dental Examination
- 3 - Patient Administration

APPENDIX 1 (Medical Examination) to Annex R (Demobilization) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance in the conduct of medical examinations for demobilizing personnel.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Medical screening/examinations will be provided to all demobilizing soldiers. All demobilizing soldiers will receive counseling regarding latent health risks and health care benefits.

5. Policy. Soldiers separating from the Army will receive a separation medical examination if the soldier requests it, or if, on review of the medical records or the DD Form 2697, a physician, physician assistant, or nurse practitioner feels an examination is appropriate.

6. Responsibilities. The MEDCOM is responsible for providing medical screenings/examinations to all demobilizing soldiers.

7. Procedures. Demobilization procedures are provided in MEDCOM Regulation 500-5-5, Commanders' and Medical Mobilization Planners' Handbook, MEDCOM-MPS.

APPENDIX 2 (Dental Examination) to Annex R (Demobilization) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. **References.** See Annex Y.
2. **Purpose.** To provide policy and guidance in the conduct of dental examinations for demobilizing personnel.
3. **Assumptions.** See paragraph 1d, basic plan.
4. **Concept.** All demobilizing soldiers will receive a dental screening/examination prior to separation from active Federal service.
5. **Policy.** Dental conditions which existed prior to service (EPTS) may not be treated at government expense after separation from active Federal service. Prior to separation, RC soldiers are eligible to have dental conditions treated in the dental treatment facility (DTF). After separation, RC soldiers are only eligible for in line of duty (LOD) conditions to be treated in the DTF or at government expense.
6. **Responsibilities.** The DENCOM has the responsibility to ensure all demobilizing soldiers receive a dental screening/examination prior to separation from active Federal service.
7. **Procedures.** Demobilization dental examination procedures are provided in MEDCOM Reg 500-5-5, Commanders' and Medical Mobilization Planners' Handbook, MEDCOM-MPS.

APPENDIX 3 (Patient Administration) to Annex R (Demobilization) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. **References.** See Annex Y.
2. **Purpose.** To provide policy and guidance on patient administration during demobilization.
3. **Assumptions.** See paragraph 1d, basic plan.

4. **Concept.** Soldiers who become ill or are injured during the demobilization process will be treated at the appropriate medical facility and returned to duty or regulated to the MTF closest to their PPP or PSP that has the necessary treatment capabilities.

5. **Policy.** Not used.

6. **Responsibilities.** Not used.

7. **Procedures.** Patient administration demobilization procedures are provided in MEDCOM Reg 500-5-5, Commanders' and Medical Mobilization Planners' Handbook, MEDCOM-MPS.

ANNEX S (Provost Marshal) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. **References.** See Annex Y.
2. **Purpose.** To provide policy and guidance for law enforcement and security under contingency operations and/or mobilization conditions.
3. **Assumptions.** See paragraph 1d, basic plan.
4. **Concept.** Law enforcement and security activities provide a secure and orderly environment to expedite the mobilization process. The MEDCOM will experience turbulence, rapid growth, and a marked change in mission demands as installations and medical activities expand to meet contingency operations or mobilization requirements. Prior planning is essential to ensure effective security is established to support mobilization operations.

5. **Policy.** Not used.

6. **Responsibilities.** Not used.

7. **Procedures.** Provost Marshal procedures are governed by references in Annex Y.

APPENDICES:

- 1 - Physical Security
- 2 - Confinement Operations

APPENDIX 1 (Physical Security) to ANNEX S (Provost Marshal) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y, this plan.

2. Purpose. To provide command policy, guidance, and procedures for safeguarding personnel, equipment, and facilities under mobilization conditions.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. An increased population and level of activity can be expected during the transition from peacetime to mobilization. This increased activity requires that physical security programs be capable of meeting the increased threat to persons and property.

5. Policy. Commanders at all levels will implement physical security programs in accordance with applicable directives to ensure precautions are taken to safeguard personnel and material.

6. Responsibilities. The MEDCOM Provost Marshal has staff responsibility for physical security within the command.

7. Procedures. The physical security procedures are governed by the references in Annex Y.

APPENDIX 2 (Confinement Operations) to Annex S (Provost Marshal) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance for confinement procedures at MEDCOM installa-

tions under contingency operations or mobilization.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Designated MEDCOM installations may have a confinement mission. The increased population and level of activity experienced during contingency operations or mobilization may result in an increase in these confinement operations.

5. Policy. Not used.

6. Responsibilities. The MEDCOM installation commanders are responsible for the confinement and administration of U.S. military prisoners and the operation of U.S. Army confinement facilities, unless an MOU with a supporting installation or facility has been approved.

7. Procedures.

a. Each installation must plan for its expanded confinement requirements. If prisoners are to be confined on the installation, the installation mobilization plan and MOBTDA must reflect the additional personnel, facilities, and equipment requirements. If confinement requirements are to be supported by another installation, Service, or agency, a comprehensive support agreement must be developed.

b. Coordination must be made with the Director of Public Works (DPW) to ensure any requirements for facility modification, expansion, or new construction is included in the Master Mobilization Plan. Confinement planners should consider those increased post-mobilization confinement requirements may be temporary and should decline as mobilizing units deploy, therefore temporary facilities may be adequate.

ANNEX T to MEDCOM Mobilization Plan (MEDCOM-MP)

(NOT USED)

ANNEX U (Emergency Operations Center) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance in the operation of an Emergency Operations Center under contingency operations and/or mobilization conditions.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept.

a. The EOC, when activated, becomes the focal point for command, control, coordination, and monitoring of contingency operations and mobilization actions. All staff actions pertaining to the crisis will be coordinated through the EOC, and all incoming and outgoing crisis related messages will be transmitted through the EOC after being entered in the message log.

b. Streamlined staff procedures are required during contingency operation or mobilization due to the significant increase in the volume of decisions to be made and the actions that will be generated prior to, during, and after a contingency operation or mobilization. During the contingency or mobilization, the timeliness of decisions is critical. The purpose of the modified staff action process is to facilitate a prompt and reasonable solution to a problem in order to make a timely decision.

5. Policy. All MEDCOM activities will establish an EOC in response to a contingency operation or mobilization.

6. Responsibilities. Commanders are responsible for activation of the activity EOC.

7. Procedures. Emergency operations center procedures are governed by the references in Annex Y.

ANNEX V (Historical Activities) to MEDCOM Mobilization Plan (MEDCOM-MP)

1. References. See Annex Y.

2. Purpose. To provide policy and guidance for historical activities under contingency or mobilization conditions.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. Historical material is useful to commanders and staff in analyzing and evaluating past operations. Since important events and developments may be nearly impossible to authoritatively reconstruct long after the event, contemporaneous research and writing are needed to adequately describe such developments. Historical records become the basis for "lessons learned."

5. Policy. All MEDCOM activities will establish and maintain current historical activities operations to assist in the preparation and submission of historical report.

6. Responsibilities. The commander at all levels is responsible for ensuring historical information is captured and submitted in a timely manner.

7. Procedures.

a. Key to the preparation of any history is the capture of important supporting documents. A historical file should be maintained at the activity level. The historical file consists of messages, memoranda, charts,

graphs, situation reports, activation orders, etc., that form the basis for historical reports and lessons learned. The entire activity staff must be aware of the importance of building these historical files, and submit input to the historian on a regular basis.

b. The annual historical report of AMEDD activities is the principal historical vehicle for activities to provide HQ MEDCOM with historical activities.

c. Periodic special historical reports. Recognizing that the duration of a contingency operation may not fit the timing of the annual historical report, this headquarters may require the submission of a one-time special historical report covering the contingency operation.

ANNEX W to MEDCOM Mobilization Plan (MEDCOM-MP)

(NOT USED)

ANNEX X (Glossary) to MEDCOM Mobilization Plan (U) (MEDCOM-MP) (U)

1. **References.** Not applicable.
2. **Purpose.** To provide a listing of acronyms and abbreviations used in this plan.
3. **Assumptions.** See paragraph 1d, basic plan.
4. **Concept.** This annex consists of an alphabetical listing of acronyms and abbreviations used in this plan.
5. **Policy.** Not applicable.
6. **Responsibilities.** Not applicable.
7. **Procedures.** The acronyms used in this regulation are listed in alphabetical order.

- AC..... Active Component
- ACLS..... Advanced Cardiac Life Support
- ACSIM..... Assistant Chief of Staff for Information Management
- ACSLOG..... Assistant Chief of Staff for Logistics
- ACSOPS..... Assistant Chief of Staff for Operations
- ACSPER..... Assistant Chief of Staff for Personnel
- ACSRM..... Assistant Chief of Staff for Resource Management
- AHC..... Army Health Clinic
- AMEDD..... Army Medical Department
- AMEDDC&S..... U.S. Army Medical Department Center and School
- AMEDDPAS..... Army Medical Department Property Accounting System
- AMOPES..... Army Mobilization and Operations Planning and Execution System
- AOC..... Area of Concentration
- APOE..... Aerial Port of Embarkation
- AR..... Army regulation

AR-PERSCOM.....	U.S. Army Reserve Personnel Com- mand	System -D-
ASBPO.....	Armed Services Blood Program Office	DA..... Department of the Army
ASD-HA.....	Assistant Secre- tary of Defense for Health Affairs	DAMPL..... Department of the Army Master Priority List- ing
ASWBPL.....	Armed Services Whole Blood Processing Laboratory	DENCOM..... U.S. Army Dental Command
AUTODIN.....	Automatic Digi- tal Network	DENTAC..... Dental Activity
	-B-	DHS..... Director of Health Services
BASOPS.....	Base Operations	DMRIS..... Defense Medical Regulating Information System
BDC.....	Blood Donor Center	DOD..... Department of Defense
BLS.....	Basic Life Support	DPCA..... Director of Personnel and Community Activities
	-C-	DPCCM..... Director of Primary Care and Community Medi- cine
CAPR.....	Capability requirements	DPTMS..... Directorate of Plans, Training, Mobilization and Security
C-E.....	Communications- Electronics	DPW..... Directorate of Public Works
CHPPM.....	U.S. Army Center for Health Pro- motion and Pre- ventive Medicine	DSN..... Defense Switch- ing Network
CINC.....	Commander-in- Chief	DTF..... Dental Treatment Facility
CONUS.....	Continental United States	DVA..... Department of Veterans Affairs
CONUSA.....	Continental United States Army	
CT-PROFIS.....	Caretaker Pro- fessional Filler	

-E-
 EOC..... Emergency Operations Center

EPTS..... Existed Prior to Service

-F-
 FCC..... Federal Coordinating Center
 FORSCOM..... U.S. Army Forces Command

-G-
 GCCS-A..... Global Command and Control System - Army

GHE..... Graduate Health Education

GME..... Graduate Medical Education

GMR..... Graduated Mobilization Response

GPMRC..... Global Patient Movement Requirements Center

-H-
 HQ..... Headquarters
 HQDA..... Headquarters, Department of the Army
 HSA..... Health Service Area

-I-
 IAW..... In Accordance With
 IDSU..... Installation and Deployment Support Unit

IM..... Information Management

IMA..... Individual Mobilization Augmentee

IMSA..... Installation Medical Supply Activity

IMSU..... Installation Medical Support Unit

IRR..... Individual Ready Reserve

ISSA..... Inter-Service Support Agreement

IV. Intravenous

-J-
 JMRO..... Joint Medical Regulating Officer

-K-

-L-
 LOD..... Line of Duty
 LOGCAP..... Logistics Civil Augmentation Package

-M-
 M-Day..... Mobilization Day

MACOM..... Major Army Command

MEDCASE..... Medical Care Support Equipment

MEDCEN..... U.S. Army Medical Center

MEDCOM..... U. S. Army Medical Command

MEDCOM-MP.....	U. S. Army Medical Command Mobilization Plan	-N-
MEDCOM-MPS.....	MEDCOM Mobiliza- tion Planning System	NDMS..... National Disas- ter Medical System
MEDDAC.....	Medical Depart- ment Activity	NGB..... National Guard Bureau
MEDSITREP.....	Medical Situa- tion Report	-O-
MEPCOM.....	Military En- trance Process- ing Command	OCAR..... Office, Chief Army Reserve
MEPS.....	Military En- trance Process- ing Station	OCONUS..... Outside the Continental United States
MOA.....	Memorandum of Agreement	OMA..... Operations and Maintenance, Army
MOBARPRINT.....	Mobilization Army Program of Individual Training	OPSEC..... Operations Security
MOBPOI.....	Mobilization Program of Instruction	-P-
MOBTDA.....	Mobilization Table of Distri- bution and Allowances	PA..... Physicians Assistant or Public Affairs
MOS.....	Military Occupa- tional Specialty	PAD..... Patient Admini- stration Divi- sion
MOU.....	Memorandum of Understanding	PERSCOM..... U.S. Army Per- sonnel Command
MPA.....	Military Pay Account	PMC..... Precious Metals Coordinator
MRMC.....	U.S. Army Medi- cal Research and Materiel Command	PPP..... Power Projection Platform
MSC.....	Major Subordi- nate Command	PRC..... Primary Receiv- ing Center
MTF.....	Medical Treat- ment Facility	PROFIS..... Professional Filler System
		PSP..... Power Support Platform
		PSRC..... Presidential Selected Reserve Call-up

-Q-

TPU..... Troop Program Unit

-R-

TSG..... The Surgeon General

RBC..... Red Blood Cell

TTAD..... Temporary Tour of Active Duty

RC..... Reserve Component

RDC..... Regional Dental Command

-U-

REG..... Regulation

UIC..... Unit Identification Code

RMC..... Regional Medical Command

UMT..... Unit Ministry Team

RT-18..... Recently Trained Within 18 Months

U.S..... United States

RVC..... Regional Veterinary Command

USAF..... U.S. Air Force

-S-

USAMMA..... U.S. Army Medical Materiel Agency

SICC..... Service Item Control Center

USAR..... U.S. Army Reserve

SPOE..... Seaport of Embarkation

USARC..... U.S. Army Reserve Command

SRP..... Soldier Readiness Processing

USASAM..... U.S. Army School of Aviation Medicine

SSI..... Specialty Skill Identifier

USR..... Unit Status Report

SWS..... Social Work Services

-V-

VETCOM..... U.S. Army Veterinary Command

-T-

-W, X, Y, Z-

TDA..... Table of Distribution and Allowances

ANNEX Y (References) to MEDCOM Mobilization Plan (MEDCOM-MP)

TMC..... Troop Medical Clinic

1. **References.** This annex.

TOE..... Table of Organization and Equipment

2. **Purpose.** This annex provides a listing of references applicable to mobilization, deployment, and demobilization.

TPMRC..... Theater Patient Movement Requirements Center

3. **Assumptions.** See paragraph 1d, basic plan.

4. **Concept.** References are listed by annexes.

5. **Policy.** Not applicable.

6. **Responsibilities.** Each staff office is responsible for keeping the references for their applicable annex/appendix current.

7. **Procedures.** References are listed by annexes.

Annex A (Concept of Operations)

MEDCOM Reg 500-5-2, U.S. Army Medical Command Concept of Operations.

Annex B (Health Care Services)

Public Law 97-174, Section 5011A, Department of Veterans Affairs (DVA) and Department of Defense (DoD) Health Resource Sharing and Emergency Operations Act.

CFR, Title 21, Code of Federal Regulations, Parts 600 to 799.

DOD Dir 6010.17, National Disaster Medical System (NDMS).

DOD Dir 600-12, Armed Services Blood Program.

DODI 6015.1-M, Glossary of Health Care Terminology.

DODI 6480.4, Blood Program Mobilization Planning Factors, Blood Products and Resuscitation Fluids.

DOD Military Blood Program Mobilization Plan 1-75 (C).

JCS Pub 33, Volume I, Section IV, Military Blood Program.

AR 40-2, Army Medical Treatment Facilities: General Administration, Chapter 12, Army Blood Program.

AR 40-3, Medical, Dental, and Veterinary Care.

AR 40-4, Army Medical Department Facilities/Activities.

AR 40-5, Preventive Medicine.

AR 40-40, Documentation Accompanying Patients Aboard Military Common Carriers.

AR 40-350, Patient Regulating to and within the Continental United States.

AR 40-501, Standards of Medical Fitness.

AR 40-535, Worldwide Aeromedical Evacuation.

AR 190-47, The Army Corrections System.

AR 500-60, Disaster Relief.

AR 600-8-101, Personnel Processing (In and Out and Mobilization Processing).

AR 600-25, Salutes, Honors, and Visits of Courtesy.

AR 600-75, Exceptional Family Member Program.

AR 601-142, Army Medical Department Professional Filler System.

AR 608-1, Army Community Service Program.

AR 608-10, Child Development Services.

AR 608-18, The Army Family Advocacy Program.

DA PAM 360-525, Family Assistance Handbook for Mobilization.

Army Mobilization and Operations Planning and Execution System (AMOPES).

MEDCOM Reg 10-1, Organization and Functions Policy.

MEDCOM Reg 40-21, Regional Medical Commands and Regional Dental Commands.

MEDCOM Reg 500-3, Veterans Administration and the Department of Defense (DOD) Contingency Hospital System Plan.

MEDCOM Reg 500-5-2, U.S. Army Medical Command Mobilization Concept of Operations.

MEDCOM Reg 525-3, Emergency Operations Control.

FM 8-70, Standards for Blood Banks and Transfusion Services.

TM 8-227-3, The Technical Manual of the American Association of Blood Banks.

TM 8-227-11, Operational Procedures for the Armed Services Blood Program Elements.

AFM 164-1, Administration of Aeromedical Staging Flights.

DVA Cir 10-95-007, DVA/DoD Contingency Planning and Planning in Support of Federal response Plan (FRP). National Disaster Medical System Coordinating Center Guide. National Disaster Medical System Disaster Exercise Guide.

Annex C (Resource Management)

AR 140-145, Individual Mobilization Augmentation (IMA) Program.

AR 570-4, Manpower Management.

DA Pam 570-557, Staffing Guide for U.S. Army Medical Department Activities.

Military Occupational Classification and Structure Update.

MEDCOM Reg 10-1, Organization and Functions Policy.

Annex D (Logistics)

AR 40-2, with MEDCOM Suppl 1, Army Medical Treatment Facilities: General Administration.

AR 40-61, Medical Logistics Policies and Procedures.

AR 40-63, Ophthalmic Services.

AR 58-1, Management, Acquisition, and Use of Administrative Use Motor Vehicles.

AR 700-137, Logistics Civil Augmentation Program (LOGCAP).

AR 710-1, Centralized Inventory Management of the Army Supply System.

AR 710-2, Inventory Management Supply Policy Below the Wholesale Level.

AR 725-50, Requisitioning, Receipt, and Issue System.

AR 735-5, Policies and Procedures for Property Accountability.

AR 750-1, Army Materiel Maintenance Policy and Retail Maintenance Operations.

Army Mobilization and Operations Planning and Execution System (AMOPES).

MEDCOM Reg 500-5, The U.S. Army Medical Command Mobilization Planning System.

MEDCOM Reg 40-21, Regional Medical Commands and Regional Dental Commands.

MEDCOM Reg 750-1, Maintenance of Medical Equipment.

FORSCOM Reg 500-3-3, Reserve Component Unit Commanders Handbook.

TB 38-750-2, Maintenance Management Procedures for Medical Equipment.

SB 8-75-MEDCASE, Army Medical Department Supply Information. ADSM 1 8-HL3-RPB-IBM-M, AMEDDPAS User's Manual.

Annex E (Facilities)

AR 415-15, Army Military Construction Program Development and Execution.

Army Mobilization and Operations Planning and Execution System (AMOPES).

Message HQDA, DACS-ZB, 112215Z, Dec 90, Subject: Facilities Reduction.

Annex F (Reserve Components)

AR 135-200, Active Duty for Training, Annual Training, and Active Duty for Special Work of Individual Soldiers.

AR 135-210, Order to Active Duty as Individuals for Other than a Presidential Selected Reserve Call-Up, Partial or Full Mobilization.

AR 140-1, Army Reserve: Mission, Organization, and Training.

AR 140-10, Army Reserve: Assignments, Attachments, Details, and Transfers.

AR 140-145, Individual Mobilization Augmentation (IMA) Program.

Army Mobilization and Operations Planning and Execution System (AMOPES).

FORSCOM Reg 500-3-1, FORSCOM Mobilization Plan.

TMOPS, TRADOC Mobilization and Operations Planning System.

Annex G (Personnel)

AR 570-4, Manpower Management.

AR 601-142, Army Medical Department Professional Filler System.

AR 690-11, Mobilization Planning and Management.

Army Mobilization and Operations Planning and Execution System (AMOPES).

Federal Personnel Manual, Chapter 910.

Annex H (Preventive Medicine)

AR 40-5, Preventive Medicine.

HSC Reg 40-30, HSC Operating Program - Preventive Medicine Program for MEDCEN/MEDDAC.

MEDCOM Pam 40-3, Environmental Health Program.

Annex I (Safety/Accident Prevention)

AR 385-10, with HSC Suppl 1, The Army Safety Program.

AR 385-11, Ionizing Radiation Protection (Licensing, Control, Transportation, Disposal and Radiation Safety).

AR 385-40, Accident Reporting and Records.

AR 385-55, with MEDCOM Suppl 1, Prevention of Motor Vehicle Accidents.

FM 101-5, Staff Organization and Operations, Sec III, Paragraph 4-5b(5), Appendix B.

NFPA Pubs 3M, 10, 56A, 56B, 56C, 70, 76A, and 82.

Annex J (Dental Services)

AR 40-3, Medical, Dental, and Veterinary Care.

AR 40-35, Preventive Dentistry.

AR 40-66, Medical Record Administration and Health Care Documentation.

AR 135-381, Incapacitation of Reserve Component Soldiers.

AR 600-8-101, Personnel Processing (In-and-Out and Mobilization Processing).

AR 635-10, Processing Personnel for Separation.

Annex K (Veterinary Services)

DoD DIR 6015.5, Joint Use of Military Health and Medical Facilities.

AR 30-12, Inspection of Subsistence Supplies and Services.

AR 40-1, Composition, Mission, and Functions of the Army Medical Department.

AR 40-3, Medical, Dental, and Veterinary Care.

AR 40-5, Preventive Medicine.

AR 40-656, Veterinary Surveillance Inspection of Subsistence.

AR 40-657, Veterinary/Medical Food Inspection and Laboratory Service.

AR 40-905, Veterinary Health Services.

MEDCOM Reg 10-1, Organization and Functions Policy.

MEDCOM Reg 40-28, Veterinary Standardization Policies and Procedures.

Annex L (Training)

AR 40-1, Composition, Mission, and Functions of the Army Medical Department.

AR 350-1, Army Training.

AR 350-10, Management of Army Individual Training Requirements and Resources.

AR 350-28, Army Exercises.

Army Mobilization and Operations Planning and Execution System (AMOPES)

MEDCOM Reg 350-4, Readiness Training Requirements.

FORSCOM Reg 500-3-1, FORSCOM Mobilization Plan.

TRADOC Mobilization and Operations Planning System (TMOPS).

AMEDDC&S Training Base Expansion Plan (AMEDDC&S TBEP).

Annex M (Security)

AR 380-5, with MEDCOM Suppl 1, Department of the Army Information Security Program.

AR 380-10, Technology Transfer, Disclosure of Information and Contacts with Foreign Representatives.

AR 380-13, Acquisition and Storage of Information Concerning Nonaffiliated Persons and Organizations.

AR 380-19, Information Systems Security.

AR 380-19-1, Control of Compromising Emanations.

AR 380-40, Policy for Safeguarding and Controlling Communications Security (COMSEC) Materiel.

AR 380-53, Information Systems Security Monitoring.

AR 380-67, The Department of the Army Personnel Security Program.

AR 380-150, with MEDCOM Suppl 1, Access to and Dissemination of Restricted Data.

AR 381-12, Subversion and Espionage Directed Against the U.S. Army (SAEDA).

AR 381-14, Technical Surveillance Countermeasures (TSCM).

AR 381-19, Intelligence Dissemination and Production Support.

AR 381-45, Investigative Records Repository.

AR 530-1, with MEDCOM Suppl 1, Operations Security.

AR 604-10, Military Personnel Security Program.

MEDCOM Pam 380-2, Handbook for Security Managers.

Annex N (Operations Security)

AR 530-1, with MEDCOM Suppl 1, Operations Security.

Annex O (Staff Chaplain)

AR 140-145, Individual Mobilization Augmentation (IMA) Program.

AR 165-1, Chaplain Activities in the U.S. Army.

AR 601-10, Management and Mobilization of Retired Soldiers of the Army.

AR 614-30, Overseas Service.

Army Mobilization and Operations Planning and Execution System (AMOPES).

FORSCOM Reg 500-3-1, FORSCOM Mobilization Plan.

UMT Information Handbook on Mobilization.

Annex P (Public Affairs)

AR 360-5, Army Public Affairs Public Information.

AR 360-61, Community Relations.

AR 360-81, Command Information Program.

DA Pam 360-3, Army Hometown News Program.

Annex Q (Information Management)

AR 25-1, The Army Information Resources Management Program.

AR 25-30, The Army Publishing and Printing Program.

AR 25-51, Official Mail and Distribution Management.

AR 25-400-2, The Modern Army Recordkeeping System (MARKS).

AR 340-21, The Army Privacy Program.

AR 380-19, with MEDCOM Suppl 1, Information Systems Security.

Army Mobilization and Operations Planning and Execution System (AMOPES).

DA Pam 25-1-1, Installation Information Services.

Annex R (Demobilization)

AR 40-66, Medical Record Administration and Health care Documentation.

AR 40-501, Standards of Medical Fitness.

AR 135-381, Incapacitation of Reserve Component Soldiers.

AR 360-5, Army Public Affairs, Public Information.

AR 360-61, Community Relations.
AR 360-81, Command Information Program.

AR 600-8-1, Army Casualty Operations/Assistance/Insurance.

AR 600-8-101, Personnel Processing (In-and-Out and Mobilization Processing).

AR 600-110, Identification, Surveillance, and Administration of Personnel Infected with HIV.

AR 635-10, Processing Personnel for Separation.

Annex S (Provost Marshal)

AR 190-5, Motor Vehicle Traffic Supervision.

AR 190-9, Absentee Deserter Apprehension Program and Surrender of Military Personnel to Civilian Law Enforcement Agencies.

AR 190-11, with MEDCOM Suppl 1, Physical Security of Arms, Ammunition, and Explosives.

AR 190-12, Military Police Working Dogs.

AR 190-13, with MEDCOM Suppl 1, The Army Physical Security Program.

AR 190-14, Carrying of Firearms and Use of Force for Law Enforcement and Security Duties.

AR 190-22, with MEDCOM Suppl 1, Searches, Seizures, and Disposition of Property.

AR 190-24, Armed Forces Disciplinary Control Boards and Off-Installation Liaison and Operations.

AR 190-27, Army Participation in National Crime Information Center (NCIC).

AR 190-29, Misdemeanors and Uniform Violation Notices Referred to U.S. Magistrates or District Courts.

AR 190-30, with MEDCOM Suppl 1, Military Police Investigations.

AR 190-40, with MEDCOM Suppl 1, Serious Incident Report.

AR 190-45, with MEDCOM Suppl 1, Law Enforcement Reporting.

AR 190-47, The Army Corrections System.

AR 190-48, Protection of Federal Witnesses on Active Army Installations.

AR 190-51, Security of Unclassified Army Property (Sensitive and Nonsensitive).

AR 190-53, Interception of Wire and Oral Communications for Law Enforcement Purposes.

AR 525-13, Anti-terrorism Force Protection (AN/FP).

MEDCOM Reg 40-21, Regional Medical Commands and Regional Dental Commands.

MEDCOM Reg 190-1, MEDCOM Key and Lock Control and Physical Security Standards.

FM 19-10, The Military Police Law and Order Operations.

FM 19-15, Civil Disturbances.

FM 19-20, Law Enforcement Investigations.

FM 19-25, Military Police Traffic Operations.

FM 19-30, Physical Security.

FM 19-60, Confinement and Correctional Treatment of U.S. Military Prisoners.

MCM 1969 (Rev), Geneva Convention.

Annex T

(Not Used)

Annex U (Emergency Operations Center)

AR 525-1, The Department of the Army Command and Control System (DACCS).

MEDCOM Reg 525-3, Emergency Operations Control.

FM 101-5, Staff Officers Field Manual, Staff Organization and Operations.

Annex V (Historical Activities)

AR 40-226, Annual Historical Report, AMEDD Activities.

AR 870-5, Military History: Responsibilities, Policies, and Procedures.

MEDCOM Pam 870-1, A Guide for the Additional-Duty HSC Historian.

Annex W

(Not Used)

Annex X

(No References)

Annex Y

(No References)

Annex Z

(No References)

**ANNEX Z (Distribution) to MEDCOM
Mobilization Plan (MEDCOM-MP)**

1. References. Not Used.

2. Purpose. To provide a distribution listing for this plan.

3. Assumptions. See paragraph 1d, basic plan.

4. Concept. The MEDCOM Mobilization Plan will be distributed to all commands, activities, and offices with a need to know.

5. Policy. Not applicable.

6. Responsibilities. Not applicable.

7. Procedures. This plan will be distributed to each MEDCOM Staff Office, MEDCOM subordinate command and activity, OTSG, HQDA Agencies, Army Installations, Commanders-in-Chief of Unified and Specified Commands, Department of Veterans Affairs, and each WARTRACE aligned Reserve Component unit.

The proponent of this publication is the Office of the Assistant Chief of Staff for Operations. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, U.S. Army Medical Command, ATTN: MCOP-P, 2050 Worth Road, Fort Sam Houston, Texas 78234-6007.

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