

Army Regulation 40-61

Medical Services

Medical Logistics Policies

**Headquarters
Department of the Army
Washington, DC
28 January 2005**

UNCLASSIFIED

SUMMARY of CHANGE

AR 40-61

Medical Logistics Policies

This revision, dated 28 January 2005--

- o Establishes separate policies and chapters for medical logistics systems (chap 2), facilities management (chap 8), and optical fabrication (chap 11).
- o Designates funding of medical supply support activities' stock accounts through Operations and Maintenance, Army (table of organization and equipment), Operations and Maintenance, Defense (designated tables of distribution and allowances), or the Defense Wide Working Capital Fund (designated tables of distribution and allowances) (para 3-3).
- o Designates acquisition methodologies (paras 3-5 and 3-6).
- o Defines materiel standardization and provides implementation instructions, role descriptions, and parameters (paras 3-16 through 3-19).
- o Provides guidance for equipment acquisition for deployed medical table of organization and equipment units (para 5-23).
- o Establishes policies for the acquisition of supplies and equipment for medical modified table of organization and equipment units operating troop medical clinics or dispensaries in garrisons (para 5-23i).
- o Establishes policies for the Patient Movement Item Program (para 5-27).
- o Changes the term "services management in health care organizations" to "environmental services management" (chap 7).
- o Changes the Army Reserve Program to focus on medical materiel readiness (chap 9).
- o Specifies that medical materiel readiness applies to the total force throughout all phases of planning, program, and execution (para 9-1b).
- o Outlines major organization readiness policies and responsibilities (para 9-2).
- o Rescinds DA Form 2717 (Optical Laboratory Report).
- o Rescinds DA Form 3321 (Request for Acknowledgment of Loaned Durable Medical Equipment).
- o No longer prescribes DA Form 4996-R (Quality Control Card), DA Form 4997-R (Locator Card), and DA Form 4998-R (Quality Control and Surveillance Record for TOE Medical Assemblages). (They will be prescribed in SB 8-75-11.)

Medical Services

Medical Logistics Policies

By Order of the Secretary of the Army:

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General, United States Army
Chief of Staff

Official:


SANDRA R. RILEY
Administrative Assistant to the
Secretary of the Army

History. This publication is a major revision.

Summary. This regulation prescribes policies for managing medical materiel and for accomplishing functions peculiar to medical logistics management.

Applicability. This regulation applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve. This publication is applicable during mobilization.

Proponent and exception authority. The proponent of this regulation is The

Surgeon General. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or a direct reporting unit or field operating agency of the proponent agency in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Army management control process. This regulation contains management control provisions and identifies key management controls that must be evaluated.

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from the Office of the Surgeon General, ATTN: DASG–LOZ,

5109 Leesburg Pike, Falls Church, VA 22041–3258.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to the Office of the Surgeon General, ATTN: DASG–LOZ, 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Committee Continuance Approval. The Department of the Army Committee Management Officer concurs in the establishment of the Linen Management Committee and the Materiel Standardization Committee.

Distribution. This publication is available in electronic media only and is intended for command levels A, B, C, D, and E for the Active Army, and command level B for the Army National Guard/Army National Guard of the United States and the U.S. Army Reserve.

Contents (Listed by paragraph and page number)

Chapter 1

Medical Logistics Policy, page 1

Section 1

Introduction, page 1

Purpose • 1–1, page 1

References • 1–2, page 1

Explanation of abbreviations and terms • 1–3, page 1

Responsibilities • 1–4, page 1

Overview • 1–5, page 1

*This regulation supersedes AR 40–61, dated 25 January 1995.

Contents—Continued

Section II

Responsibilities, page 1

The Surgeon General/Commander, U.S. Army Medical Command • 1–6, *page 1*

The Office of the Surgeon General Director of Logistics and U.S. Army Medical Command Assistant Chief of Staff for Logistics • 1–7, *page 2*

Assistant Chief of Staff for Installations, Environment, and Facility Management • 1–8, *page 2*

Command surgeons and commanders of regional medical commands/major subordinate commands • 1–9, *page 2*

Commandant, Army Medical Department Center and School • 1–10, *page 2*

Commander, U.S. Army Medical Research and Materiel Command • 1–11, *page 3*

Commander, U.S. Army Medical Materiel Agency • 1–12, *page 3*

Commanders of U.S. Army Medical Centers and Medical Department Activities • 1–13, *page 3*

Chiefs of logistics/directors of logistics at U.S. Army medical centers, medical department activities, and U.S. Army Medical Research and Materiel Command activities • 1–14, *page 4*

Chiefs of installation medical supply activities/medical supply officers, commanders of medical logistics battalions, commander, U.S. Army Medical Materiel Center, Europe, and designated medical supply unit commanders • 1–15, *page 4*

Commanders of modified table of organization and equipment units and commanders of separate medical activities not authorized stock record • 1–16, *page 5*

Commanders of battalion/company/detachment-level medical, dental, and veterinary units/activities/sections • 1–17, *page 5*

The Defense Supply Center, Philadelphia • 1–18, *page 5*

The Defense Medical Standardization Board • 1–19, *page 5*

Section III

Logistics Assistance Program, page 5

Program purpose • 1–20, *page 5*

Program policy • 1–21, *page 5*

U.S. Army Medical Materiel Agency logistics assistance visits • 1–22, *page 6*

Army National Guard/Army National Guard of the United States and U.S. Army Reserve support • 1–23, *page 6*

Chapter 2

Medical Logistics Systems, page 6

Medical logistics automated information systems guidance • 2–1, *page 6*

Medical logistics automated information systems definitions and exception policy • 2–2, *page 7*

Chapter 3

Army Medical Materiel Management, page 8

Section I

Medical Materiel Management Policy, page 8

Medical materiel policy applicability • 3–1, *page 8*

Characteristics of medical materiel • 3–2, *page 8*

Section II

Supply Support Activities, page 8

Medical supply support activities • 3–3, *page 8*

Medical materiel acquisition • 3–4, *page 9*

Acquisition methodologies and guidance • 3–5, *page 9*

Expanded acquisition guidance • 3–6, *page 9*

Logistics automated information systems policy • 3–7, *page 10*

Stockage policy • 3–8, *page 10*

Stockage criteria • 3–9, *page 10*

Requisition policy • 3–10, *page 10*

Identification of nonstandard medical materiel • 3–11, *page 10*

Medical materiel issue policy • 3–12, *page 11*

Storage policy • 3–13, *page 11*

Contents—Continued

Excess materiel management • 3–14, *page 11*

Transferring medical materiel within the Department of Defense • 3–15, *page 11*

Section III

Materiel Standardization, page 12

Materiel standardization definition • 3–16, *page 12*

Implementing materiel standardization • 3–17, *page 12*

Materiel standardization parameters • 3–18, *page 13*

Materiel standardization efforts • 3–19, *page 13*

Section IV

Materiel Evaluation Process, page 13

Commercial materiel testing • 3–20, *page 13*

Program components • 3–21, *page 14*

Materiel demonstrations, examinations, evaluations, aeromedical suitability determinations, and certifications • 3–22, *page 14*

Section V

Controlled Medical Items, page 15

Security precautions • 3–23, *page 15*

Controlled substances • 3–24, *page 15*

Shipment of controlled medical items • 3–25, *page 16*

Storage and issue of installation stocks of controlled medical items • 3–26, *page 16*

Periodic inventories of controlled medical items • 3–27, *page 16*

Other items requiring control • 3–28, *page 16*

Controlled medical items as components of medical equipment sets • 3–29, *page 16*

Controlled medical item components of aviation survival kits • 3–30, *page 17*

Section VI

Materiel Management in Modified Table of Organization and Equipment Activities, page 17

Medical logistics battalions • 3–31, *page 17*

Materiel management in other than medical logistics battalions • 3–32, *page 17*

Ordering service regulated items • 3–33, *page 17*

Reference book sets for medical modified table of organization and equipment units • 3–34, *page 18*

Section VII

Army National Guard/Army National Guard of the United States Units, page 18

Medical supply support • 3–35, *page 18*

Pharmaceuticals • 3–36, *page 18*

Medical materiel quality control messages • 3–37, *page 18*

Section VIII

Management Indicators and Supply Performance Indicators, page 18

Use of management and supply performance indicators • 3–38, *page 18*

Performance indicator data • 3–39, *page 18*

Chapter 4

Quality Control, Shelf-life, and Medical Materiel Complaints, page 19

Section I

Quality Control of Medical Materiel, page 19

Quality control information • 4–1, *page 19*

Quality control responsibilities • 4–2, *page 19*

Sources of quality control information • 4–3, *page 19*

Contents—Continued

Section II

Storage and Shelf Life of Medical Materiel, page 20

Storage policy • 4-4, *page 20*

Quality control of medical gases • 4-5, *page 20*

Storage periods for medical materiel • 4-6, *page 20*

Management of shelf-life items • 4-7, *page 21*

Section III

Surveillance, Recalls, and Suspension, page 21

Surveillance of materiel • 4-8, *page 21*

Recall of nonstandard drugs and devices • 4-9, *page 22*

Suspension of medical materiel • 4-10, *page 22*

Section IV

Disposal and Destruction of Medical Materiel, page 22

Disposal policy • 4-11, *page 22*

Disposal procedures • 4-12, *page 22*

Section V

Medical Materiel Complaints, page 22

Complaint policy • 4-13, *page 22*

Types of medical materiel complaints • 4-14, *page 23*

Chapter 5

Medical Equipment Management, page 23

Section I

Medical Equipment Accountability and Acquisition, page 23

Purpose • 5-1, *page 23*

Property management in Army Medical Department table of distribution and allowances activities • 5-2, *page 23*

Property management responsibilities • 5-3, *page 23*

Loan of property • 5-4, *page 24*

Retention of medical materiel by military patients after separation • 5-5, *page 25*

Loan of table of distribution and allowances equipment to modified table of organization and equipment organizations • 5-6, *page 25*

Medical equipment on loan between U.S. Army organizations and other activities • 5-7, *page 25*

Transfer of specialized equipment with specialists • 5-8, *page 25*

Managing excess medical materiel on property books • 5-9, *page 26*

Reporting unsatisfactory equipment • 5-10, *page 26*

Exemption for reporting or accounting of industrial plant equipment • 5-11, *page 26*

Privately owned medical equipment • 5-12, *page 26*

Asset and transaction reporting • 5-13, *page 26*

Section II

Table of Distributions and Allowances Equipment Wartime Procedures, page 27

Equipment management during medical evacuation • 5-14, *page 27*

Patient movement item program • 5-15, *page 27*

Section III

Equipment Acquisition in Army Medical Department Table of Distribution and Allowances Activities, page 27

Equipment acquisition objectives • 5-16, *page 27*

Equipment acquisition policy • 5-17, *page 27*

Medical care support equipment program • 5-18, *page 28*

Medical care support equipment approval policy • 5-19, *page 28*

Acquisition of investment equipment • 5-20, *page 28*

Acquisition of furniture and furnishings • 5-21, *page 29*

Contents—Continued

Equipment rental, lease, or loan • 5–22, page 29

Section IV

Modified Table of Organization and Equipment Management Guidance, page 30

Medical and nonmedical equipment acquisition and management in modified table of organization and equipment units • 5–23, page 30

Equipment acquisition for deployed medical tables of organization and equipment units • 5–24, page 31

Property accountability • 5–25, page 31

Section V

Equipment Acquisition for the Army National Guard, page 31

Equipment authorization procedures for Army National Guard physical examination facilities • 5–26, page 31

Equipment authorization procedures for troop medical clinics at Army National Guard training sites • 5–27, page 32

Chapter 6

Medical Equipment Maintenance, page 32

Section I

Maintenance Concepts, page 32

Maintenance elements • 6–1, page 32

Maintenance policy • 6–2, page 32

Levels of maintenance • 6–3, page 34

Section II

Primary Equipment Maintenance Services, page 35

Preventive maintenance checks and services • 6–4, page 35

Electrical safety inspections and tests • 6–5, page 35

Calibration, verification, and certification • 6–6, page 36

Calibration of audiometers • 6–7, page 36

Remedial maintenance (repair) • 6–8, page 36

Overhaul • 6–9, page 37

Rebuild • 6–10, page 37

Ancillary services • 6–11, page 37

Section III

Maintenance Operations, page 37

Contract maintenance • 6–12, page 37

Repair and overhaul costs • 6–13, page 37

Test, measurement, and diagnostic equipment • 6–14, page 38

Cannibalization and controlled exchange • 6–15, page 38

Technical assistance • 6–16, page 39

Modification and alteration of medical equipment • 6–17, page 39

Medical standby equipment program • 6–18, page 39

Maintenance performance measures and reports • 6–19, page 40

Repair parts procedures • 6–20, page 40

Section IV

Anesthetizing Locations in Health Care Activities, page 40

Anesthetizing locations policy • 6–21, page 40

Conductive flooring policy • 6–22, page 40

Section V

Army Warranty Program, page 40

Overview • 6–23, page 40

Warranty implementation • 6–24, page 41

Contents—Continued

Warranty claim actions • 6–25, *page 41*

Chapter 7

Environmental Services, *page 41*

Section I

Environmental Services Management, page 41

Operations • 7–1, *page 41*

Management • 7–2, *page 41*

Section II

Medical Textile Care Services, page 41

Medical textile care services management • 7–3, *page 41*

Medical textile care services operations • 7–4, *page 42*

Medical textile accounting • 7–5, *page 42*

Textile stockage levels • 7–6, *page 42*

Medical textile handling and storage • 7–7, *page 42*

Textile marking • 7–8, *page 43*

Textile disposal • 7–9, *page 43*

Contract laundry and/or textile distribution services • 7–10, *page 43*

Section III

Medical Housekeeping Services, page 43

Medical housekeeping services management • 7–11, *page 43*

Medical housekeeping services operations • 7–12, *page 43*

Contract medical housekeeping services • 7–13, *page 44*

Section IV

Medical Waste Disposition, page 44

Regulated medical waste • 7–14, *page 44*

Radioactive regulated medical waste • 7–15, *page 44*

Chapter 8

Facility Management in Health Care Activities, *page 44*

Facility management overview • 8–1, *page 44*

Facility management operations • 8–2, *page 45*

Facility management functions • 8–3, *page 45*

Office administration functions • 8–4, *page 45*

Automation function • 8–5, *page 45*

Project management and technical support functions • 8–6, *page 46*

Operations and maintenance functions • 8–7, *page 46*

Contract administration and quality assurance functions • 8–8, *page 46*

Regional medical command facility director responsibilities • 8–9, *page 46*

Chapter 9

Medical Materiel Readiness, *page 47*

Section I

Deployment and Mobilization, page 47

Readiness program overview • 9–1, *page 47*

Readiness policies and responsibilities • 9–2, *page 47*

Section II

Materiel Readiness Programs, page 49

Centrally managed Class VIII materiel • 9–3, *page 49*

Army prepositioned stock • 9–4, *page 49*

Contents—Continued

Medical policy for management of medical nuclear, biological, and chemical defense materiel • 9–5, *page 49*

Army war reserve sustainment • 9–6, *page 49*

Operational projects • 9–7, *page 49*

Programs directed by the Office of The Surgeon General • 9–8, *page 50*

Chapter 10

Managing Medical Assemblages, *page 50*

Section I

Medical Assemblages Management Overview, page 50

Purpose • 10–1, *page 50*

Operational policy • 10–2, *page 50*

Section II

Medical Equipment Sets, page 51

Identifying medical equipment sets • 10–3, *page 51*

Composition of medical equipment sets • 10–4, *page 51*

Requisition, issue, and turn-in of medical equipment sets • 10–5, *page 52*

Section III

Medical Materiel Sets, page 52

Identifying medical materiel sets • 10–6, *page 52*

Composition and support of medical materiel sets • 10–7, *page 52*

Requisition, issue, and turn-in of medical materiel sets and dental materiel sets • 10–8, *page 53*

Accounting for components of medical materiel sets • 10–9, *page 53*

Total package fielding • 10–10, *page 53*

Section IV

Maintenance and Management of Medical Assemblages, page 53

Maintenance of medical assemblages • 10–11, *page 53*

Loan of modified table of organization and equipment materiel (equipment) in support of projects at health care activities • 10–12, *page 54*

Loan of medical equipment to civilian authorities • 10–13, *page 54*

Newly developed medical assemblages • 10–14, *page 54*

Chapter 11

Optical Fabrication, *page 54*

Optical fabrication authority and overview • 11–1, *page 54*

Optical fabrication laboratory production guidance • 11–2, *page 55*

Optical fabrication contingency contracts • 11–3, *page 55*

Optical laboratory and unit operating supplies • 11–4, *page 55*

Performance measures • 11–5, *page 55*

Optical fabrication enterprise report • 11–6, *page 55*

Completing optical fabrication enterprise report worksheets • 11–7, *page 56*

Appendixes

A. References, *page 57*

B. Management Control Evaluation Checklist, *page 64*

Glossary

Chapter 1 Medical Logistics Policy

Section I Introduction

1–1. Purpose

This regulation prescribes policies, procedures, and responsibilities for medical logistics (MEDLOG) management within the Total Army, including the Active Army, U.S. Army Reserve, and Army National Guard (ARNG)/Army National Guard of the United States (ARNGUS).

1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms

Abbreviations and terms used in this regulation are explained in the glossary.

1–4. Responsibilities

Responsibilities are listed in section II of chapter 1.

1–5. Overview

a. MEDLOG provides intensive management of specialized products and services required to operate an integrated health service system, anywhere in the world, in peace and through the full spectrum of military operations. In accomplishing this purpose, MEDLOG must be immediately and completely responsive to all health care requirements of the Army community. Support must be responsive to differences in professional training and specialty requirements. Each activity must maintain the ability to predict specific requirements and possess the capability to rapidly adapt to large increases in patient workload and widely varying environments with a minimum adverse effect on efficiency. Close rapport between the medical logistician and the health care provider is essential for maintaining the health of Army personnel and the Army's retention of trained professionals.

b. Establishing Army MEDLOG requirements is a highly technical process that requires extensive capabilities to research, develop, field, evaluate, and repair medical items. Owing to the Federal Government's stringent control on medical products, the Army continuously works with other agencies at the professional level on all logistical matters. MEDLOG management aids the Army by integrating public health policy and technical guidance from a variety of sources into highly specialized Army requirements. The unique nature of MEDLOG management is recognized throughout the Department of Defense (DOD). To promote both efficiency and effectiveness, MEDLOG will align itself with commercial business practices to the greatest extent possible and will minimize inventory and maximize commercial distribution channels.

c. To maintain high standards of medical support, MEDLOG management provides exceptions to Army regulations (ARs) in the 700 series with specific policies, procedures, and systems. The intent is to follow 700-series regulations to the maximum extent possible, however, where conflicts exist, the provisions of this regulation will take precedence for medical materiel management.

Section II Responsibilities

1–6. The Surgeon General/Commander, U.S. Army Medical Command

The Surgeon General (TSG)/Commander, U.S. Army Medical Command (MEDCOM) as the Army manager for MEDLOG, will—

a. Approve all aspects of the organization, administration, and staff supervision of activities that manage medical materiel.

b. Approve medical materiel management systems, including automated and manual, and the medical materiel acquisition process, programs, and program data throughout the Army. This includes the composition and budgeting of medical assemblages and procurement appropriation-funded medical materiel equipment.

c. Provide advice and assistance to Headquarters, Department of the Army (HQDA) agencies and Army activities on MEDLOG procedures and MEDLOG systems.

d. Appoint one Army Medical Department (AMEDD) general officer to serve as a member of the Defense Medical Standardization Board (DMSB).

e. Provide the Army's functional input to DOD MEDLOG systems and serve as the functional proponent of Department of the Army (DA) MEDLOG systems.

- f.* Exercise overall responsibility as the force provider for all medical materiel mobilization programs and support for deployed and deploying forces. (See chap 9 for special organization responsibilities.)
- g.* Be the responsible official for medical materiel in the Army prepositioned stock (APS) program.
- h.* Manage the MEDLOG applications of the Army Logistics Civil Augmentation Program (AR 700–137).
- i.* Manage worldwide medical materiel logistics assistance for Army activities (AR 700–4) and for non- U.S. forces as approved by the Army Security Assistance Program (AR 1–75/Secretary of the Navy Instruction (SECNAVINST) 4900.49/Air Force Joint Instruction (AFJI) 16–104).
- j.* Ensure health hazard assessments of equipment and systems that emit radiation or contain radioactive material have been completed as early as practical in their development and before fielding (AR 11–9 and AR 40–10).

1–7. The Office of the Surgeon General Director of Logistics and U.S. Army Medical Command Assistant Chief of Staff for Logistics

The Office of the Surgeon General (OTSG) Director of Logistics (DOL) and MEDCOM Assistant Chief of Staff for Logistics (ACSLOG) will—

- a.* Serve as the medical functional proponent representative to logistics systems for TSG.
- b.* Serve as the principal advisor for MEDLOG systems and TSG representative for all logistical functions and systems.
- c.* Serve as the strategic logistics planner for contingency and mobilization requirements.
- d.* Be responsible for planning, programming, and budgeting TSG’s MEDLOG portion of the program objective memorandum (POM).

1–8. Assistant Chief of Staff for Installations, Environment, and Facility Management

The Assistant Chief of Staff for Installations, Environment, and Facility Management (ACSIE&FM) will—

- a.* Have primary staff responsibility for all facilities management and engineering support.
- b.* Provide facility strategic planning, facility policy, funding allocation, and oversight of medical military construction (MILCON) programs.
- c.* Provide supervision, guidance, and overall coordination of medical facilities management programs.
- d.* Be responsible for coordination and review of medical facility mobilization plans.
- e.* Serve as the program manager for real property maintenance activity funding and transition funding.
- f.* Provide supervision, guidance, and overall coordination of the Army Medical Fisher House Management Program.

1–9. Command surgeons and commanders of regional medical commands/major subordinate commands

Each command surgeon and commander of a regional medical command (RMC)/major subordinate commands (MSC) will—

- a.* Conduct a command logistics review program in accordance with AR 11–1 and this regulation.
- b.* Plan, coordinate, and oversee the provision of responsive medical acquisition and logistics support to authorized units/organizations within his or her area of responsibility.
- c.* Publish Capital Equipment Expense Program (CEEP) procedure information, guidance, compliance information, execution instructions, and monitoring information for fixed health care activities or other medical table of distribution and allowances (TDA) activities.
- d.* Appoint a senior clinical staff member to be the Materiel Standardization Committee chairperson to improve patient care through the standardization of supplies and equipment throughout their region.
- e.* Coordinate regional logistics readiness and mobilization contingency support requirements.
- f.* Oversee optical fabrication contingency contracts.

1–10. Commandant, Army Medical Department Center and School

The Commandant, AMEDD Center and School (AMEDDC&S) serves as the combat developer for AMEDD and will oversee—

- a.* Recommendations concerning and design, development, and updating of the composition of medical assemblages (except for medical resupply sets, medical supply planning modules, and optical resupply sets) in accordance with AR 40–60.
- b.* Administration of the AMEDD Board materiel evaluation process.
- c.* Determination of the components of reference book sets and the annual review of book sets.
- d.* The development process for sets, kits, and outfits and determination, with TSG approval, of medical equipment set (MES) components, including associated support items of equipment (ASIOE).
- e.* Development and coordination of approval by the Commanding General, U.S. Army Training and Doctrine Command (TRADOC) of all operational requirements documents and basis of issue plans for medical and nonmedical equipment to support deployable medical units according to established TRADOC policies and procedures.

f. Develop tables of organization and equipment (TOEs) for Standard Requirements Code 08 medical units and coordinate the medical portion of nonmedical TOEs.

g. Develop and crosswalk priorities with the materiel developer and medical logistician for new materiel in support of organizations.

h. Provide AMEDD resourcing recommendations and priorities to TRADOC for inclusion in various funding programs.

1–11. Commander, U.S. Army Medical Research and Materiel Command

The commander, U.S. Army Medical Research and Materiel Command (USAMRMC) will monitor the life cycle management of—

a. Army Class VIII (medical) materiel, to include research, development, acquisition, sustainment, and modernization.

b. Health care automated systems.

1–12. Commander, U.S. Army Medical Materiel Agency

The U.S. Army Medical Materiel Agency (USAMMA) is a subordinate element of USAMRMC. The Commander, USAMMA will—

a. Ensure USAMMA serves as the service item control center (SICC) for medical materiel and as the proponent agency and publisher of the Supply Bulletin (SB) 8-75 series and Medical Logistics Battlebooks.

b. Manage the Army Secondary Inventory Control Activity for medical materiel and provide continuous support to develop and maintain the Federal catalog system and Army cataloging operations.

c. Manage and maintain Army MEDLOG data in the—

(1) Defense Logistics Information Service (DLIS)/Army Master Data File (AMDF).

(2) Army central logistics data bank.

(3) Universal Data Repository (UDR).

d. Ensure recordation and collaboration of user interest on nonmedical national stock number (NSN) items are in the DLIS and the AMDF to support AMEDD mission requirements.

e. Perform medical materiel functions to support the Army health care delivery system to include redistribution of excess medical materiel.

f. Perform functions to improve and assist in the development, management, and execution of MEDLOG support.

g. Serve as the medical materiel acquisition logistician and nondevelopmental item mission assignee in the medical materiel acquisition process. (See AR 40–60 for additional information on medical materiel acquisition policies and procedures.)

h. Perform technology surveillance and assessment via the Technology Assessment and Requirements Analysis for TDA health care activities (HCAs) and the Combat Support Equipment Assessment for TOE equipment and units.

i. Conduct medical materiel management studies as directed by TSG, MEDCOM, and USAMRMC.

j. Provide advanced post-graduate medical materiel management training.

k. Operate the AMEDD national maintenance point (NMP). (See AR 750–1 for additional information on Army materiel maintenance.)

l. Provide depot-level maintenance support for standard and selected nonstandard medical materiel to—

(1) The Active Army.

(2) The U.S. Army Reserve (USAR).

(3) The ARNG/ARNGUS.

(4) Authorized DOD activities.

(5) Other Federal agencies as directed.

m. Serve as the Army focal point for medical materiel maintenance matters and provide staff support to MEDCOM for maintenance policies.

n. Manage the medical care support equipment (MEDCASE) program based on policy and guidance from TSG, MEDCOM, and USAMRMC.

o. Perform medical materiel readiness and logistics assistance functions.

p. Serve as the central quality assurance coordinating activity for medical materiel for the Army. The USAMMA will ensure the acquisition, maintenance, dissemination, and follow-up of medical materiel quality assurance data and actions throughout the Army.

q. In coordination with OTSG, plan, program, and budget for all materiel and care of supplies in storage (COSIS) requirements for the Class VIII portion of the APS program.

r. Provide management to the Class VIII portion of the APS program.

1–13. Commanders of U.S. Army Medical Centers and Medical Department Activities

Commanders of U.S. Army Medical Centers (MEDCENs) and Medical Department Activities (MEDDACs) will—

a. Provide supply and maintenance support, technical assistance, and guidance to organizational elements of the HCA, dental activities, regional veterinary activities, and other units and activities that are authorized support (that is, Active Army, Army Reserve, ARNG/ARNGUS, and other Federal and State agencies).

b. Provide direct medical staff support functions and technical advice to supported installation commanders to fulfill all Class VIII and medical maintenance requirements of the DA-designated deployment platform.

c. Receive, staff, and approve all MEDCASE program requirements from customers (SB 8-75 MEDCASE).

d. Publish procedures regarding and execute the CEEP.

e. Appoint a logistics readiness officer in accordance with AR 700-138 and this regulation.

f. Administer a command supply discipline program in accordance with AR 710-2.

g. Appoint a senior clinical staff member to be the Materiel Standardization Committee chairperson to improve patient care through the standardization of supplies and equipment throughout their HCA.

h. Manage recovery and disposal programs.

1-14. Chiefs of logistics/directors of logistics at U.S. Army medical centers, medical department activities, and U.S. Army Medical Research and Materiel Command activities

Each chief of logistics/director of logistics is responsible for all logistics operations in the activity and satellite activities to the extent authorized by command surgeons or RMCs/MSCs. These operational responsibilities can include—

a. The acquisition, receipt, storage, issue, movement, maintenance, repair, and accountability of materiel and equipment.

b. Environmental services management, including—

(1) Housekeeping.

(2) Textile care services (linen distribution and laundry services).

(3) Waste collection and disposal.

c. Facility management, including—

(1) Real property repair and maintenance.

(2) Interior design and decoration.

(3) Construction and renovations (minor/new).

(4) Grounds maintenance.

(5) Physical security.

(6) Preventive maintenance.

(7) Energy conservation.

(8) Facility space utilization.

(9) Master planning.

d. Transportation management, including—

(1) Transportation coordination.

(2) Justification and management of non-tactical vehicles.

e. Communications (with the information management officer and the plans and operations staff).

f. Optical fabrication.

g. Contracting support coordination.

1-15. Chiefs of installation medical supply activities/medical supply officers, commanders of medical logistics battalions, commander, U.S. Army Medical Materiel Center, Europe, and designated medical supply unit commanders

Chiefs of installation medical supply activities (IMSAs)/medical supply officers (MSOs), commanders of medical logistics battalions (MEDLOG Bns), commander, U.S. Army Medical Materiel Center, Europe (USAMMCE), and designated medical supply unit commanders will manage medical materiel, including—

a. Requirements computation.

b. Storage—quality control (QC).

c. Distribution of supplies and equipment.

d. Formal accountability.

e. Financial monitoring and budgeting as required.

f. Optical fabrication.

g. Medical maintenance.

1-16. Commanders of modified table of organization and equipment units and commanders of separate medical activities not authorized stock record

Commanders, modified table of organization and equipment (MTOE) units and separate medical activities not authorized stock record will manage authorized medical materiel or on-hand materiel in accordance with this regulation.

1-17. Commanders of battalion/company/detachment-level medical, dental, and veterinary units/activities/sections

Commanders of battalion/company/detachment-level medical, dental, and veterinary units/activities/sections will control, safeguard, and maintain medical materiel in accordance with this regulation.

1-18. The Defense Supply Center, Philadelphia

The Defense Supply Center, Philadelphia (DSCP) serves as the commodity manager for medical materiel under the Defense Logistics Agency (DLA), and performs the central management, contracting, and acquisition of medical materiel for the DOD and other Federal activities. The DSCP is responsible for—

- a.* Identifying, categorizing, cataloging, contracting, and issuing medical materiel under a variety of programs.
- b.* Managing war reserve, stock rotations, corporate exigency and surge option contracts, as well as industrial preparedness planning, financial accounting and disposal of excess materiel. Central management allows for the bundling of requirements for leverage buying through a variety of logistical support programs using traditional and commercial identification, transportation, and billing processes.

1-19. The Defense Medical Standardization Board

The Defense Medical Standardization Board (DMSB) is a joint activity of DOD agencies, subject to professional policy provided through the Assistant Secretary of Defense for Health Affairs. (See AR 10-64/OPNAVINST) 6700.2/AFR 160-29/MCO 5420.18A for additional information on AMEDD Joint field operating agencies.) One AMEDD general officer will serve as a member of the DMSB. The staff director of the DMSB is responsible for the effective management of the clinical and technical aspects of medical materiel used in deployable medical systems (DEPMEDSs). This includes—

- a.* Standardization or deletions of items in the wholesale supply system.
- b.* Evaluation of the need for the item.
- c.* Determination of the essential characteristics of the item.
- d.* Performance of other related coordination and investigative functions.
- e.* Development of DEPMEDSs by ensuring they are standardized to the maximum extent possible and are consistent with the distinct missions of the military Services.

Section III

Logistics Assistance Program

1-20. Program purpose

The purpose of the Logistics Assistance Program (LAP) is to—

- a.* Assist commanders in improving MEDLOG readiness.
- b.* Recommend improvements in unit MEDLOG management.
- c.* Provide medical maintenance assistance.
- d.* Provide information on current logistical issues.
- e.* Resolve MEDLOG problems in the unit.
- f.* Provide assistance in facility life cycle management issues.

1-21. Program policy

a. Command surgeons, RMC/MSD commanders, and the commander, USAMMA are responsible for medical materiel logistics assistance within their respective commands. This includes—

- (1) Resolving problems related to medical materiel support and medical equipment maintenance.
- (2) Conducting liaison and logistics assistance visits (LAVs).
- (3) Providing technical guidance and assistance.
- (4) Conducting follow-on evaluations of newly introduced items of materiel for MTOE activities.

b. RMC/MSD commanders will provide assistance to subordinate activities and installations by—

(1) Conducting reviews every 12 months of the logistics program at their subordinate activities. Results of these reviews will be provided to the MEDCOM ACSLOG within 30 days of the visit.

(2) Reviewing logistics policy, doctrine, training, personnel, and funding matters that affect logistics.

(3) Reviewing logistics operations to include as appropriate:

- (*a*) Medical materiel inventory management.

- (b) Medical maintenance.
- (c) Property management.
- (d) MEDCASE.
- (e) Transportation.
- (f) Environmental and textile care services.
- (g) Facilities engineering functions that impact logistics.
- (h) Financial management.
- (i) Special medical augmentation reaction teams.
- (j) MEDLOG readiness.
- (4) Identifying problems at all levels so commanders and staff can take corrective action.
- (5) Providing a vertical assessment through command and technical channels to identify the root causes of problems.

c. Commanders of AMEDD activities (MTOE and TDA) will establish and formally document a Command Supply Discipline Program (CSDP) at each activity. The CSDP is a commander's program. Therefore, commanders, supervisors, and managers must implement the provisions of AR 710-2 to standardize supply discipline throughout the AMEDD and the Army. As a mandatory program, CSDP is meant to simplify command, supervisory, and managerial responsibilities. The program includes the evaluation of hand-receipt holders at all levels.

1-22. U.S. Army Medical Materiel Agency logistics assistance visits

a. USAMMA LAV teams will visit field medical units based on major Army command (MACOM) determination of need and availability of USAMMA resources. When possible, LAVs will coincide with USAMMA modernization efforts such as major fielding.

(1) USAMMA LAV schedules will be published upon coordination with and concurrence of the MACOM.

(2) LAV team chiefs will keep assisted commanders informed of their activities and findings by using procedures such as in- and out-briefings and after-visit reports.

(3) Copies of customer assistance visit reports will be provided to the visited commander.

b. The areas of interest for LAVs are dependent on MACOM determination of need, but may include the following:

(1) Medical materiel support to the unit.

(2) Medical materiel fielding issues and follow-on evaluations.

(3) Medical materiel containerization, storage, and transportation topics.

(4) Quality assurance of medical materiel.

(5) Medical equipment maintenance support.

(6) Readiness reporting, including nonmedical ASIOE.

c. Based on unique personnel and experience within the USAMMA, direct communication between field medical units and USAMMA is authorized and encouraged. However, this coordination must be shared within the requesting unit's chain of command.

d. The USAMMA may provide assistance concerning problems with unsatisfactory support from nonmedical sources of supply if these problems cannot be resolved at the MACOM level.

1-23. Army National Guard/Army National Guard of the United States and U.S. Army Reserve support ARNG/ARNGUS units may obtain MEDLOG assistance from their chain of command and from supporting IMSAs/MEDLOG Bns and the USAMMA/USAMMCE. Army Reserve units will use regional training sites-medical (RTS-MEDs) to assist in maintaining their medical equipment.

Chapter 2 Medical Logistics Systems

2-1. Medical logistics automated information systems guidance

This paragraph applies to MEDLOG automated information systems (ISs) at automated MEDLOG operations, medical fixed facilities, division, and corps-level units (Echelon II through Echelon V). This paragraph is in accordance with AR 25-1.

a. MEDLOG ISs will support the following core business functions:

(1) Acquisition, accountability, maintenance, and distribution of materiel and equipment.

(2) Use, maintenance, and repair of facilities supporting the AMEDD medical mission.

b. Army medical fixed facilities and units conducting MEDLOG operations will use existing DOD/Army standard MEDLOG ISs. Units will migrate to future DOD/Army ISs when they are implemented.

c. Medical fixed facilities and units conducting MEDLOG operations will not use locally developed or procured

nonstandard MEDLOG systems when DOD or Standard Army Management Information Systems (STAMISs) are available.

2-2. Medical logistics automated information systems definitions and exception policy

a. The following systems are authorized as standard DOD and Army logistics management ISs:

(1) *Theater Army Medical Management Information System (TAMMIS)*. TAMMIS consists of a medical supply (MEDSUP) module that provides automated and comprehensive inventory management of medical materiel.

(2) *Army Medical Department Property Accounting System (AMEDDPAS)*. AMEDDPAS is the primary IS for planning, acquiring, establishing, and maintaining formal accountability and maintenance of medical equipment.

(3) *Defense Medical Logistics Standard Support (DMLSS)*. DMLSS is the DOD migration IS that will replace TAMMIS and AMEDDPAS.

(4) *Purchase Request Web (PRWeb)*. PRWeb is a Web-enabled application used to create, modify, and route paperless purchase requests to the contracting Procurement Desktop-Defense, which supports the Standard Procurement System.

(5) *Defense Blood Bank System (DBBS)*. The DBBS automates blood bank operations and currently is fielded to MEDLOG units and deployable and fixed hospitals with blood bank/donor center support missions. This application will be integrated as part of the Theater Medical Information Program suite of software to support the forward support medical company (FSMC), main support medical company (MSMC), MEDLOG units, and deployable hospitals in the corps and echelons above corps (EAC) levels.

(6) *Spectacle Request Transmission System (SRTS)*. SRTS automates the patient record portion of the optical prescription and order transmission process to MEDLOG units and Optical Fabrication Laboratories in the corps and EAC levels.

(7) *Global Combat Support System-Army (GCSS-A) Maintenance (MNT)*. GCSS-A-MNT is the replacement for the Unit Level Logistics System-Ground (ULLS-G) that must be used in all Battalion Aid Stations, FSMCs, and MSMCs at Echelons I and II and selected Echelon III units. GCSS-A-MNT also will be the migration system for all MEDLOG units, as well as deployable hospitals in the corps and EAC levels. GCSS-A-MNT will be used in all medical units that are authorized a company or battalion level medical maintenance operation in the division, corps, and EAC levels.

(8) *GCSS-A-Supply and Property (SPR)*. SPR is the replacement for the Unit Level Logistics System—Staff Level Logistics (ULLS—S-4) and Standard Property Book System-Re-designed (SPBS-R). It must be used in all medical units at the battalion level and higher that maintain their own property books in the corps and EAC levels.

(9) *Defense Property Accounting System (DPAS)*. DPAS may be used in some MEDCOM non-patient treatment activities. The decision to utilize DPAS will be made by MEDCOM.

b. When standard systems do not provide the functionality to support a required MEDLOG business practice, nonstandard AISs are authorized only after approval through the AMEDD DOL/ACSLOG. Units will submit requests for waivers through their respective RMCs to Commander, MEDCOM, ATTN: MCLO-LS, 2050 Worth Rd., Ste. 8, Fort Sam Houston, TX 78234-6008.

c. Army medical activities and units operating manual medical accounting systems will follow this regulation and procedures in AR 710-2 and DA Pam 710-2-2.

d. Army medical fixed facilities are authorized to use commercial automated medication and supply management systems, known as point of use (POU) systems. Command approval is required to purchase or lease POU systems. Requests to purchase or lease POU systems will be submitted through the respective RMC to Commander, MEDCOM, ATTN: MCLO-LS, 2050 Worth Rd., Fort Sam Houston, TX 78234-6000. Activities will submit justification, including projected economic and clinical benefits, for these requests.

(1) Activities with POU systems will follow prescribed security measures and system requirements for medication management outlined in AR 190-51. Activities with POU systems will maintain written policies and procedures for security, accountability, and emergency situations. These policies and procedures are intended to supplement existing MEDCOM, Army, and DOD regulations and directives.

(2) The AMEDD has developed standard interfaces for POU with the TAMMIS, DMLSS, and Composite Health Care System. Activities implementing POU will ensure that these interfaces are implemented. Activities are not authorized to use stand-alone POU systems for supply or medication management. Activities will coordinate the installation of interfaces through the Commander, MEDCOM, ATTN: MCLO-LS, 2050 Worth Rd., Ste. 8, Fort Sam Houston, TX 78234-6008.

(3) Army medical activities with automatic identification technology (AIT) equipment, including radio frequency devices such as base radio units, repeaters, handheld terminals, scanners, and printers, will utilize and maintain the equipment. Trouble calls for AIT equipment in support of DMLSS applications will be submitted to the DMLSS Customer Support Office, in accordance with established procedures.

(4) Trouble calls for AIT equipment in support of TAMMIS and AMEDDPAS will be submitted to the U.S. Army Medical Information Systems and Services Agency Customer Support Office, in accordance with established procedures.

e. Army Reserve units will use the Property Book/Unit Supply Enhanced/SPBS–R and Reserve End Item Management System to manage property book items.

Chapter 3

Army Medical Materiel Management

Section I

Medical Materiel Management Policy

3–1. Medical materiel policy applicability

This chapter—

a. Provides policy for the management of medical materiel for TDA organizations, MTOE units (Active Army and Army Reserve), and the ARNG/ARNGUS.

b. Establishes special considerations used to manage the medical commodity.

3–2. Characteristics of medical materiel

The medical materiel category possesses certain characteristics that set it apart from other commodities. These factors place unique requirements on Army medical materiel managers.

a. Effective medical materiel management provides immediate and completely responsive support to the Army's health care community. Its ultimate purpose is to maintain Army effectiveness, which is affected by soldier health issues. It is not enough that medical support be adequate to meet most needs of the Army. The ability to predict a specific requirement demands responsive supply support.

b. Health care activities are the primary users of medical materiel within the Army. These activities are field medical units in direct support of combat forces and fixed facilities (MEDDACs, MEDCENs, dental activities, and area dental laboratories). MEDDACs and MEDCENs are unique in the Army in that their many elements are functional parts of the medical activity.

Section II

Supply Support Activities

3–3. Medical supply support activities

Supply support activities (SSAs) for medical materiel provide direct, general, and/or installation support to units and activities within a designated command or area. Each unit or activity's MTOE, TDA, or MACOM directive will state the mission for providing this support. Establishing new SSA accounts that require Defense Wide Working Capital Fund (DWWCF) or Defense Health Program (DHP) funding must be coordinated with the MEDCOM ACSLOG.

a. SSAs for medical materiel include—

(1) IMSAs.

(2) MEDLOG Bns. In peacetime, MEDLOG Bns may perform full SSA functions, have training missions, or have area supply missions. Upon mobilization and/or deployment, MEDLOG Bns normally will perform all SSA functions.

(3) USAMMCE.

b. SSAs will—

(1) Operate stock record accounts in accordance with AR 710–2 and this regulation.

(2) Operate with standard MEDLOG automated systems, following the systems' prescribed procedures.

(3) Requisition/order materiel directly from the DLA, Department of Veterans Affairs (DVA), supporting contracting offices, or other SSA/distribution centers.

(4) Conduct prescribed financial inventory accounting and financial management of the—

(a) Operation and Maintenance, Army (OMA) fund in TOE units.

(b) Operation and Maintenance, Defense (OMD) fund in designated TDA hospitals within the AMEDD.

(c) DWWCF in selected AMEDD activities.

c. Under the Army's Single Stock Fund initiative, the retail stock fund for Class VIII was excluded from the Army Working Capital Fund. SSAs for the AMEDD now are funded depending on their mobilization and deployment support missions. If an activity is designated as a U.S. Army Forces Command (FORSCOM) Power Projection Platform (or it supports a FORSCOM-designated Power Projection/Power Support Platform), a planned Reach-back site, or an outside continental United States (OCONUS) distribution center, it will use the DWWCF through the DSCP. Activities that do not meet the above criteria will use DHP funds to support their SSAs.

d. Other supply operations for medical materiel maintain informal stock control records in support of direct support or area supply missions.

3-4. Medical materiel acquisition

AR 40-60 outlines the medical materiel acquisition process from initiation (identification of mission need or mission profile) through completion of development, procurement, deployment, and management. This process specifies military medical materiel fielding requirements for MTOE units.

3-5. Acquisition methodologies and guidance

a. Acquisition methodologies are designed to provide the most cost-effective and efficient support within the MEDCOM regions, while capitalizing on better business practices. Automated order entry and a paperless acquisition environment are integral to achieving better materiel support. The goal is to migrate to greater use of electronic commerce alternatives and decrease reliance on manual, labor-intensive procurements. Regional logistics chiefs, HCA logistics division chiefs, and accountable officers will ensure the procurement method utilized provides the best corporate value and allows a corporate view of procurement for standardization of materiel and services. The acquisition methodology used to purchase materiel and services may vary by item. At all times, the method used will be planned and selected to provide the product or service when needed at the best price. Additionally, the method utilized must enhance the materiel and service acquisition strategies within MEDCOM and the RMC.

b. The following are the acquisition method strategies, listed in the established priorities for acquisition:

(1) The DSCP Prime Vendor (PV) Program (PV-distributed items, including Distribution and Pricing Agreement (DAPA) items, Federal Supply Schedule items, PV non-usage items, PV committed volume/Regional Incentive Agreements (RIAs), and PV Program e-commerce and other e-tool sources).

(2) The DSCP Electronic Catalog (ECAT).

(3) PRWeb/Local Purchase Instruments (Decentralized Blanket Purchase Agreements (DBPAs), Blanket Purchase Agreements (BPAs), Indefinite Delivery Indefinite Quantity (IDIQ) contracts.

(4) Other e-commerce and dot-coms (for example, Department of Veterans Affairs (DVA) ordering sites).

(5) The DSCP Depot (centrally-managed and Military/Service-unique items).

(6) Government credit cards.

3-6. Expanded acquisition guidance

a. Commercial distributor (PV) is the primary acquisition method for materiel purchasing. Use of the DSCP PV Program is mandatory for the acquisition of products that are available through the program. MEDCOM will establish management goals and objectives to provide accountability for this mandatory business process. These goals and objectives will be published in SB 8-75-11.

b. The DSCP ECAT program can be used for laboratory, optical, dental, and medical equipment product lines, and other medical materiel as the program expands. AMEDD organizations will use ECAT as a mandatory source of supply for items that are available through the program. Using ECAT minimizes administrative overhead through streamlined financial processes available through the Military Standard Billing System.

c. The use of local purchase will be minimized for repetitive purchases. If local purchase is required (for example, PVs or ECATs are unavailable), DBPAs, BPAs or IDIQ contracts will be established with vendors to obtain the best pricing and reduce inventory investment. A just-in-time philosophy will be used in the place of automatic deliveries that could contribute to unnecessary and expensive inventory stockpiles.

(1) Within MEDCOM, paperless contracting via PRWeb is the method for generating and processing local purchase requests for supply purchases above Government credit card/International Merchant Purchase Authorization Card (IMPAC) authorizations. PRWeb is used to gain process efficiency and establish a closed-loop process from acquisition to contracting to finance, and minimize Prompt Payment Act penalties.

(2) DBPAs will be established through MEDCOM, DSCP, or DVA with suppliers of medical materiel, equipment, and limited repair parts not otherwise available through PVs or other requirements contracts.

d. The use of other electronic commerce purchasing sites, such as PV or DVA sites, is authorized. Specifically, DVA is an authorized source of medical materiel. The Office of Acquisition and Materiel Management's National Acquisition Center (NAC) is the largest combined contracting activity within DVA. The NAC is responsible for supporting DVA health care requirements as well as the needs of other Government agencies. The NAC solicits, awards, and administers DVA's Federal Supply Schedule and National Contract Programs, including the acquisition and direct delivery of pharmaceuticals, medical/surgical/dental supplies, high-technology medical equipment, and just-in-time distribution programs (also known as PV Distribution Programs). The NAC is comprised of the Federal Supply Schedule Service and National Contract Service. These services oversee specific programs for commodities such as medical, dental, and surgical supplies and equipment, pharmaceuticals, chemicals, medical equipment, and laboratory items. Local purchases of medical materiel, equipment items, and other specialty items using the Federal Supply Schedule Service are authorized.

e. DSCP Depot procurements will be used only for centrally managed, Military/Service-unique items.

f. Government credit cards may be used for payment when purchasing materiel through other methods, for example, BPAs or Web-based ordering. However, Government credit cards are the least preferred payment methods when purchasing recurring demand materiel or services. MEDCOM activities will use only MEDCOM contracting office-

issued credit cards. MEDCOM activities will not apply for, accept, or use credit cards issued by other MACOMs. Credit card decentralization and ease of use produces procurement situations that often are not planned or managed, may circumvent PV or other more cost-effective acquisition methods, and may ultimately result in paying higher or commercial prices for materiel and services. Credit cards can remain decentralized for sites with peculiar, unique or specialized requirements (for example, veterinary activities, dental activities, and pharmacies). Credit card purchases will be captured in logistics IS databases (TAMMIS/DMLSS) for retrospective review by the accountable officer to capture demands for standardization and ensure that more cost-effective procurement methods are considered in future procurements.

3-7. Logistics automated information systems policy

a. Maximize use of logistics ISs (TAMMIS/DMLSS) to maintain centralized visibility of all materiel and service procurements. Where available, DOD/Army ISs will be used regardless of who is managing the commodity, for example, a pharmacy. All transactions will be loaded into the logistics IS database so that accountable officers can functionally review and effect necessary changes to the procurement processes being used. Medical/surgical and medical maintenance procurement processes will be centralized to provide oversight and management through the most preferred acquisition method/strategy and to capture usage for standardization efforts. Regional logistics chiefs advise regional commanders to the extent of centralizing acquisition processes within HCA logistics divisions.

b. IMSAs and MEDLOG Bns are mandated to establish an electronic ordering process with all external deployable units/customers. Electronic ordering implies that a remote connection is established and data is transferred from the customer to the supporting IMSA or MEDLOG Bn. IMSAs, MEDLOG Bns, and their supported customers may use only approved Class VIII automated information management systems to accept and transmit Class VIII requisitions. These mandated electronic ordering processes will be used during peacetime and wartime operations.

3-8. Stockage policy

SSA peacetime stockage must be acquired within the parameters set in the acquisition guidance (see paras 3-5 and 3-6). Stockage will be minimized without unduly jeopardizing customer support. SSAs may stock—

- a.* Standard (catalogued) items listed in the AMDF or Federal Logistics Data on Compact Disc (FEDLOG).
- b.* Nonstandard items (items listed in the UDR medical catalog on CD-ROM).

3-9. Stockage criteria

IMSAs and MEDLOG Bn SSAs must provide responsive support to customers making recurring demands for medical items. Commercial contract services (that is, commercial distribution contracts) and/or stocking selected items locally, based on demands, are two ways of providing this responsive support.

a. The preferred method for providing responsive support is through a commercial contract service such as the DOD PV Program. When using this method, IMSAs and MEDLOG Bn SSAs must coordinate new requirements for recurring items with supporting commercial distributors.

b. Local stockage of selected items will be used when—

- (1) The items are not available through the supporting commercial distributor.
- (2) The distance between the IMSA and MEDLOG Bn SSAs and the supporting commercial distributors warrants stocking items to preclude interrupting supply support.
- (3) The items are identified as "critical" for operating or contingency support.

3-10. Requisition policy

a. Commercial distribution contracts or other local purchase procedures will be used to fill routine supply requirements.

b. Requisitions for depot stocked, military-unique (MU) and/or Service-regulated items will be submitted using Military Standard Requisitioning and Issue Procedures (MILSTRIP) contained in AR 725-50.

c. The most expedient mode of transportation and routing will be used to meet the needs of operating forces for high-priority materiel demands. The objective is to meet the materiel demand on time without operating and transportation costs becoming overriding factors.

d. High-priority requisitions will be held to a minimum consistent with the urgency of the need.

e. SSAs will make supply decisions based on priority designators.

3-11. Identification of nonstandard medical materiel

a. Medical items without NSNs will be identified by either their medical item identification numbers (MIINs) or locally assigned management control numbers.

b. MIINs normally are used to identify nonstocked medical items without NSNs. They are numbers that help customers, vendors, DSCP, and contracting offices identify items. Examples of MIINs are F1284310110 for a drug, G1326 for a medical gas, P73462 for a repair part, and H8137023590 for an item other than a drug or repair part.

3-12. Medical materiel issue policy

- a.* IMSAs/MEDLOG Bns/USAMMCE will issue medical materiel to HCAs and other units or activities that are authorized medical supply support.
- b.* Other medical supply operations will issue medical materiel to activities in accordance with the logistics support plan for the command area.
- c.* Medical materiel will be issued in accordance with AR 710-2, DA Pam 710-2-2, and SB 8-75-11. To ensure maximum stock rotation, issues for shelf-life items will comply with the shelf life of medical materiel policy in chapter 4 of this regulation.
- d.* Issue policy and procedures for medical materiel items will include appropriate QC measures in accordance with chapter 4 of this regulation and SB 8-75-11.
- e.* Emergency or urgent requests will be honored whether they are in written or verbal form. Materiel issues will be made on such requests at any time, regardless of administrative shutdown for inventory or other reasons, with subsequent adjustment of stock record accounts. IMSAs/MEDLOG Bns/USAMMCE will establish a suspense system for walk-through transactions to ensure that they are posted to the accountable record.
- f.* All materiel issues from the IMSA/MEDLOG Bn/USAMMCE will be in unit of issue quantity unless the supporting automated medical supply system has the capability to issue stock in both unit of issue and less than unit of issue quantity.

3-13. Storage policy

- a.* The MSO at each MEDCEN, MEDDAC, or other AMEDD activity has overall responsibility to—
 - (1) Care, preserve, and survey medical materiel within the IMSA or supply activity.
 - (2) Establish storage policies for all MEDCEN, MEDDAC, or other organic elements.
 - (3) Provide technical advice and assistance to all supported units.
- b.* MEDLOG Bn and other medical supply operation commanders are responsible for the care, preservation, and surveillance of medical materiel in their organizations.

3-14. Excess materiel management

The excess materiel management goals are to—

- a.* Eliminate excess medical materiel. Any materiel on hand and no longer required to satisfy any mission requirement will be considered excess materiel.
- b.* Ensure timely and cost-effective identification of excess materiel and equipment.
- c.* Aggressively report and advertise excess materiel for possible redistribution of serviceable items to other activities or units.

3-15. Transferring medical materiel within the Department of Defense

- a.* Joint use and/or transfer of medical materiel (supplies and equipment) among military departments will be accomplished without reimbursement when appropriate and feasible.
- b.* Joint MEDLOG support is appropriate when realigning MEDLOG support—
 - (1) For the operation of Single Integrated Medical Logistics Managers (SIMLMs) within joint and specified commands.
 - (2) In pursuing formal and informal joint Service sharing programs. These include, but are not limited to, programs identified in operating arrangements, memorandums of understanding (MOUs), memorandums of agreement (MOAs), and inter-Service support agreements (ISSAs).
- c.* Prior to transferring accountability to other Services (for example, U.S. Air Force or U.S. Navy), AMEDD activities will coordinate materiel transfers through supporting RMC/MSCs to USAMMA. USAMMA will—
 - (1) Advertise for redistribution within the AMEDD using the USAMMA Web site at <http://www.usamma.army.mil/>.
 - (2) Provide disposition instructions back to the HCA within 30 days. If the disposition instructions require local disposal of the item, the HCA will process and transfer accountability to the local Defense Reutilization and Marketing Office (DRMO).
- d.* IMSAs closing under base realignment and closure will—
 - (1) Follow supply procedures in AR 725-50, chapter 10.
 - (2) Obtain templates of timelines for all logistical functions through command channels.
 - (3) Use Defense Finance and Accounting Service-Indianapolis Regulation (DFAS-IN Reg) 37-1, table 3-1 when closing financial records.

Section III

Materiel Standardization

3–16. Materiel standardization definition

Materiel standardization is an integral part of the decision-making processes and functions associated with medical surgical supply items and cost analysis for medical equipment and services purchases. Materiel standardization is the cornerstone initiative of regional logistics programs, and presents significant opportunities for direct and indirect financial savings. Materiel standardization can support clinical efforts for utilization management and development of outcome-based pathways and protocols. Successful materiel standardization methods require clinically led processes that select and procure the most appropriate products, based on cost and clinical acceptance, for use throughout DOD health care regions or RMCs. Standardization ranges from the selection of individual items to broad product groups.

3–17. Implementing materiel standardization

a. Materiel standardization consists of two tiers: product decisions, including items with large-volume usage or increased cost, and reduction in the variety and number of different items purchased. RMCs and HCAs will participate actively in their DOD health care region's standardization efforts under the regional logistics support program. RMCs and HCAs must establish processes to support and document participation in DOD health care regional standardization initiatives. Each RMC will support regional standardization and other logistics initiatives by serving as a focal point for coordination among regional customers and HCAs, supporting acquisition agencies, and private-sector vendors.

b. RMCs and HCAs will work with and support their Tri-Service Regional Business Office, the operation and management arm of the DOD health care region's standardization program, and the DOD health care region's logistics chief to—

(1) Define target products and product groups. This is the first step with an analysis of where regional supply dollars are spent. This step identifies the primary users of the major product groups and assesses the degree of clinician preference for each product group.

(2) Select and prioritize products for standardization. The standardization of broad product groups targets those products that account for high-volume and high-dollar expenditures. This allows the standardization of many individual product lines with a single effort.

(3) Develop and select acquisition strategies. Specific acquisition strategies vary by product groups. High-demand items that fall into major product groups will be negotiated into committed-volume regional incentive agreements through the PV. Items that are low-demand, items with high unit cost, and items with highly specialized clinical applications will be purchased through Web-based ordering systems such as DSCP's ECAT program.

(a) Items that have higher quality requirements or lower costs than current stocked items are strong candidates for standardization review.

(b) Item groups with common functions will be identified for periodic review. Examples of item groups are catheters, surgical packs, needles and syringes, surgical gloves, and plastics.

(4) Conduct evaluations. A clinically led team composed of clinicians from appropriate specialties and from each military Service for regional evaluations, will evaluate product groups. This clinical product team (CPT) will conduct an impartial, clinical evaluation of proposed products from the users' perspective. The team will establish selection criteria and evaluation strategy for product groups under consideration. Recommendations and findings will be reported back through the DOD health care region. The CPT process will be facilitated and documented using the Federal logistics portal standardization tool.

(5) Review the critical item list to ensure critical items are considered for standardization.

c. Activity level standardization processes will be established within RMCs and HCAs. Internal processes that support DOD health care region standardization efforts and decisions will be developed and documented. Processes will include review mechanisms that indicate how activities are in compliance with standardization decisions. Each RMC and HCA will support data calls for the DOD health care region standardization process. Additionally, each will support the Tri-Service Product Review Board. The regional medical director/senior clinical leader will chair this board, which will have clinical and logistics representation from each Service. Individual RMCs and HCAs may establish local standardization committees to ensure organized and proactive approaches to materiel standardization within RMCs and HCAs, and to support the DOD health care region's standardization efforts. If a local standardization committee is established, products and/or product categories approved through that process will complement and not compromise DOD health care region annual priority standardization efforts.

d. Each RMC will establish, implement, and monitor the progress of initiatives to meet the goals and objectives of the standardization program. Each will establish procedures to identify and document resources, costs, and savings to this program. Standardization efforts throughout each DOD health care region focus on—

(1) Reducing variation in items purchased throughout the region.

(2) Facilitating clinical participation and acceptance of standardization efforts.

(3) Complying with mandatory participation in DOD health care regional initiatives and negotiated incentive agreements/RIAs.

(4) Decreasing inventory while increasing product velocity.

(5) Creating supply cost savings or avoidances.

e. RMC commanders will ensure all HCAs within their regions are in compliance with DOD health care regional standardization initiatives. RMC commanders will establish mechanisms to measure compliance for materiel and equipment standardization, which is approved regionally by the lead agent. The only exception is dental and veterinary unique items or issues that are approved by the Area Dental Laboratory, U.S. Army Veterinary Command, or U.S. Army Dental Command.

f. Any items or products standardized at the local, HCA level not provided under the DSCP committed volume contracts initiative (PV, Federal Supply Schedule (FSS)), must receive approval through the RMC and DOD health care regional logistics chiefs.

3–18. Materiel standardization parameters

All medical materiel used by more than one functional area within the HCA is subject to standardization policies, except for the following:

a. Drugs (AR 40–3).

b. Books, periodicals, and journals.

c. Medical gases.

d. Repair parts.

e. Hearing aids, prosthetic devices, and implants.

f. Materiel for supported medical research and development.

g. Food supplements.

3–19. Materiel standardization efforts

The objectives of materiel standardization throughout RMCs and at the HCA/activity level are to—

a. Reduce the number of different medical products and equipment items procured by the Military Health System (MHS).

b. Ensure that the military is buying the right products and improving acquisition strategies to achieve the lowest cost.

c. Work with the regional logistics chief, logistics division chief, and acquisition agencies to produce consumption data on items under consideration for standardization to negotiate committed volume discounts from manufacturers.

d. Enforce the use of standardized equipment and supplies throughout RMCs and HCAs.

e. Finalize and implement standardization decisions that achieve supply cost savings and/or cost avoidances. Each region must ensure an integrated reporting process exists to review and submit final recommendations within the DOD health care region standardization process. Product decision implementation includes the execution of purchasing acquisition methods such as RIAs and DAPAs. This decision implementation will be coordinated with the PV. DAPA and RIA use is mandatory. The implementation and introduction of the standardized product involves the phase-in inventory, any product trade-in, credit, or equipment exchange. Phasing also may involve marketing and education to promote use of the new product with the clinical staff.

f. Monitor compliance. This will ensure that the products are introduced and used as agreed with the selected vendor. This also will ensure that expected benefits from the purchasing agreements are realized.

Section IV

Materiel Evaluation Process

3–20. Commercial materiel testing

a. This section governs the investigation of commercially marketed (not prototype) materiel for potential use by TOE and TDA medical facilities. It provides activities with information that may be essential in determining quality assurance of materiel requirements, when developing minimum essential specifications for the materiel acquisition process, and for resolving certain materiel-related problems.

b. This section does not apply to the following:

(1) Clinical investigation activities (AR 40–38).

(2) Research and development activities (AR 70–1).

(3) User testing of TOE equipment (AR 73–1).

(4) Drugs, biologicals, reagents, medicated cosmetics, and toiletries (AR 40–3).

c. Written agreements between the Government and vendors are mandatory for examinations/evaluations and are strongly recommended for demonstrations. Supporting contracting offices will execute these written agreements. See paragraph 3–22b(3) for minimum elements to be included in the agreement.

3-21. Program components

a. The U.S. Army Medical Department Board (USAMEDDBD), AMEDDC&S, Fort Sam Houston, TX 78234-6100, administers the materiel evaluation process as described below. The board will—

- (1) Maintain a repository of medical or medical-related product information according to this section.
- (2) Manage approved materiel evaluations requested by activities.

b. Activities performing demonstrations, examinations, or evaluations will—

- (1) Provide copies of materiel examination results to USAMEDDBD.
- (2) Comply with approved evaluation plans for materiel evaluations and provide results to USAMEDDBD.

3-22. Materiel demonstrations, examinations, evaluations, aeromedical suitability determinations, and certifications

a. *Materiel demonstrations.* Demonstrations consist of the exhibit, use, or application of items by vendors. They do not involve action by Army personnel beyond observation of vendor product operation or use.

- (1) Commanders of Army HCAs may approve demonstrations.
- (2) No endorsements or statements of results or opinions will be provided to vendors.
- (3) All expenses incident to demonstrations will be borne by vendors. These include product transportation, installation, and operation costs.

(4) Close coordination with the supporting contracting office is mandatory to avoid contracting violations or claims.

b. *Materiel examinations.* A materiel examination is the use of an item by an activity. Its primary purpose is to determine whether that item or a similar item must be requested for purchase and use. Materiel examinations will be of limited duration, usually not exceeding 30 days. This time limitation is necessary so as not to imply an acceptance or obligation to the vendor.

(1) Commanders of Army HCAs may approve examinations when demonstrations are not expected to be adequate for determining the desirability of items for future use.

(2) When a commander determines that an examination is necessary, a written agreement between the activity and the vendor will be prepared in coordination with the supporting property management officer or MSO and the supporting contracting officer. The supporting contracting officer will execute this agreement.

(3) Materiel examination agreements will include the following points:

- (a) Items will be delivered, installed, operated, and removed at no cost to the Government.
- (b) The Government will not be responsible for the loss, damage, or destruction of materiel in its possession.
- (c) Vendors will bear the expenses for the return of materiel to them after examinations.
- (d) Vendor will provide special maintenance or operator training prior to examinations at no cost to the Government.

(e) Activities and individuals examining items assume no obligation to furnish oral or written reports to vendors regarding the results of the examinations.

(f) Under no circumstances will reports be released to activities outside the Federal Government without prior written approval from TSG.

(g) Vendors will not reference examinations for advertising or other promotional purposes unless the information has been published or presented through recognized professional media or its specific release has been approved by TSG.

(4) When an examination item is delivered, the property management officer will enter the item and all major components on the property records. A separate record file will be established for each examination agreement. The file will contain a copy of the examination agreement, applicable amendments, and receipt/turn-in documentation. Medical maintenance will inspect all medical equipment prior to delivery to the activity conducting the examination. The primary hand receipt holder for the activity conducting the examination will sign for the equipment. These property records will be maintained with the property book in accordance with AR 25-400-2.

(5) The materiel examination must follow a simple plan. The plan must consider functional performance, improved capability, compatibility with existing systems, reliability, maintainability, safety, and overall value to the Government.

(6) If volunteers are required for evaluation of a procedure, refer to AR 70-25.

(7) Each investigator will provide an examination report through the HCA commander with a copy forwarded directly to USAMEDDBD. While the report is not intended to be technically detailed, it must address the points in b (3) above in general terms, with a brief discussion of each. Details normally related to formal evaluations are not expected.

c. *Materiel evaluations.* Evaluations are formal investigations of materiel that may have AMEDD-wide potential for improving health care or efficiency. They require evaluation protocols, milestone schedules, and progress reports. Evaluations should not be undertaken to support sole source purchases. Comparative evaluations of competitive equipment can be required to ensure objectivity and evaluation of the best available materiel. Demonstrations and examinations will be considered prior to requesting evaluations.

(1) Commanders of HCAs will submit evaluation requests through Commander, MEDCOM (MCHA-P) to USAMEDDBD, in accordance with MACOM/MEDCOM procedures.

(2) On receipt of each request, USAMEDDBD will prepare a resume sheet for presentation to the MEDCOM Test Schedule and Review Committee.

(3) USAMEDDBD will prepare an evaluation plan and milestone schedule in coordination with the designated evaluation activity.

(4) Each evaluation activity will accomplish the evaluation actions above, conduct the evaluation according to the approved evaluation plan, submit evaluation results to USAMEDDBD, and participate with USAMEDDBD as required in preparation of the evaluation report.

(5) USAMEDDBD will prepare the evaluation report.

(6) TSG will review the evaluation report and act on recommendations, as appropriate, for potential AMEDD-wide use.

d. Aeromedical suitability determinations. Aeromedical evacuation (AE) suitability determinations are made after specialized tests and/or evaluations are conducted. Items that require air certification are those designated by DMSB as patient movement items (PMIs) and items used by Army AE, as determined by the combat developer or field commander. PMIs are medical equipment items required to support patients during air evacuation. The purpose of PMIs is to ensure effective and safe interfaces between PMIs, patients, crews, and aircraft.

(1) AE suitability determinations are handled by the combat developer at AMEDDC&S. Requests must state whether the equipment is for—

(a) Wartime.

(b) Peacetime movement of military members or military dependents.

(c) Peacetime movement of civilians.

(2) Forward all requests to Commandant, AMEDDC&S, ATTN: HSMC-FC, Fort Sam Houston, TX 78234-6100.

e. Materiel certification. After AMEDDC&S has determined the materiel suitable for AE, the requirement will be sent to USAMRMC.

(1) USAMRMC—

(a) Has oversight responsibility for AMEDD in the airworthiness release certification process.

(b) Reviews, as a part of the acquisition function, the requirement to determine the appropriate activity to handle certification for rotary wing usage.

(c) Prioritizes items that are being forwarded to the U.S. Army Aeromedical Research Laboratory (USAARL) or the appropriate testing activity.

(2) USAARL is the primary activity that performs airworthiness evaluations and tests. These services are provided on a reimbursable basis.

Section V

Controlled Medical Items

3-23. Security precautions

Controlled medical items such as controlled substances, precious metals, and other items designated by the HCA commander require security precautions. Research, development, test, and evaluation facilities will follow the policies and procedures in AR 70-65 when managing controlled substances and hazardous biological substances.

3-24. Controlled substances

a. Identification. The Drug Enforcement Administration (DEA) identifies drugs as controlled substances. Appendix C of SB 8-75-S3 contains a list of these drugs and changes that are published annually. The Federal Supply Catalog (FSC) identifies standard controlled substances as "Notes R and Q" in the Notes column. The AMDF or FEDLOG identifies these substances as "controlled inventory item codes (CIICs) R or Q."

b. Schedule designations. The DEA assigns controlled substances to one of the five following schedules, depending on the degree of control required:

(1) Schedule I. Substances/drugs having no accepted medical use in the United States.

(2) Schedule II. Substances/drugs having high abuse potentials with severe psychological or physical dependence liabilities. Identified as—

(a) Symbol "R" in the FSC.

(b) CIIC "R" in the AMDF or FEDLOG.

(3) Schedule III. Substances/drugs having an abuse potential less than Schedule I and Schedule II substances. Identified as—

(a) Symbol "Q" in the FSC.

(b) CIIC "Q" in the AMDF or FEDLOG.

(4) Schedule IV. Substances/drugs having an abuse potential less than Schedule III substances. Identified as—

- (a) Symbol "Q" in the FSC.
- (b) CIIC "Q" in the AMDF or FEDLOG.
- (5) Schedule V. Substances/drugs having an abuse potential less than Schedule IV substances. Identified as—
 - (a) Symbol "Q" in the FSC.
 - (b) CIIC "Q" in the AMDF or FEDLOG.

c. Requisitioning standard controlled substances. Only Army activities identified in the SB 8-75 series can requisition controlled substances. DSCP will ship only to those DOD activity address codes (DODAACs) cited in the series.

d. Controlled substance turn-in. Controlled substances that are complete units of issue will be turned-in to the supporting IMSA/USAMMCE/MEDLOG BN. Less than complete units of issue will be destroyed by the organization. If the unit lacks the ability to destroy controlled substances, packages containing less than the unit of issue will be turned-in to the supporting pharmacy for destruction.

e. Local purchase of controlled substances.

(1) All local purchases must comply with DEA instructions and procedures contained in SB 8-75-11.

(2) Each HCA commander may designate a minimum number of essential personnel within the IMSA/MEDLOG Bn/USAMMCE or pharmacy as authorized to sign exempt certificates for the purchase of controlled substances for official use.

f. ARNG/ARNGUS policies and procedures for controlled substances.

(1) ARNG/ARNGUS activities will, within 30 days of mission completion, return stock symbol "R" controlled substances acquired for patient care missions (such as annual training, inactive duty training, and site support) to one of the following activities for proper control:

(a) The ARNG/ARNGUS Troop Medical Clinic (TMC) that will accept the materiel.

(b) A U.S. Property and Fiscal Office.

(c) Any active duty installation medical supply activity.

(2) ARNG/ARNGUS activities will complete the following actions to stock symbol "Q" controlled substances:

(a) Return, if not required for future patient care missions. Follow the same procedures as symbol "R" controlled substances.

(b) Store, if retained, in a field safe that has been secured to the structure or has been placed in a more secure container that meets the security requirements of AR 190-51.

3-25. Shipment of controlled medical items

Federal laws (Chapter 13, Title 21, United States Code (21 USC Chapter 13)), govern the handling of controlled medical items within the U.S. and its territories. Controlled medical items must be safeguarded at all times to prevent illegal use and pilferage. Controlled items must be removed from assemblages and packed and shipped separately.

3-26. Storage and issue of installation stocks of controlled medical items

a. Physical security. Storage facilities will follow the physical security standards in AR 190-51 for controlled medical items, other medically sensitive items, and all other items.

b. Managing controlled medical items.

(1) HCA commanders or command surgeons will appoint MSOs and at least one alternate to serve as custodians of their activities' stocks of controlled medical items.

(2) In activities where logistics personnel no longer maintain functioning vaults, pharmacy officers may be appointed.

3-27. Periodic inventories of controlled medical items

Disinterested officers, appointed by HCA commanders or command surgeons, will conduct inventories of all symbols "R" and "Q" controlled items monthly. These inventories will exclude components of aviation survival kits that are on hand in aviation units. Inventories of these components must be conducted at the same time as the periodic inspections of complete kits (every 120 days). If officer personnel are limited or not available, noncommissioned officers (E7 or above) or civilians (General Schedule-7 or above) will be appointed. Logistics and pharmacy personnel cannot be used or appointed as disinterested officers.

3-28. Other items requiring control

RMC/MSO/HCA commanders will—

a. Designate items that are expensive and known to be highly vulnerable to theft or potential abuse as controlled items.

b. Determine which storage and handling precautions will be used.

3-29. Controlled medical items as components of medical equipment sets

a. MESs containing controlled medical items will be stored to provide the best security available.

b. When the operational readiness of an MTOE unit requires that the controlled medical item components of an MES be maintained in the unit, the unit commander will store the items in a secure location (see para 3–26). If controlled medical item components cannot be extracted for special storage, the items must be stored in chests that are handled or otherwise appropriately secured. The entire MES also must be stored in the most secure manner possible.

3–30. Controlled medical item components of aviation survival kits

Issue controlled medical items (Schedule V drugs) that are components of aviation survival kits with the complete kit to the requesting unit. At the unit level—

- a. Keep aviation survival kits in the possession of authorized personnel.
- b. Secure kits in the same manner as other aviation life support equipment (for example, in a locked room, cage, or individual locker).
- c. Keep controlled medical item components with survival kits at all times. This ensures crewmembers can use the items in emergency survival situations.
- d. Replace controlled medical item components that have expired.

Section VI

Material Management in Modified Table of Organization and Equipment Activities

3–31. Medical logistics battalions

a. In peacetime, MEDLOG Bns may perform full SSA functions, have training missions, or have area supply missions. Upon mobilization and/or deployment, MEDLOG Bns normally will perform all SSA functions.

b. MEDLOG Bns assigned to medical SSA missions will support all customers according to the logistics support plans developed for their commands or areas of operation. Plan also will outline the relationship between the MEDLOG Bn and the next higher level of supply support. Continental United States (CONUS) MEDLOG Bns' supporting commands will coordinate the logistics support plans with the supported RMCs.

3–32. Materiel management in other than medical logistics battalions

a. *Authorized Stockage.* MTOE medical supply operations can stock—

(1) Consumable items authorized in MESs (for MTOE hospitals, the required resupply module fulfills this requirement).

(2) Items used to meet contingency missions and training requirements and items used to provide garrison medical support, if approved by the command surgeon. Units with these missions, training, and/or support requirements will maintain command surgeon-approved authorized stockage lists (ASLs) that reflect wartime and peacetime requirements.

b. *Stockage criteria.*

(1) Command surgeons determine peacetime stockage objectives for MTOE medical supply operations. Stockage objectives will not exceed 30 days.

(2) MTOE medical supply operations will follow MACOM guidance when establishing stockage criteria for items that support ASLs and mandatory parts lists or re-supply of medical MES components.

(3) Local policy will govern ASL distribution.

c. *Calculating stockage levels.*

(1) Command surgeons determine peacetime stockage objectives for MTOE medical supply operations. Stockage objectives will not exceed 30 days.

(2) MTOE medical supply operations will use the days of supply method or inventory management modules of approved automated systems to compute requisitioning objectives (ROs). Logistics support plans should establish days of supply needed to support designated unit operations when mobilized. Each MTOE medical supply operation will obtain authorization from the supporting IMSA/USAMMCE for the local purchase of non-stocked medical surgical (MEDSURG) items using a Government/IMPAC credit card. MTOE medical supply will utilize the supporting IMSA/USAMMCE for medical local purchases exceeding the purchase card threshold.

3–33. Ordering service regulated items

To route requisitions for acquisition advice code (AAC) “A” regulated medical items, follow these procedures:

a. For CONUS and OCONUS active duty units:

- (1) The requester must submit requisitions to the supporting IMSA/USAMMCE.
- (2) The IMSA/USAMMCE sends the requisition to USAMMA and an information copy to the requester's MACOM.
- (3) USAMMA validates the requirement with the appropriate MACOM, as required.

b. CONUS and OCONUS USAR and ARNG/ARNGUS units will follow procedures contained in SB 8–75–11.

3-34. Reference book sets for medical modified table of organization and equipment units

- a.* The MTOE and other Army authorization documents authorize book sets for MTOE units. The AMEDDC&S—
- (1) Determines book set components.
 - (2) Reviews book sets annually.
- b.* To obtain individual books for book sets:
- (1) Use local purchase procedures.
 - (2) Use the current General Services Administration FSS for Federal Supply Group 76.

Section VII

Army National Guard/Army National Guard of the United States Units

3-35. Medical supply support

- a.* U.S. Property and Fiscal Office (USPFO) commodity managers are designated to provide medical materiel/IMSA-type support to ARNG/ARNGUS units. USPFOs and ARNG/ARNGUS MTOE units assigned medical supply support missions will requisition Class VIII items with NSNs using MILSTRIP procedures contained in AR 725-50.
- b.* Direct delivery from vendors to end users is a cost-effective and responsive delivery methodology and will be used whenever feasible. The medical surgical and pharmaceutical prime vendors fulfill this requirement. ARNG/ARNGUS organizations may pass all Class VIII materiel requisitions, less those for which USPFOs initiate local purchase actions, to the supporting Power Projection Platform (PPP) medical activity (IMSA) or other designated medical support element. States have the option of establishing or not establishing a support relationship with the PPP/IMSA.

3-36. Pharmaceuticals

ARNG/ARNGUS units will maintain State surgeon-approved formularies in accordance with SB 8-75-S10.

3-37. Medical materiel quality control messages

The Chief, National Guard Bureau (CNGB) will, upon receipt, distribute copies of all medical materiel quality control (MMQC) messages to the division medical supply office and ARNG/ARNGUS training sites operating TMCs. Additionally, the CNGB immediately will distribute all MMQC messages concerning Type I medical materiel complaints and Food and Drug Administration (FDA) Class I recalls to the State safety office and all State medical elements, including separate medical detachments and medical sections of maneuver battalions.

Section VIII

Management Indicators and Supply Performance Indicators

3-38. Use of management and supply performance indicators

- a.* Management indicators are factors that measure supply function performance. For example, management indicators include the adequacy of policies and procedures, placement of supply activities within an organization, span of control, productivity, responsiveness to customer needs, management controls, and operating practices. Supply performance indicators are standards used to measure supply operation results.
- b.* Medical-specific management and supply performance indicators are contained in SB 8-75-11.
- c.* Management and supply performance indicators will be used as standards to measure—
- (1) Management effectiveness.
 - (2) Organizational placement appropriateness.
 - (3) Management control adequacy.
 - (4) Organization supply activity quality.
 - (5) Staff productivity.

3-39. Performance indicator data

Command surgeons, RMCs/MEDCENS/MEDDACs, and commanders operating IMSAs/MEDLOG Bns will develop, maintain, and evaluate supply effectiveness data on support received and support rendered.

Chapter 4 Quality Control, Shelf-life, and Medical Materiel Complaints

Section I Quality Control of Medical Materiel

4-1. Quality control information

This chapter provides policy for medical materiel—

- a. QC.
- b. Storage and shelf life.
- c. Surveillance, recalls, and suspension.
- d. Disposal and destruction.
- e. Complaints.

4-2. Quality control responsibilities

- a. MEDLOG activities (IMSAs/MSAs/MEDLOG Bns/USAMMCE) and pharmacies will—
 - (1) Serve as focal points for dissemination and collection of MMQC information.
 - (2) Establish and operate medical materiel surveillance programs.
 - (3) React to QC information by insuring that all sequentially numbered DOD MMQC messages, DOD shelf life extension program (SLEP) messages, USAMMA medical materiel information (MCMR–MMI) messages, vendor generated messages, SB 8–75 series notices, and recall notices from supporting commercial distributors' PVs are received, registered, validated, observed, and disseminated to customers.
 - (4) Provide QC information to medical receiving, storage, shipping, and maintenance elements and to supported activities that consume medical materiel.
 - (5) Provide QC information (such as reports of materiel defects) to the wholesale system based on surveillance findings and reports from customers.
 - (6) Prepare reports or take other actions as required by this regulation.
 - (7) Establish procedures to ensure that materiel is marked to reflect current QC information.
 - (8) Ensure that materiel is stored in such a manner to prevent deterioration.
 - (9) Provide logistics assistance to supported units for QC matters.
 - (10) Act as QC information sources by conducting constant surveillance programs of medical materiel in storage or use.
 - (11) Suspend, report, or dispose of unserviceable materiel using national, regional, or local disposal contracts.
- b. MSOs will coordinate with risk managers at HCAs to ensure that medical materiel QC procedures are included in the HCA Quality Assurance Programs in accordance with AR 40–68. Risk managers will be advised of all potential compensable medical materiel problems.
- c. When medical materiel complaints are submitted, every effort to preserve evidence will be made by turning in suspect medical materiel to IMSAs/MSAs/MEDLOG Bns/USAMMCE or pharmacies.
- d. Non-supply support activity (SSA) medical supply operations (that is, deployable hospitals, area support medical battalions, and TDA clinics) will maintain QC programs for their medical materiel stocks. These medical supply operations will respond to requests from the wholesale system for QC information by conducting appropriate research or surveillance, and provide information through their supporting IMSAs/MSAs/MEDLOG Bns/USAMMCE to the wholesale system. These medical supply operations will receive MMQC messages and information from IMSAs/MSAs/MEDLOG Bns/USAMMCE for internal use and distribution to supported customers.
- e. Local QC procedures will be established detailing how the above responsibilities will be accomplished.

4-3. Sources of quality control information

The following sources of QC information will be used by all activities involved with medical materiel:

- a. USAMMA QC messages are referred to as DOD MMQC and DOD SLEP messages. DOD MMQC messages and DOD SLEP messages are identified by a numbering sequence that starts in the beginning of each calendar year, for example, DOD MMQC 01–1001 and DOD SLEP 01–5001. USAMMA MCMR MMI messages (issued to Army activities only) also are identified by a numbering sequence that starts in the beginning of each calendar year, for example, MCMR MMI 01–4001.
- b. DOD MMQC, DOD SLEP, and Army MMI messages contain information of system-wide interest. This includes:
 - (1) Suspension of medical materiel.
 - (2) Extension of storage time periods (potency expiration dates).
 - (3) Disposition instructions.
 - (4) Other significant QC information.
- c. DOD MMQC and DOD SLEP messages issued by USAMMA are transmitted worldwide to units and activities of

the Active Army, USAR, and ARNG/ARNGUS, as well as to the other Services. USAMMA MMI messages are transmitted worldwide to units and activities of the Active Army, USAR, and ARNG/ARNGUS only.

Section II

Storage and Shelf Life of Medical Materiel

4-4. Storage policy

MSOs are responsible for—

- a. Care, preservation, and surveillance of all medical materiel under their control.
- b. Establishment of storage policies for all supported activities.
- c. Provision of technical advice and assistance to all supported customers.
- d. QC of medical gasses.

4-5. Quality control of medical gases

a. For medical purposes, gases (such as oxygen, nitrous oxide, and ethylene oxide) require strict QCs. These QCs cover the receipt, storage, testing (gas and cylinders), record keeping, handling (cylinders only), disposal, and turn-in of cylinders.

b. Medical-grade gases are those that meet standards set forth in Title 21, Code of Federal Regulations, Sections 210–211 (21 CFR 210–211). These gases are available in bulk (liquid) and in cylinders (gas).

c. Bulk (liquid) gases may be oxygen or ethylene oxide.

4-6. Storage periods for medical materiel

a. For medical materiel, the term "shelf life" is used when referring to expiration-dated (potency and dated (P&D)) items and items of supply that possess deteriorative or unstable characteristics to the degree that storage time periods are assigned to ensure that the items will perform satisfactorily in service. Medical materiel storage periods are categorized as follows:

(1) *Type I shelf-life items.* Type I items are items of supply that have definite storage periods terminated by expiration dates established by empirical and technical test data. Routinely, these supply items are considered nonextendable, except when large quantities are being stored for contingency purposes. In these cases, the supply items may qualify (based on technical and economic considerations) as candidates for the DOD/FDA SLEP. The DOD/FDA SLEP requires FDA testing. Type I shelf life items are identified by "01" in the fourth and fifth positions of the materiel category structure code (MCSC) and by an alpha character in the shelf life code (SLC).

(2) *Type II shelf-life items.* Type II items are items of supply that have definite storage periods terminated by expiration dates that may be extended after prescribed inspections or restorative actions. Type II items are those items of supply having a definite storage period terminated by an expiration date that may be extended after a prescribed inspection or restorative action. They are identified by "02" in the fourth and fifth positions of the MCSC and by a numeric entry in the SLC.

(3) *Selected Type II shelf-life items.* Selected Type II shelf-life items are those that require specific actions by local activities prior to extensions. (See AR 702–18/DLAD 4155.37/NAVY Supply Instruction (NAVSUPINST) 4410.56A/AFJMAN 23–232/MCO 4450.13A for materiel quality storage standards policy for shelf-life materiel.)

(4) *Estimated storage-life items.* Estimated storage-life items are items of supply with estimated storage periods, during which the items are expected to retain their serviceable qualities. These items are identified by "03" or "08" in the fourth and fifth positions of the MCSC and by a zero in the SLC.

(5) *Minimum shelf-life items.* Minimum shelf-life items are shelf-life medical materiel that have potency dates with the minimum shelf-life potency acceptable for procurement. Minimum shelf-life potencies are identified by the SLC and published in AR 702–18/DLAD 4155.37/ NAVSUPINST 4410.56A/AFJMAN 23–232/MCO 4450.13A.

(6) *Shelf-life condition codes.* Shelf-life medical materiel are condition coded in accordance with AR 702–18/DLAD 4155.37/ NAVSUPINST 4410.56A/AFJMAN 23–232/MCO 4450.13A as follows:

- (a) Condition code "A" signifies more than 6 months of remaining shelf life.
- (b) Condition code "B" signifies 3 to 6 months of remaining shelf life.
- (c) Condition code "C" signifies less than 3 months of remaining shelf life.

(7) *Reclassified materiel.* Medical materiel bearing expiration dates are reclassified from condition code "A" to "B" or "C" based upon the number of months remaining in the dating periods before expiration. CONUS and OCONUS activities may receive condition code "A" stocks for shelf-life materiel issued from DSCP. Condition code "B" stocks are issued to CONUS activities, but may be issued to OCONUS activities with prior approval from the requisitioner. Activities will report (see section V, below) newly procured potency dated materiel. For OCONUS activities, newly procured potency dated materiel is shelf-life condition coded "B" or "C" upon receipt; for CONUS activities, this materiel is shelf-life condition coded "C."

b. The FDA, under the DOD/FDA SLEP, is the approving authority for medical activities requesting extensions on selected shelf-life items.

c. The relationships and differences between shelf-life items and estimated storage life items are:

(1) Shelf-life items have specific storage periods that are terminated by expiration dates. Certain shelf-life items can be extended after accomplishing prescribed actions at the local level. Others require inspection and testing through the DOD/FDA SLEP or the manufacturer.

(2) Estimated storage life items do not have specified storage periods. The fact that an estimated storage life item has exceeded its storage period is not sufficient evidence that the item is unsuitable for continued issue and use.

4-7. Management of shelf-life items

a. *General.* Active management of shelf-life items to preclude destruction requires the following:

(1) Establishing procedures that—

(a) Support the optimum use of shelf-life items, both contingency and peacetime.

(b) Ensure the earliest dated materiel is issued first.

(2) Establishing local management and performance criteria that provide incentives for reducing excess and disposal/destruction workloads and costs.

(3) Seeking and exploiting opportunities to return short-dated and expired materiel to the manufacturers/distributors through contracting channels.

(4) Considering the use of alternative materials or alternative contracts to support operations requiring shelf-life materiel.

b. *Local testing procedures.* X-ray film, adhesive tape, microscope slides, and certain blood collecting tubes are Type II expiration-dated items that may be tested and extended using local testing procedures. (See AR 702-18/DLAD 4155.37/ NAVSUPINST 4410.56A/AFJMAN 23-232/MCO 4450.13A for materiel quality storage standards policy for shelf-life materiel.) Do not use outdated medical items unless extensions have been received from USAMMA or other official sources.

c. *Potency extension.* Medical materiel may receive extension of potency from—

(1) The DOD/FDA SLEP. Under this program, the FDA tests shelf-life materiel for the military Services. Each Service requests specific materiel for FDA testing by NSN, nomenclature, manufacturer, quantity per lot, lot number, and manufacture expiration date. The FDA will extend materiel that tests successfully, provided it has been stored properly. USAMMA coordinates this program for the Army.

(2) Field initiated extension requests. Army activities will initiate extension requests for materiel that meet extension criteria (para 4-7g below).

d. *MU and medical nuclear, biological, and chemical defense materiel (MNBCDM) mandatory extension actions.* USAMMA publishes a list of items currently approved for testing in the DOD/FDA SLEP at <http://www.usamma-army.mil/html/dodshelf.html>.

e. *Autoinjectors.* Autoinjectors will not be relabeled at the unit level. Materiel is placed in the shelf-life extension program and relabeled only as required. Only the manufacturer will accomplish relabeling.

f. *Biologicals.* The FDA will not accept shelf-life extension requests for FSC 6505 items classified as "biologicals." USAMMA will provide guidance through QC messages on reporting and disposal of biologicals.

g. *Criteria for field initiated extension requests.* Items reported for potential extension will meet the following criteria:

(1) Stocks on hand will reach their expiration dates or assigned shelf life prior to use.

(2) Generally, the quantity projected to be on hand at the time of shelf-life expiration must have acquisition costs of \$10,000 or more per lot. USAMMA will authorize by message the destruction of lines with acquisition costs of less than \$10,000 per lot once the stocks reach the assigned expiration dates, unless extensions have been given.

(3) MU/MNBCDM items must be reported for potency extension regardless of the dollar values of stock on hand.

(4) The testing of P&D items for possible shelf-life extension will be confined to MU items and medical pharmaceutical items that are in limited production and/or indefinite manufacture backorder and could have potentially adverse impacts on medical readiness.

Section III

Surveillance, Recalls, and Suspension

4-8. Surveillance of materiel

a. Activities that stock medical materiel will establish surveillance programs to provide for scheduled inspections of medical materiel. When appropriate, activities will rotate mobilization reserve stocks with operating stocks. Timely action is necessary to preclude undue loss through deterioration or destruction.

b. The basic publications used for surveillance programs are as follows:

(1) AMDF or FEDLOG.

(2) AR 702-18/DLAD 4155.37/ NAVSUPINST 4410.56A/AFJMAN 23-232/MCO 4450.13A, appendix M.

(3) SB 8-75 series.

- (4) Military Item Disposition Instructions (MIDI). (Available at <http://chppm-www.apgea.army.mil/>.)
- (5) UDR.
- (6) DLIS
- (7) Military Environmental Information Source.
- (8) DOD MMQC messages.

c. AR 702-18/DLAD 4155.37/ NAVSUPINST 4410.56A/AFJMAN 23-232/MCO 4450.13A, appendix M contains the procedures and standards for visual inspections of medical materiel. The standards identify the physical properties (discoloration, precipitation, odor change, and so forth) that would indicate product deterioration and render the item unsuitable for issue and use. AR 702-18/DLAD 4155.37/ NAVSUPINST 4410.56A/AFJMAN 23-232/MCO 4450.13A, appendix M may be viewed at <http://www.usamma.army.mil/>.

4-9. Recall of nonstandard drugs and devices

- a. A nonstandard drug is any item that does not have a DMSB-approved NSN. Nonstandard drugs and devices announced by the FDA as being recalled by manufacturers or distributors will be published in DOD MMQC messages.
- b. Procedures for the recall of nonstandard drugs and devices are contained in SB 8-75-11.

4-10. Suspension of medical materiel

- a. USAMMA will publish suspension instructions for medical materiel through MMQC messages.
- b. Procedures for the suspension of medical materiel are contained in SB 8-75-11.

Section IV

Disposal and Destruction of Medical Materiel

4-11. Disposal policy

- a. Unclaimed excess or unserviceable medical materiel will be retained at HCAs and disposed of through DRMO channels.
- b. AMEDD will use contracted services for the disposal and return of medical materiel wherever possible. Use of such contractual services enables AMEDD to obtain monetary credits and/or replace unserviceable materiel with like or similar serviceable materiel. For nonhazardous waste items that cannot be disposed of through the use of such contracted services, medical materiel (except for nonhazardous supply class 6505 items that DRMO will not accept) will be destroyed or disposed of through the supporting DRMO. For all items determined to be hazardous waste, disposal through the supporting DRMO is required unless comparable local disposal mechanisms are available and approved by HQDA through the MACOMs.
- c. The DSCP Directorate of Medical Materiel and DVA have established a national contract with a reverse distributor (contractor) capable of assisting with the Pharmaceutical Returns Management Program for DOD and DVA pharmaceutical PV customers. Under the Pharmaceutical Returns Management Program, the awarded contractor will assist DOD and DVA pharmacies and medical treatment facilities (MTFs) to achieve maximum credit for the return of expired and soon-to-be expired pharmaceutical products, while remaining in compliance with all applicable regulations related to hazardous waste handling. All individuals responsible for administering the pharmaceutical returns contract must be certified as contracting officers' representatives (CORs). Each commander will appoint a primary and, wherever appropriate, an alternate COR.
- d. Disposal of medical items will adhere to MIDI and any applicable Federal, State, and local regulations.

4-12. Disposal procedures

Procedures for the disposal and destruction of medical materiel are contained in SB 8-75-11.

Section V

Medical Materiel Complaints

4-13. Complaint policy

Assistant Secretary of Defense (Health Affairs) has appointed the DSCP as the focal point for DOD medical QC issues.

- a. Report complaints involving medical materiel found to be injurious or unsatisfactory on SF 380 (Reporting and Processing Medical Materiel Complaints/Quality Improvement Report) and, when necessary, in accordance with American, British, Canadian, and Australian Quadripartite Standardization Agreement (QSTAG) 287 ED.3. SF 380 may be reported online at <http://www.usamma.army.mil/html/dodshelf.html>.
- b. Medical, supply, and maintenance personnel will thoroughly evaluate materiel before complaints.
- c. Do not report materiel that produces the same side effects described on package inserts.
- d. In complaints involving blood grouping and blood reagents, keep the actual bottles or reagents involved as well as the cells and serum used with the reagents available for testing.

4-14. Types of medical materiel complaints

a. Complaints concerning defective or unsatisfactory medical materiel are classified as follows:

(1) *Type I.*

(a) Type I complaints are submitted for materiel, including equipment, determined by use or test to be harmful or defective to the extent that using the materiel has or may cause death, injury, or illness. Immediate action must be taken to report such materiel and suspend its issue and use.

(b) Type I complaints can be initially classified only by medical or dental officers familiar with the details of the complaints. Professional personnel will carefully ascertain and evaluate all pertinent facts to preclude unnecessary delay or undue alarm because of the immediate worldwide notification required for Type I complaints. Disseminated information must include all information required on SF 380. Additionally, individuals initiating the complaints will be available to respond to telephone inquiries.

(2) *Type II.* Type II complaints are used to report materiel, other than equipment, that is suspected of being harmful, defective, deteriorated, or otherwise unsuitable for use. Personnel must take expeditious action to report such materiel and to suspend its issue and use.

(3) *Type III.* Type III complaints are used to report equipment that is determined to be unsatisfactory because of malfunction, design, defects (attributable to faulty materiel, workmanship, or quality inspection), or performance. Such complaints do not necessarily require suspension of the items.

b. Medical materiel complaint procedures are contained in SB 8-75-11.

Chapter 5 Medical Equipment Management

Section I Medical Equipment Accountability and Acquisition

5-1. Purpose

This chapter provides policy for the accountability and purchase of medical equipment for TDA organizations, MTOE units (Active Army and Reserve), and the ARNG/ARNGUS. AMEDDPAS or DMLSS, as applicable, will be used in TDA activities for property accountability.

5-2. Property management in Army Medical Department table of distribution and allowances activities

a. This section provides policy for managing medical and nonmedical equipment items at AMEDD TDA activities and installations. These activities will account for all nonexpendable equipment on hand or in use at the activity in accordance with AR 25-1, AR 25-400-2, DA Pam 25-91, AR 710-2, DA Pam 710-2-1, AR 700-142, DA Pam 700-142, and AR 735-5.

b. The following categories of equipment for use in AMEDD activities will be accounted for on property records:

(1) All maintenance-significant medical equipment regardless of cost and non-maintenance-significant medical furniture valued at more than or equal to the current micro-purchase threshold.

(2) Nonexpendable, nonmedical equipment, as defined in AR 710-2, authorized for use by medical activities. This includes organizational clothing and individual equipment (OCIE), but only for those TDA activities that have requested and received HQDA waivers to AR 710-2 and DA Pam 710-2-1. Waiver procedures are contained in SB 8-75-11.

(3) Automated data processing equipment and telecommunications equipment.

(4) All rented, leased, or loaned equipment.

(5) Any item, regardless of unit cost, considered pilferable or sensitive may be maintained on accountable records at the discretion of the property book officer (PBO).

c. Property accounting procedures will provide reports of asset visibility and equipment requirements as stated in SB 8-75 MEDCASE.

d. All items on property books will be identified with bar coded labels to improve inventory accuracy.

e. Equipment furnished by contractors will be listed in their contracts. Copies of the contracts will be furnished to PBOs for review and applicable equipment accountability.

f. Excess equipment will be reported in accordance with the provisions outlined in SB 8-75-11.

5-3. Property management responsibilities

a. *Chief, Property Management.* The Chief, Property Management is responsible for—

(1) Providing direction, leadership, and general supervision in the implementation and maintenance of the property management program throughout the organization.

- (2) Establishing and maintaining the organization's regulations and procedures.
 - (3) Defining hand receipt/custodial areas within the organization.
 - (4) Establishing and training the organization's property management team, comprised of the PBO, hand receipt/custodial managers, and hand receipt holders/custodians.
 - (5) Developing and implementing inventory schedules for the organization, monitoring inventory progress, and reconciling property records.
 - (6) Ensuring that required reports are provided.
 - (7) Implementing procedures for the repair and rehabilitation of property within the organization.
 - (8) Ensuring excess property is promptly inspected and reported for disposition, and that final disposition instructions are followed when received.
 - (9) Ensuring that lost, stolen, or damaged property is investigated in accordance with AR 735-5.
- b. PBO.* The PBO is responsible for—
- (1) Ensuring effective administration and maintenance of the system of control and accountability for property belonging to the organization.
 - (2) Ensuring that hand receipt holders/custodians have current records for assigned accountable property.
 - (3) Ensuring that physical inventories are taken, records are reconciled, and discrepancies are investigated and resolved.
 - (4) Ensuring that reports of survey for lost, damaged, or destroyed property are promptly processed in the property accounting system. Overall report of survey processing times are a function of the report of survey appointing authority.
 - (5) Ensuring that property is fully utilized and safeguarded from misuse or theft, and that unneeded property is promptly reported for reutilization, redistribution, or disposal.
 - (6) Coordinating criteria for replacing or upgrading over-age equipment with the Chief, Property Management.
 - (7) Ensuring that bar coded labels are affixed to accountable property.
 - (8) Ensuring that additions, transfers, and deletions are entered into the property accounting records in a timely manner.
- c. Hand receipt holder/custodian.* The hand receipt holder/custodian is responsible for the immediate physical custody of all property under his or her control. Appointment as a hand receipt holder/custodian may or may not correspond to the individual's official job title. The hand receipt holder/custodian is responsible for—
- (1) Maintaining current hand receipt/custodial records for all accountable property within his or her assigned area.
 - (2) Initiating or processing, in accordance with local procedures, documents affecting the accountability or custody of property.
 - (3) Ensuring that property has proper maintenance and protection, and is used only for official purposes.
 - (4) Identifying and reporting to the PBO any property excess to the needs of the area.
 - (5) Promptly initiating reports of survey for lost, damaged, or destroyed property.
 - (6) Assisting with and/or conducting physical inventories and reconciling property records.
 - (7) Assisting with exit clearance procedures to ensure that all assigned property is accounted for and transferred to the new hand receipt holder/custodian.

5-4. Loan of property

The issue or loan of public property for unofficial use is prohibited. Activity commanders may approve temporary loans of durable supplies and equipment to other Army or DOD HCAs. Automated or manual hand receipts will be prepared in duplicate and used to issue property loaned in this manner.

a. Where military medical benefits property (MMBP) exists, HCA commanders may authorize the loan of equipment and durable supplies to outpatient or convalescent military personnel or their family members, including chronically ill individuals who are authorized to receive treatment in Army HCAs. This materiel and equipment is required for the treatment of injuries or illnesses and is needed to improve the function of malformed body members or to retard further deterioration. Hospital beds, oxygen monitors, and wheelchairs are examples of such equipment. Approved loans require health care provider prescriptions or letters and will not exceed 6 months in duration. Where no MMBP exists, refer patients to applicable TRICARE Service Centers for supplemental care or to alternative sources to obtain equipment.

b. Durable supplies will be provided by the appropriate HCA using activity, for example, central materiel service or outpatient clinic.

c. HCA commanders may approve lists of supplies and equipment for any equipment loan program.

d. PBOs will maintain records of all materiel on loan. PBOs or hand receipt managers will issue automated hand receipts to patients. If automation is unavailable, they will prepare DA Form 3161 (Request for Issue or Turn-In) in duplicate and use the form to issue property on loan.

e. PBOs will conduct annual inventories on all MMBP equipment not on loan. During these inventories, PBOs and hand receipt managers will reconcile records of equipment on loan by verifying that borrowers still have and require

the loaned equipment. Borrower may be contacted by telephone for this purpose. PBOs and account managers will annotate the automated hand receipts or DA Form 3161 (Request for Issue or Turn-In) with the dates and the names of the individuals they contacted. Concurrently, they will obtain medical equipment repair verification that required maintenance and calibrations were completed.

f. When patients no longer require the borrowed equipment, it will be returned to PBOs for accountability. Biomedical equipment technicians (BMETs) must inspect the returned equipment before it is returned to service.

g. When an individual with loaned equipment moves to an area that is the responsibility of another HCA, the HCA commander of the losing HCA may approve a transfer of loaned unique or specialized equipment to the HCA assuming responsibility for patient care. When the patient transfers to an HCA where no MMBP exists, the losing HCA PBO must coordinate with the gaining PBO to provide the medical maintenance branch with documentation to establish continued services on the Government owned equipment. The losing PBO will provide the patient with the applicable information to coordinate and establish equipment services.

5-5. Retention of medical materiel by military patients after separation

a. Retention of medical materiel is not authorized.

b. Upon separation from the Armed Forces, a military patient who requires medical equipment or appliances for his or her comfort and safety will be referred to the applicable TRICARE Service Center. If unable to obtain the equipment, the TRICARE office must coordinate the equipment request through the HCA commander with full justification and circumstances for retention. The HCA commander can approve retention of medical equipment by exception, in writing.

c. HCA commanders will establish issue procedures using local standing operating procedures (SOPs). They will submit requests for issue to the responsible PBOs.

5-6. Loan of table of distribution and allowances equipment to modified table of organization and equipment organizations

HCA commanders may temporarily loan medical and nonmedical equipment items to MTOE units. Equipment will be loaned only to satisfy urgent deployment requirements and/or those requirements needed to meet extended DA/Joint Chief of Staff directed exercises. When loaning equipment, HCA commanders will follow the guidance in AR 700-131.

5-7. Medical equipment on loan between U.S. Army organizations and other activities

a. HCA commanders will ensure that equipment accompanying patients received from other Government or civilian medical facilities is promptly returned to the originating facility.

b. Commanders may make emergency loans of medical equipment to other local government or civilian health care facilities. These loans may not exceed 15 days in duration. (See AR 700-131 for additional information on Army medical equipment loans.)

c. Borrowing equipment from aviation organizations is not authorized unless specifically approved by TSG.

5-8. Transfer of specialized equipment with specialists

a. The AMEDD mission requires many highly specialized personnel who require specific equipment to perform their duties. HCA commanders may authorize the transfer of this equipment to the specialists' new duty stations if the gaining units need the equipment and the specialists will be performing services using the equipment at their new duty stations, and if the equipment will not be used at the losing units. Supplies and repair parts peculiar to the specialty equipment may be transferred with the basic equipment. Such transfers reduce excesses at the losing activities and avoid funding unnecessary equipment acquisitions at the gaining activities.

b. If requested, PBOs will ship this specialized equipment. These items will not be formally turned in to IMSAs or posted to the stock record accounts. Post transfers to the appropriate property books in accordance with lateral transfer procedures contained in AR 710-2 and DA Pam 710-2-1. Transfer supplies on hand that are no longer required to support the transferred equipment from the losing IMSA to the gaining IMSA. Use normal stock record accounting procedures contained in DA Pam 710-2-2 for these transactions.

c. This transfer authorization applies only to intra-Army transfers. Perform inter-Service transfers or transfers to civilian agencies in accordance with DOD 4160.21-M.

d. Equipment bought for and used by a specialist will be turned in to the PBO for proper disposition upon expiration of the specialist's term of service.

e. Prescription surgical loupes will be transferred with the individual for whom prescribed, and accounted for as outlined for special measurement clothing and footwear in AR 700-84. Upon departure from the Service, the individual may purchase these items at cost minus depreciation. However, surgical loupes can be refabricated for reuse. When directed by the department chief, the departing individual will turn in the surgical loupes to the receipt holder for reissue.

5-9. Managing excess medical materiel on property books

The following specific procedures apply:

a. PBOs will ensure that medical equipment is inspected by the supporting medical maintenance activity. Qualified medical maintenance personnel will condition code equipment. (See DOD 4160.21-M and AR 725-50 for additional information on condition codes.)

- (1) Dispose of unserviceable items that are not economically repairable.
- (2) Screen serviceable or economically repairable items for possible use within the same activity.
- (3) If an item cannot be used, report it for excess disposition. See SB 8-75-11 for disposition procedures and guidance for reporting excess equipment.
- (4) Qualified medical maintenance personnel must condition code excess ARNG/ARNGUS medical materiel only if that materiel is excess to State requirements and must be reported to the National Guard Bureau (NGB). If qualified medical maintenance personnel are unavailable within the State, request support from the MEDCOM activity with area support responsibility.

b. MSOs will not post these transactions to stock record accounts or reflect them as stock fund transactions. PBOs will coordinate transfers of investment equipment with USAMMA to ensure the MEDCASE program is updated.

5-10. Reporting unsatisfactory equipment

Equipment reported to PBOs as unsatisfactory will be processed through the supporting medical maintenance activity. If the condition is not remedied, report details to the IMSA for medical materiel complaint processing.

5-11. Exemption for reporting or accounting of industrial plant equipment

Equipment utilized in fixed HCAs, AMEDDC&S, and U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) is not considered industrial plant equipment. Such equipment will not be accounted for or reported.

5-12. Privately owned medical equipment

a. Privately owned medical equipment is any item that is brought to an HCA by a staff member or patient and used for treatment purposes. The Army does not authorize the use of privately owned equipment within HCAs. Using such equipment jeopardizes an HCA's Joint Commission on Accreditation of Healthcare Organization (JCAHO) accreditation. AR 25-1 provides guidance on using privately owned automation equipment. Coordination with PBOs for accountability on all automated data processing equipment (ADPE) is mandatory.

b. HCA commanders will enforce this policy regarding the use of privately owned medical equipment. Staff members or patients can submit requests for waivers through HCA commanders to Commander, MEDCOM, ATTN: MCLO, 2050 Worth Rd., Ste. 8, Fort Sam Houston, TX 78234-6008.

c. The Comprehensive Accreditation Manual for Hospitals: The Official Handbook imposes extensive requirements for written documentation for all equipment, regardless of ownership, used in HCAs. These requirements are key factors in the JCAHO accreditation decision process.

- d.* When health care is provided on a contractual basis, the contract must—
- (1) Clearly identify all medical equipment used in the treatment facility.
 - (2) Determine liability, security, accountability, and maintenance responsibilities.
 - (3) Specify JCAHO compliance requirements.

e. Patient-owned, nonmedical comfort equipment (for example, hair dryers, curling irons, electric razors, radios, and so forth) falls under the authority of HCA safety officers/managers. HCA safety officers/managers will establish policies for the introduction to and use of such items within MTFs and, if these items are allowed to be introduced, will inspect and document these items and all other nonmedical electrical equipment. To maintain JCAHO accreditation, inspections must be conducted in accordance with National Fire Protection Association (NFPA) 99.

5-13. Asset and transaction reporting

a. MEDCOM installations will establish local procedures to ensure asset reporting complies with AR 710-3. This compliance also applies to unique item tracking system rebaselining instructions provided by MEDCOM and/or the logistics support activity. The unique item tracking system includes reportable items covered by the following programs:

- (1) DOD Small Arms Serialization Program.
- (2) Controlled Cryptographic Item Serialization Program.
- (3) DOD Radiation Testing and Tracking System Program.

b. Each MEDCOM installation commander will appoint an installation serialization officer to serve as a central point of contact (POC) for reporting purposes. Installation serialization officers reports installation and supply supported customer assets. Each installation commander must forward the name and phone number of the installation serialization officer to Commander, MEDCOM, ATTN: MCLO, Ste. 8, 2050 Worth Rd., Fort Sam Houston, TX 78234-6008.

- c. MEDCOM PBOs at other than MEDCOM installations will—
 - (1) Report through their host installations.
 - (2) Comply with instructions provided by their host installations.
 - (3) Be responsible for the accuracy of the assets they report.

Section II

Table of Distributions and Allowances Equipment Wartime Procedures

5–14. Equipment management during medical evacuation

a. *Implementation.* Implementation of the policy in this section is effective upon direction from the Secretary of the Army to implement the wartime accountability procedure in AR 710–2.

b. *Originating HCA.*

(1) Medical evacuation coordinating officer will notify PBOs when nonexpendable equipment is required for patient evacuation.

(2) Each PBO will prepare DD Form 1149 (Requisition and Invoice/Shipping Document) or, when authorized, DA Form 3161 to document the posting of the property book for all equipment transferred with patients. A copy of the admission and disposition sheet showing the patients evacuated will be attached as the authority for the action.

(3) PBOs will request replacement equipment by submitting routine supply requests to their supporting MSOs.

c. *Destination HCA.* Nonexpendable equipment that is not part of the patient movement item (PMI) program will be returned to the accountable supply officer as excess air evacuation property. The accountable MSO will process this excess equipment as air evacuation items. Equipment that is part of the PMI program will be reported to USAMMA for disposition instructions. However, PBOs may pick up returned nonexpendable equipment upon inspection by medical maintenance personnel.

5–15. Patient movement item program

a. PMIs are equipment needed to support medical evacuation in combat/contingency operations.

b. The intent of the PMI program is to—

(1) Ensure evacuated patients have required life support equipment.

(2) Ensure using TOE authorized medical equipment for evacuation does not degrade medical care within the theater.

(3) Enhance the rapid evacuation of patients from forward areas of the battlefield.

c. PMI assets are established/authorized as follows:

(1) USAMMA will maintain accountability for Army-owned PMI assets prior to fielding to the medical logistics company (MLC) or the medical logistics support company (MLSC).

(2) PMIs must be approved by the DMSB and be certified for use on fixed and rotary wing aircraft.

(3) PMIs will be considered components of MEDLOG unit (MLC/MLSC) ASLs and will not placed on unit property books.

d. Responsibilities for PMI.

(1) PMI location and maintenance history will be maintained at all levels using an automated tracking system.

(2) Each MLC/MLSC has the responsibility to manage the PMI program, including handling maintenance and asset distribution within their support area of operations.

Section III

Equipment Acquisition in Army Medical Department Table of Distribution and Allowances Activities

5–16. Equipment acquisition objectives

The objective of equipment acquisition and management is to reduce costs and the type and quantity of medical equipment that is generally similar. This business improvement process will enable cost reductions for materiel supply and preventive maintenance.

5–17. Equipment acquisition policy

a. Commanders of all TDA medical activities will establish equipment requirements. This regulation provides the authority for medical activities to acquire medical equipment, with the exception of Army-adopted medical items (See Universal Data Repository (UDR)). AR 71–32 provides equipment authorization policies and procedures for Army-adopted medical and nonmedical equipment.

b. Procure equipment using the following priorities:

(1) Meets medical emergencies.

(2) Supports AMEDD health care programs.

(3) Supports approved construction projects.

(4) Completes phased equipment replacement through structured 5-year replacement and modernization programs and acquisition of new medical technologies.

c. The Army uses Defense Health Program Other Procurement, Defense (OPD), OMD, or DOD MILCON funds to acquire equipment through the MEDCASE program. SB 8-75 MEDCASE provides detailed guidance on equipment eligibility criteria and submission procedures.

5-18. Medical care support equipment program

a. The MEDCASE program is the AMEDD program for the acquisition of capital investment equipment for HCAs and the initial outfitting of expanded or newly constructed health care facilities. The MEDCASE program does not apply to equipment procured with research, development, test, and evaluation (RDTE), or other centrally managed DA-level funded capital investment equipment acquisition programs.

b. TSG manages the MEDCASE program, and USAMMA executes the program in coordination with command surgeons and RMCs/SCs/MEDCENS/MEDDACs. The MEDCASE requirements are submitted to USAMMA with supported documents in accordance with SB 8-75 MEDCASE.

c. USAMMA periodically will provide file data and reports from the asset visibility file (AVF) and MEDCASE Requirements and Execution (MRE) system to TSG, MEDCOM, and HCAs. The file data and reports will be maintained on MEDCASE on an individual item basis (not line item). USAMMA maintains the AVF and MRE systems. As such, USAMMA will routinely take action to keep these systems current and consistent with program policies established by TSG. Above the local level, management information about the MEDCASE program will be generated only from the AVF and MRE systems; no other automated systems will be developed to accomplish this task without TSG approval.

5-19. Medical care support equipment approval policy

a. Medical activity commanders, MSC commanders, and MEDCOM will approve or disapprove MEDCASE candidate requirements in accordance with SB 8-75 MEDCASE. The U.S. Army Health Facility Planning Agency (USAHFPA) or its on-site representative must approve all budget line item code-new facilities (Defense Health Program funded (BLIC-NF)) and budget line item code-new facilities (military construction (MILCON) funded (BLIC-MB)) requirements before final MEDCASE approval. Each level of review will disapprove candidate requirements—

- (1) If the justification is inadequate.
- (2) If the item is not eligible for the MEDCASE program.
- (3) When the item is not appropriate for—
 - (a) The mission.
 - (b) Assigned personnel.
 - (c) Density of similar equipment.
 - (d) Other factors from the requester.

b. Policies for equipping initial outfitting projects are as follows:

- (1) Only USAHFPA may determine if a project is eligible for initial outfitting funds.
- (2) In order for a requirement to be funded by initial outfitting funds, there must be a direct correlation between the requirement and the construction project. If the requirement is not for the construction project, it will not be eligible for initial outfitting funds.

(3) The scope of the project will determine whether initial outfitting funds are released. Equipment acquisitions that can be accomplished with OPD funding, MILCON funding, or initial outfitting equipment funds are not eligible for transition funding. (See SB 8-75 MEDCASE for additional information on funding.) OPD funding seldom is provided in support of—

- (a) Life safety upgrades.
- (b) Renewals.
- (c) Renovations.
- (d) Electrical-mechanical upgrade projects.

c. Equipment replaced through the MEDCASE program will not routinely be retained for back up. Retention of replaced equipment at or above the high dollar value (HDV) MEDCASE threshold may be authorized by MEDCOM only. Replaced equipment below the HDV threshold may be retained with MACOM/command surgeon or RMC/MS approval only.

5-20. Acquisition of investment equipment

a. HCAs must finance MEDCASE investment equipment within OPD Defense Health Program procurement limitations.

b. Each request for excess investment equipment is required to have an approved MEDCASE requirement. USAMMA will concur/nonconcur on all requests for lateral transfers that exceed the MEDCASE threshold. All other

concurrences/nonconcurrences will follow the same approval and disapproval processes applicable to the MEDCASE program.

c. Fund nonexpendable equipment required to initially equip major medical MILCON projects with either OPD or medical MILCON. Military Standard (MIL-STD)1691F establishes the logistical category that determines the funding source. Fund nonexpendable equipment and medical systems not included in the scope of work approved by the U.S. Congress with OPD using DD Form 1391 (Fiscal Year (___) Military Construction Project Data) (RCS ENG-240).

d. Fund equipment not eligible for OPD or medical MILCON with OMD Defense Health Program operation and maintenance limitations.

e. Acquire equipment identified in AMDF, UDR, supply catalogs, and bulletins as centrally funded through nonmedical program funding channels.

f. Acquire other equipment through existing authorization and funding procedures. Request photographic, audiovisual, and television systems in accordance with AR 25-1. Request RDTE-funded special purpose equipment in accordance with AR 70-6.

g. Non-excess personal property may be offered for exchange (trade in) along with acquiring new equipment in accordance with DFARS, Subpart 217.70.

h. Include senior medical maintenance managers in every aspect of medical equipment procurement.

5-21. Acquisition of furniture and furnishings

a. HCA commanders have approval authority for all nonmedical furniture and furnishing requests. This includes the authority to determine when furniture will be repaired or rehabilitated. HCA commanders may delegate this approval authority but they remain responsible for accountability and the appropriate use of Government funds. HCA commanders or designated representatives will identify individuals to provide information and assistance to customers making furniture acquisition decisions and to establish controls on furniture expenditures.

b. Furnishings required for patient contact areas (such as waiting areas, clinician offices, reception areas, patient lounges, and solariums) will provide an aesthetic and pleasant atmosphere and will not be limited by Common Table of Allowances (CTA) 50-909. Therefore, acquire furnishings for patient contact areas as needed and in accordance with the appropriate local approval procedures and availability of funds. Furnishings required in administrative areas, not involved with direct patient contact, must conform to CTA 50-909.

5-22. Equipment rental, lease, or loan

a. Rental, lease, or loan of equipment for use in an HCA is authorized when determined more advantageous or cost effective to the Government and approved by the HCA commander or equipment approval authority. Process authorization requests for equipment rental or lease in the same manner as expense equipment.

b. The requiring activity will submit requests for rental, lease, or loan of medical and nonmedical equipment for use in the HCA to the PBO. The request will include the same information that is required for equipment purchase. It will specify the period of time the rental/lease will be required and include a cost/benefit analysis of rental/lease rather than purchase.

c. Budgeting for the rental or lease of equipment is the responsibility of the using activity. The PBO will send approved rental or lease purchase requests (PRs) to contracting through the resource management office. The PR must clearly define ownership and maintenance responsibilities.

d. Loan requests will be for specified periods of time, normally not exceeding 30 days. The requesting office will submit its request through the medical maintenance branch and the facility engineer branch prior to submission to the PBO. The PBO will forward the request to the contracting office for legal review and approval. The contracting office will provide the PBO and medical maintenance branch with copies of the approved request. Loans longer than 30 days but less than 180 days will be approved through RMCs. Requests for loans exceeding 180 days will be submitted to MEDCOM for approval. In order to ensure compliance with JCAHO and safety requirements, all loaned equipment will be formally accounted for on property books. The hand receipt holder for the activity requesting the temporary loan of equipment will sign for the equipment. If the equipment is specialized and will be used by a specialist for a unique procedure, the hand receipt holder will sub-hand receipt the equipment to the responsible individual.

e. Each PBO will keep a separate file for each rental/lease/loan contract containing the approved authorization, a copy of the rental/lease/loan contract, applicable amendments, and receipt/return documentation. USAR equipment will not be loaned without U.S. Army Reserve Command (USARC) approval.

f. Applicable maintenance records will be maintained on all rental/lease/loan equipment for 2 years or for the duration of accountability.

g. Each applicable hand receipt holder will notify the PBO and medical maintenance branch immediately upon removal and/or return of loaned, leased, or rented equipment.

Section IV

Modified Table of Organization and Equipment Management Guidance

5–23. Medical and nonmedical equipment acquisition and management in modified table of organization and equipment units

a. Medical MTOE units must have on hand or on order those items of medical and nonmedical equipment authorized by the MTOE.

b. The type of funding will determine the specific procedures for requesting and managing medical equipment. Obtain authorized medical equipment through one of the following funding programs:

(1) Other Procurement, Army (OPA)-funded capital investment equipment items with materiel category structure code “CQ.” (See AR 710–1, chap 5 for information on financial inventory management.)

(2) OMA-funded MESs.

(3) OMA-funded expense equipment items with materiel category structure code “C2.”

c. Acquire and manage OPA-funded capital investment equipment as follows:

(1) ASIOE components in supply catalogs that reflect line item numbers are for information purposes only. This does not constitute separate authorization. The unit assemblage (UA) listing may provide interim authorization for OPA-funded items pending—

(*a*) Line item number assignment.

(*b*) Migration from the MES to the unit’s MTOE.

(2) Identify all OPA-funded capital investment medical equipment for MTOE units as regulated medical items, acquisition advice code (AAC)–A (service/agency regulated) or as provisioned medical equipment items AAC–W, restricted requisitioning. Submit nonfunded requisitions for OPA-funded items to Commander, USAMMA, ATTN: MCMR–MMR, 1423 Sultan Dr., Ste. 100, Fort Detrick, MD 21702–5001.

(3) USAMMA will determine whether DSCP or another appropriate procurement agency will procure OPA-funded capital investment equipment. TSG will establish, upon coordination with MACOMs/command surgeons, the priorities for acquisition.

(4) The appropriate HQDA central manager will program the OPA-funded nonmedical equipment. Identification of requirements and submission of requisitions will be coordinated with the appropriate organizational (requesting unit) or installation SSA.

d. Manage MESs as follows:

(1) Include CEEP and consumables/durables in MES component listings.

(2) Include ASIOE required to support the set in the component listings. The ASIOE may be either OMA- or OPA-funded, and will be authorized separately on the MTOE. MESs may provide interim authorization for ASIOE items, pending the addition of the line item number to MTOEs by MACOMs.

(3) Acquire MESs with OMA funds.

(4) Identify major MESs (SB 8–75 series) and specified minor MESs as regulated medical items (acquisition advice code A).

(5) TSG will perform central programming and will obtain funding for MESs that—

(*a*) Are newly standardized, type classified, and fielded to MTOE units.

(*b*) Constitute major modernization of existing MESs.

(*c*) Constitute initial issue of existing MESs to newly activated units.

(6) Requisitions may be initiated by newly activated units or USAMMA, or in accordance with instructions in materiel fielding plans (MFPs).

(7) Acquire all MESs that are not centrally programmed and funded with MACOM OMA funds.

(8) With OMA funds, MACOMs will fund individual item replacement for all MES components and equipment with MCSCs of “C2.”

e. MACOMs/command surgeons may authorize nonstandard, nontype classified medical equipment instead of MTOE medical equipment for Force Package 1 and 2 units. MACOMs/command surgeons will notify USAMMA of these changes. USAMMA collects this information to ensure sustainability. Do not delegate this authorization below the MACOM/command surgeon level.

f. Modernize and field newly standardized equipment items in accordance with AR 40–60.

g. Manage equipment on hand in medical MTOE units in accordance with AR 710–2 and DA Pam 710–2–1.

h. Use OMA (Mission) funds to obtain OCIE in accordance with AR 710–2.

i. Medical MTOE units operating TMCs or dispensaries as elements of garrison- or installation-level health services will obtain equipment and ancillary supplies from their supporting HCAs. Assigned medical MTOE unit personnel staffing TMCs are responsible and accountable for TMC medical equipment. Temporary hand receipts will be used to account for TMC equipment. Consumable supplies will be paid for by the supporting HCA based on workload data submitted by the activity operating the TMC/dispensary, as specified in the MOU between the supporting HCA and medical MTOE unit.

j. AR 220–1, chapter 5 explains equipment substitutions.

5–24. Equipment acquisition for deployed medical tables of organization and equipment units

This section provides guidance to Medical Task Force commanders and commanders of deployed medical units for acquiring medical equipment that is not authorized by their current MTOEs, but is needed to perform their current contingency missions. This guidance is intended specifically for deployed U.S. Army medical units in support of contingency missions.

a. Operating guidance is as follows:

(1) Clinicians or care providers will prepare memorandums justifying requests for medical equipment. Each memorandum will contain detailed justification for the equipment as well as an explanation of the impact on the health services mission if the equipment is not obtained. Medical Task Force commanders serve as the initial review authorities for item requirements.

(2) Requirements approved by Medical Task Force commanders will be forwarded through staff channels to command surgeons for final action. Command surgeons will approve or disapprove the requests, then notify the requesting deployed Medical Task Force commanders of their decisions. Command surgeons will cite this regulation as the approval authority.

b. Command surgeons will publish instructions for requesting approved medical equipment items. Task Force funds will be used to fund medical equipment purchases. The requesting unit must ensure an accurate “ship to” address and supplementary address, which includes the unit’s DODAAC, unit identification code (UIC), location, phone and fax numbers, and E-mail address. Priority of shipment must be addressed using the MILSTRIP Priority Designator System.

c. Memorandums with command surgeon approval provide authorization for acquiring the equipment. Copies of these memorandums will be retained in the units’ equipment authorization files. The property books will cite this regulation as the authority for acquiring the equipment. Equipment authorized for a Task Force mission will be processed as excess upon completion of that mission.

5–25. Property accountability

a. AR 710–2 and DA Pam 710–2–1 provide accountability procedures for organizational and CTA-authorized equipment in MTOE units.

b. Separate property books will be maintained down to the local unit identification code level. Medical brigades and medical groups may collocate property books as long as separate books are maintained by local unit identification codes. Local unit identification codes end in “AA.” This level of unit integrity is needed to support individual unit deployments, separate from medical brigades or groups.

c. Commanders will assign property responsibilities down to the level of use. For example, in hospital units, property will be hand-receipted from the PBO to the officer-in-charge as the primary hand-receipt holder. Do not hand-receipt all unit property to one person such as the company commander.

d. Each commander, not receiving direct support from a central issue facility and having OCIE on his or her property book, will assign OCIE responsibility by issuing the OCIE to the individual soldier on a clothing record.

Section V

Equipment Acquisition for the Army National Guard

5–26. Equipment authorization procedures for Army National Guard physical examination facilities

a. States desiring to establish physical examination facilities will submit memorandums for approval to Chief, NGB, ATTN: NGB–ARS, 111 South George Mason Dr., Arlington, VA 22204–1382. Each request must—

(1) State the desired facility location.

(2) List existing Federal facilities within a 30-mile radius and specify why each of those facilities cannot satisfy the ARNG/ARNGUS physical examination requirement.

(3) Project the number of physical examinations by type (that is, enlistment, 40 and over age retention, under-40 age retention, or flight) in a 1-year period.

(4) State projected cost savings.

(5) List needed equipment.

b. Upon facility approval by the CNGB, States may submit memorandums to Chief, NGB, ATTN: NGB–ARS, 111 South George Mason Dr., Arlington, VA 22204–1382 for equipment authorization. Requests must include the state area command (STARC) TDA paragraph number to which the authorization will be added. The SB 8–75 series contains a suggested list of physical examination facility equipment.

c. The CNGB will—

(1) Authorize equipment with memorandums of authorization. These memorandums of authorization provide interim authorization only. The NGB will add authorizations to the STARC TDA at the next revision cycle; the memorandums of authorization will expire at that time.

(2) Assign NGB line item numbers to nontype classified equipment.

d. States will resubmit memorandums of authorization that have been issued for 3-year periods without being included on the STARC TDA 6 months prior to expiration. States must request that the letters of authorization be included on the STARC TDA.

5-27. Equipment authorization procedures for troop medical clinics at Army National Guard training sites

a. Each ARNG/ARNGUS training site will partially or fully equip the TMC located on the site. Submit requests for authorization of medical equipment, in letter format and fully justified, to Chief, NGB, ATTN: NGB-ARS, 111 South George Mason Dr., Arlington, VA 22204-1382.

b. For approved items, the NGB will assign NGB line item numbers, when required, and will issue letters of authorization that are valid until the next revision of the TDA.

c. Each ARNG/ARNGUS training site with an approved TDA and a TMC is authorized nontype classified medical and dental furniture. This furniture is found in Federal supply classes 6520 and 6530 only, and is on an "as required" basis for use in that facility only. The installation property book is the authorization document for such property. AR 71-32 provides guidance on authorization documents within the Army.

d. ARNG/ARNGUS training sites with valid NGB authorizations for medical equipment may substitute nontype classified items of the same quantity for Federal supply classes 6515, 6520, and 6530 items.

e. USPFO is the approval authority for specific proposed acquisitions authorized above.

Chapter 6 Medical Equipment Maintenance

Section I Maintenance Concepts

6-1. Maintenance elements

a. Maintenance of medical materiel includes maintenance engineering and medical maintenance operations.

b. The objective of medical maintenance operations is to support the health care mission. To support this objective, it is necessary to establish and maintain AMEDD capability for the performance of maintenance operations. This capability includes individual and unit training, a medical proficiency training program, and a rotation base to ensure readiness for mobilization or peacetime surge.

c. Medical maintenance operations pertain to both TDA and MTOE HCAs, unless otherwise specified.

d. HCA medical maintenance operations encompass both unit and direct support levels and are characterized by fixed (TDA) facilities located with the HCAs, research and development activities, USACHPPM, and Armed Forces Institute of Pathology (AFIP). (See Technical Bulletin-Medical (TB MED) 750-1 for additional information on medical equipment maintenance.) Medical equipment repairers (MERs) provide the services and functions for organic medical equipment within these facilities in addition to area support missions and/or ISSA missions, as directed by the commands.

6-2. Maintenance policy

a. Medical materiel maintenance is ultimately the responsibility of medical activity commanders. Commanders will establish effective maintenance management programs for all medical materiel issued to, or under the responsibility of, their activities.

b. MTOE commanders will report the status of selected medical items of equipment in accordance with AR 220-1 and AR 700-138.

c. The medical materiel maintenance function is limited to maintenance activities tasked by TSG, command surgeons, and RMCs/MSCs to support the AMEDD mission.

(1) Medical maintenance activities organic to MEDCENs, MEDDACs, MEDLOG Bns, USACHPPM, AFIP, RTS-MEDs, and USAMMA maintenance divisions will publish their external maintenance support procedures for customer use.

(2) MEDLOG Bns will establish support agreements with supported unit commanders. These agreements must define requirements of both the supported units and the supporting activities for administration of proactive medical materiel maintenance programs.

(3) Each installation, except those where RTS-MEDs are located with other HCAs, will have only one TDA HCA assigned a medical materiel maintenance function. Maintenance resourcing can be either centrally funded when MEDCOM budgets the TDA HCA, or funded on a cost reimbursement basis. TSG is the approval authority for exceptions.

d. MACOMs possessing medical materiel maintenance capabilities will coordinate maintenance resources. Formal

agreements will be established between MACOMs with primary emphasis directed toward the achievement of a high state of unit readiness and the maintenance of managerial and technical skills of their personnel.

e. TDA medical maintenance activities will accomplish their support missions to ensure that supported activities comply with applicable standards pertaining to the maintenance of medical equipment promulgated under—

- (1) Titles 21 and 29, Code of Federal Regulations (21 and 29 CFR).
- (2) College of American Pathologists Laboratory Accreditation Program.
- (3) JCAHO's Comprehensive Accreditation Manual for Hospitals: The Official Handbook.
- (4) NFPA 99 and NFPA 101.
- (5) All other applicable Federal safety and health standards.

f. The Surgeon General (TSG) must approve the use of unit, direct, and general support contract maintenance for materiel fielded under MTOE. Use of RTS-MEDs is authorized on a limited basis as Government-owned, contractor-operated activities.

g. Scheduled periodic maintenance services take precedence over all but emergency repair requirements. Equipment maintenance managers make the final decisions regarding precedence.

h. Maintenance services will be performed at the lowest level of maintenance authorized with the capability and capacity to perform the service. Units may overhaul equipment provided the capability exists and the overhauls have been approved by command surgeons or RMCs/MSCs.

i. Integrated logistics support plans will be adhered to throughout the life cycle of medical materiel to ensure adequate logistics support. (See AR 700-127 for additional information on integrated logistics support.)

j. Medical materiel acquisition policies and procedures will be followed to minimize logistics support requirements. (See AR 40-60 for additional information on medical materiel acquisition policies and procedures.)

k. Each item of medical equipment will be tested for serviceability and electrical safety prior to initial use, and at least annually thereafter, unless otherwise recommended by the original manufacturers' guidelines. The testing will be documented as prescribed by the appropriate MACOM.

l. MERs will test medical equipment in storage, including APS and operational project (OP) equipment, in accordance with TB MED 1. MERs will manage medical equipment in MTOE units, although temporarily stored (for example, between field training exercises), as equipment in use for scheduled periodic services.

m. The management of maintenance functions, operations, and programs will be accomplished through DA or MHS standard systems.

(1) Technical Bulletin (TB) 38-750-2 prescribes procedures for the preparation and management of forms and records by units.

(2) DMLSS is the automated maintenance management system that replaces AMEDDPAS in TDA HCAs.

(3) In TDA HCAs, use forms designed for and/or fielded with the MHS IS in lieu of DA Form 2407 (Maintenance Request) and so forth.

(4) The TAMMIS MEDMAINT, Standard Army Maintenance System 1 (SAMS1), and Unit Level Logistics System-Ground (ULLS-G) are automated maintenance management system for MTOE units. ULLS-G will be fielded to units with organizational maintenance missions and SAMS1 will be fielded to units or activities with direct support/general support (DS/GS). The Army STAMMIS systems will migrate to GCSS-A.

(5) MTOE medical maintenance operations will use the TAMMIS Customer Assistance Module (TCAM), SAMS1, or ULLS-G to manage repair parts.

n. The specific maintenance policies that apply to the ARNG/ARNGUS are as follows:

(1) State maintenance officers must coordinate medical maintenance support.

(2) Medical maintenance requirements beyond unit capabilities may be supported from the following resources:

(a) Other ARNG/ARNGUS medical maintenance resources in the State.

(b) MEDCOM organizations with area support responsibilities (on a reimbursable basis).

(c) USAMMA maintenance divisions (on a reimbursable basis).

(3) The SB 8-75 series provides additional ARNG/ARNGUS-specific medical equipment maintenance guidance.

o. MERs will be used for medical maintenance duties. Do not assign MERs additional duties that may adversely affect the maintenance of medical equipment. Do not routinely use MERs for duties not related to the maintenance of medical equipment. Do not assign MERs additional duties if the chief of medical maintenance has identified and documented that additional duties will impact on the following—

(1) The need for repair or inspection of medical equipment.

(2) The readiness of the unit.

(3) The costs of repair required to return medical equipment to an operational status in accordance with manufacturers' requirements or Federal standards.

p. Each activity commander with a medical equipment maintenance mission will publish a directive emphasizing the responsibilities of supervisors and equipment operators regarding the care and maintenance of medical equipment.

6-3. Levels of maintenance

a. The AMEDD maintenance system.

(1) Maintenance operations primarily are based on the policies contained in AR 750-1 and TB MED 750-1. The levels for medical materiel are as follows:

- (a) Unit.
- (b) Direct support.
- (c) General support.
- (d) Depot.

(2) Specific objectives of the AMEDD maintenance system are to—

(a) Provide a more responsive maintenance system, improve operational readiness, and increase mobility and flexibility at the lowest overall cost.

(b) Establish a vertical maintenance management structure where maintenance can be performed effectively and economically.

(c) Establish procedures where equipment is supported in peacetime and in war, commensurate with available time and other resources.

(d) Integrate the forward support maintenance concept (AR 750-1) to maximize equipment readiness.

(e) Optimize repair by replacement as far forward as possible on the battlefield.

(f) Integrate the forward support maintenance concept (AR 750-1) to maximize equipment service time.

(g) Establish equipment design criteria that emphasize modular design of end items that will promote the following maintenance priorities:

- 1. Discard.
- 2. Repair forward.
- 3. Evacuate.
- 4. Replace with medical standby equipment program (MEDSTEP) assets.

b. Unit maintenance (formerly organizational maintenance). The basic task of unit maintenance is to perform scheduled periodic services and other maintenance functions required in attaining a high level of operational readiness.

(1) Equipment user or operator personnel will—

(a) Routinely clean medical equipment.

(b) Perform before, during, and after-operation preventive maintenance checks and services (PMCS) in accordance with manufacturer literature.

(c) Replace components and accessories. User-replaceable components and accessories will not require extensive disassembly of the items, critical alignment or calibration after replacement, special tools, or maintenance of stocks and records for demand-supported parts.

(d) Use technical manuals (TMs), manufacturer literature, and local SOPs as guides for proper operator maintenance.

(e) Request support from appropriate maintenance organizations for repairs and services beyond the scope of operator maintenance.

(2) MERs will—

(a) Establish adequate administrative procedures for the control and documentation of maintenance services and functions.

(b) Schedule and perform periodic maintenance services consisting of PMCS, electrical safety inspections and tests, and calibration, verification, and certification (CVC) services.

(c) Perform unscheduled maintenance functions, with an emphasis on the replacement of components and modules when available. Use maintenance allocation charts (MACs), as they are published, to determine specific maintenance actions at each level of support.

(d) Operate repair parts programs to include stockage of medical repair parts as well as other commodity class materiel and medical equipment parts.

(e) Maintain files of TMs, TBs, SBs (SB 8-75 series), manufacturer maintenance manuals, and parts listings for all equipment items maintained.

(f) Conduct acceptance or condition coding inspections on new or laterally transferred equipment items or equipment to be turned in.

(g) Notify support maintenance activities of requirements and/or evacuation of unserviceable equipment or higher maintenance level components and/or modules.

(h) Provide instruction in safe operation of medical equipment to user or operator personnel. MERs will not provide instruction in the clinical application of medical equipment.

c. Direct and general support maintenance. Designated MEDLOG Bns or MEDCENs and MEDDACs, on an area support basis, will provide DS/GS maintenance support for medical equipment in MTOE units. These support activities

may provide on-site maintenance services when resources permit. Items that require service beyond the capability or authority of the supporting activity will be evacuated to the appropriate USAMMA maintenance division.

- (1) Direct support maintenance—
 - (a) Provides all authorized maintenance functions that exceed the authority, capability, or capacity of unit maintenance.
 - (b) Provides unit-level maintenance services to medical units without organic capabilities.
 - (c) Repairs components and/or modules identified as direct support level on MACs.
 - (d) Provides on-site support to combat zone medical units by means of mobile support teams.
 - (e) Provides technical assistance to supported units.
 - (f) Fabricates minor repair parts when necessary to meet operational readiness requirements.
- (2) General support maintenance—
 - (a) Provides all authorized repair functions that exceed the authority, capability, or capacity of direct support units.
 - (b) Provides unit-level maintenance services to medical units without organic capabilities.
 - (c) Repairs components and/or modules identified as general support level on MACs.
 - (d) Provides on-site support to communication zone units by means of mobile support teams.
 - (e) Provides technical assistance to supported units.
 - (f) Fabricates repair parts when required.
- d. *Depot level maintenance.* Depot level maintenance—
 - (1) Performs overhaul and rebuild of end items and components in support of the wholesale supply system and as "repair and return" actions.
 - (2) Performs maintenance services and functions for the wholesale supply system.
 - (3) Provides on-site mobile support teams on an as-required basis.
 - (4) Performs special inspections, tests, and modification program actions.
 - (5) Provides end items, components, and repair parts through established programs in support of MTOE and TDA medical units.
 - (6) Manufactures items and parts when required.
 - (7) Provides services on a non-reimbursable basis to consumer Defense Health Program and OMA-funded active Army units. Services are reimbursable when they are provided to ARNG/ARNGUS, USAR, or other eligible DOD or Government agencies.

e. *TDA maintenance operations.* TDA maintenance operations encompass unit, direct support, and general support maintenance functions and are characterized by fixed facilities collocated with HCAs, research and development activities, and other AMEDD activities. Services and functions are provided for organic medical equipment within these facilities and to area support missions and/or ISSA missions as directed by the commands.

Section II

Primary Equipment Maintenance Services

6-4. Preventive maintenance checks and services

PMCS are the systematic care, servicing, and inspection of medical equipment. (See TB MED 750-1 for additional information on medical equipment maintenance.) HCA commanders will oversee PMCS programs.

6-5. Electrical safety inspections and tests

- a. All HCAs must provide safe environments to prevent electrical shock hazards.
 - (1) HCA MERs will test patient care-related electrical medical equipment on a scheduled basis in accordance with NFPA 99.
 - (2) TDA HCA safety officers/managers will designate, in writing, critical care, wet, and anesthetizing locations, as defined in NFPA 99. These designations will be made annually and will be submitted to each HCA's safety committee for review and to HCA commanders for approval and signatures.
 - (3) TDA HCA safety officers will inspect and document all nonmedical electrical equipment. In order for HCAs to maintain JCAHO accreditation, these inspections must be conducted in accordance with NFPA 99.
- b. TDA HCA MERs will annotate maintenance records, denoting that initial or periodic safety tests were performed. If equipment fails, remedial maintenance work orders will be generated. Use the appropriate medical equipment safety testing forms for the type of equipment tested. (See TB 38-750-2.)
- c. The TDA HCA MERs will ensure that line isolation monitors are tested in accordance with NFPA 99.
- d. To the maximum extent possible, OCONUS fixed facilities must comply with the same standards as CONUS facilities. If unique electrical or grounding problems exist due to variations in facilities, give primary concern to patient and operator safety. MERs must take immediate action to correct identifiable electrical safety hazards.
- e. MTOE unit commanders are not mandated to comply directly with all requirements listed in NFPA 99, however, effort will be made to prevent electrical shock hazards and to establish electrically safe environments. At a minimum,

MERs will test the current leakage and ground resistance of all electrically operated medical equipment annually and upon completion of electrical repairs to ensure the equipment operates within the limits specified in NFPA 99. During prolonged exercises or missions involving patient treatment, MERs will perform semiannual scheduled testing of electrically operated medical equipment designated for use in critical care areas.

6-6. Calibration, verification, and certification

a. Perform CVC services on medical equipment in accordance with Section 1020, Subchapter J, Title 21, Code of Federal Regulations (21 CFR 1020, Subchapter J), TB MED 750-1, manufacturer literature, or other applicable standards.

b. Perform CVC services on organic medical equipment in accordance with the applicable MAC or other reference document (for example, manufacturer literature, TB MED 521).

c. Upon completion of CVC services, attach DD Form 2163 (Medical Equipment Verification/Certification) label to the item. TB 38-750-2 contains instructions for completing DD Form 2163. Subsequent CVC services will be recorded on this label.

d. Qualified personnel only will perform maintenance and calibration services on medical equipment producing ionizing radiation. Services will be conducted to verify that equipment meets performance requirements outlined in the applicable maintenance allocation chart or manufacturer's literature.

(1) The Federal requirement to provide CVC and repair services to components of medical equipment producing ionizing radiation originates in 21 CFR 1020. This regulation requires manufacturers of medical equipment that produces ionizing radiation to meet specific performance criteria defined in 21 CFR 1020.31. Manufacturers then will provide the necessary written maintenance instructions and maintenance interval schedules that, in manufacturers' opinions, keep their equipment in compliance with all specific performance criteria.

(2) MERs will calibrate all HCA (fixed or mobile) medical equipment that produces ionizing radiation annually (plus or minus 30 days).

(3) MERs will calibrate medical ionizing radiation-producing equipment that undergoes repair service and requires an exchange of parts or certified components that could affect overall calibration integrity.

e. At least semiannually, thoroughly evaluate and test defibrillators using defibrillator analyzers. Record evaluation results on DA Form 5624-R (DC Defibrillator Inspection Record). DA Label 175 (Defibrillator Energy Output Certification) must be affixed as close as possible to the control panel. DD Form 2163 is not required for defibrillators.

f. At least annually, perform scheduled CVC services in MTOE units. Portions of CVC requirements affected by replacement of components or repairs to assemblies will be performed upon completion of the service(s). MERs will perform CVC services in accordance with the applicable MAC. If the MAC does not specify, the MER will perform CVC services at the first authorized level that has the capabilities and test, measurement, and diagnostic equipment (TMDE).

6-7. Calibration of audiometers

a. Calibrate audiometers in accordance with TB 8-6515-001-35 and manufacturer literature. Designated qualified medical maintenance or contractor personnel will provide calibration services.

b. Test audiometer test environments for compliance with TB 8-6515-001-35 when—

(1) Initially installed.

(2) The test environment is disassembled or reassembled.

(3) Deterioration of the test environment is suspected.

6-8. Remedial maintenance (repair)

Remedial maintenance is the repair of medical equipment. (See TB MED 750-1 for additional information on medical equipment maintenance.) Repairs will only be performed by or under the direct supervision of clinical engineering and maintenance technicians (military occupational specialty (MOS) 670A), MERs (MOS 91A), or the civilian equivalent. Remedial maintenance consists of:

a. Technical inspections (TIs). TIs will be performed prior to repair or evacuation of unserviceable equipment in accordance with TB MED 7.

b. Verification inspections (VIs). VIs will be performed prior to repair or evacuation of unserviceable equipment in accordance with TB MED 7.

c. Classifications.

d. Testing.

e. Servicing.

f. All actions necessary to return items to fully mission capable status.

g. Those CVC services and electrical safety tests incidental to repair actions.

6-9. Overhaul

- a.* Overhaul consists of restoring an item of medical equipment to a completely serviceable or operational condition as prescribed by the applicable maintenance allocation chart or manufacturer's literature.
- b.* Overhaul of medical equipment by commercial firms under contract is authorized per AR 750-1.
- c.* MEDLOG Bns are authorized to overhaul TOE medical equipment.
- d.* MERs will make adjustments to medical equipment life expectancies as specified in TB MED 7.
- e.* MEDCENs or MEDDACs may perform overhauls if they possess the capability.
- f.* Overhauls may be performed at RTS-MEDs when approved by the appropriate MACOM.

6-10. Rebuild

- a.* The rebuild of end items or components of medical equipment is restricted to designated MEDLOG Bns, USAMMA maintenance divisions, and commercial firms.
- b.* USAMMA maintenance divisions, designated MEDLOG Bns, and commercial firms may rebuild (remanufacture) x-ray tube unit assemblies that are certified in accordance with 21 CFR.
- c.* MERs will adjust the life expectancies of rebuilt equipment as specified in TB MED 7.

6-11. Ancillary services

Ancillary services performed by medical maintenance elements in AMEDD TDA facilities include, but are not limited to—

- a.* Reviewing MEDCASE program requirements for medical equipment.
- b.* Participating with other logistical support personnel in the surveillance of stored medical materiel as outlined in TB MED 1.
- c.* Assisting with specification data when acquiring new equipment.
- d.* Conducting medical equipment orientation and education programs.
- e.* Recording and reporting ancillary services as prescribed by RMCs/MSCs.

Section III

Maintenance Operations

6-12. Contract maintenance

- a.* TSG only can authorize contract maintenance support for equipment in MTOE units.
- b.* Contract maintenance support for TDA HCAs will be based upon the following criteria and supported by periodic economic analyses:
 - (1) The cost effectiveness of organic versus contractual support to include consideration of joint organic/contractor ventures.
 - (2) The requirement for wartime support of the specific item(s) in a theater of operations.
 - (3) The timeliness and effectiveness of alternatives compared to the impact upon clinical services, that is, item availability rates.
- c.* Contracts for commercial services require a contractor to furnish the organization with an itemized list of costs for labor and parts for each service. Contractors will prepare FDA Form 2579 (Report of Assembly of a Diagnostic X-Ray System), when applicable.
- d.* Contracts for commercial services require contractors to prepare and submit all forms required by Federal law to the appropriate Federal agency with copies provided to the organizations.

6-13. Repair and overhaul costs

- a.* Elements of cost to be identified to job orders and for use in estimating the cost of repair are:
 - (1) Direct labor (military and civilian). Labor rates will be computed locally in accordance with MACOM/MEDCOM guidance.
 - (2) Direct materials.
 - (3) Indirect or overhead costs.
 - (4) Contractual services.
 - (5) Shipping and transportation costs (OCONUS activities).
 - (6) Travel and per diem expenses (including regular labor hours in travel) incurred and attributable solely to unscheduled maintenance (that is, repair). When multiple items are serviced during a trip, the costs will be prorated based on the related direct labor.
- b.* MERs will determine the maximum one-time repair limitations (maintenance expenditure limits (MELs)) and the estimated repair or overhaul costs in accordance with AR 750-1 and TB MED 7. Estimates exceeding MELs require waivers from HCA commanders or their designated representatives.
- c.* When equipment is reported to SICCs and USAMMA NMPs for disposition instructions based on cost estimates,

the NMPs will compare the labor rates used by MTOE MERs with the labor rates of the designated support maintenance activities. The cost estimates must be adjusted to reflect the labor rates of the support maintenance activities before decisions are made concerning disposition of the unserviceable assets.

d. The HCA commander may—

(1) Authorize a repair that exceeds the published maintenance expenditure limits for medical equipment as found in TB MED 7, if an urgent need exists to save lives or to prevent suffering and distress, and a replacement item will not be available in time to satisfy the clinical requirements.

(2) Delegate in writing to the Director of Logistics/Chief, Logistics Division the authority to approve waivers of expenditure limits for equipment items where the unit price falls below the MEDCASE threshold.

e. The Army Medical Command, Medical Commands, and Command Surgeons may grant a permanent waiver to a MEL provided that replacement materiel is approved and submitted for acquisition.

6-14. Test, measurement, and diagnostic equipment

a. TMDE measures, generates, gauges, tests, inspects, diagnoses, or otherwise examines equipment. Such equipment identifies or isolates actual or potential malfunctions, or determines compliance with specifications established in technical documents. Medical special purpose TMDE (TMDE-SP) is medical materiel used specifically for the test, calibration, and repair of medical equipment. Such TMDE does not include items used to diagnose or treat patients.

b. USAMMA is the AMEDD focal point for TMDE policy. As the AMEDD TMDE manager, USAMMA will manage, direct, and control the AMEDD TMDE program.

(1) USAMMA will provide life-cycle management for all type classified medical TMDE-SP in support of TOE organizations. TMDE life-cycle management includes the acquisition approval, repair, and calibration support responsibility and the modernization of TMDE requirements.

(2) All TMDE used in support of medical equipment will be calibrated in accordance with calibration intervals specified in TB 43-180.

(3) TMDE used in support of minimum essential equipment for training (MEET) will be calibrated in accordance with calibration intervals specified in TB 43-180.

(4) TMDE required by the AMEDD Army schools curriculum to provide individual training will not require cyclic calibration unless training efficiency or safety is adversely affected. MEDCOM policy specifies that all general purpose TMDE (TMDE-GP) used in AMEDD School training courses will be calibrated.

c. HCAs will requisition TMDE only after the following conditions are met:

(1) Each item of TMDE is listed on an authorization document (that is, an MTOE, TDA, CTA, or DA-approved exemption).

(2) Funding has been approved.

(3) Acquisition authority has been received through USAMMA from the U.S. Army Aviation and Missile Command. Items of equipment that are exempted from TMDE acquisition approval are listed in AR 750-43, chapter 3.

d. TMDE-GP support will be accomplished as follows:

(1) All TMDE-GP owners and users will perform operator level maintenance.

(2) TMDE-GP repair and calibration support will be provided by the area calibration repair center responsible for supporting the geographic area where the TMDE-GP owner or user is located. Calibration intervals are identified in TB 43-180.

(3) USAMMCE is the designated alternate source to provide repair and calibration support services for type classified medical TMDE-SP within the European Command.

(4) All TMDE calibration procedures will be traceable to the National Institute of Standards and Technology, or to a natural standard such as the content of oxygen in air at normal pressure and altitude.

(5) All commercial contracts for calibration and repair support will specify, at a minimum, adherence to American National Standards Institute (ANSI) Z540.1-94.

(6) AMEDD activities providing TMDE-SP calibration and repair support (C&RS) will establish and maintain an instrument master record file.

(7) DA Label 80 (U.S. Army Calibrated Instrument) will be used to document TMDE CVC services. TMDE that is limited in capability will not be partially calibrated.

e. Non-type classified medical TMDE-SP support will be accomplished as follows:

(1) All TMDE-SP owners or users will perform operator level maintenance.

(2) TMDE-SP repair and calibration support will be obtained in accordance with TB 43-180 or by contract maintenance support.

(3) TMDE-SP calibration intervals are specified in TB 43-180 or manufacturer instructions.

6-15. Cannibalization and controlled exchange

a. *Cannibalization.*

(1) Using units are not authorized to cannibalize medical equipment during peacetime unless approved by the appropriate MACOM/MEDCOM or USAMMA.

(2) Cannibalization approval is limited to the following:

(a) Removal of serviceable parts, components, and assemblies from unserviceable, uneconomical repairable items to immediately restore one or more unserviceable like items to a serviceable condition.

(b) Removal of serviceable parts, components, and assemblies from unserviceable end items for storage at approved cannibalization points to maintain nonsupportable, nonsustainable items as published in the SB 8-75 series.

(3) For additional guidance on cannibalization, see AR 750-1 and AR 710-2.

b. *Controlled exchange*. Controlled exchange will be done in strict accordance with AR 750-1.

6-16. Technical assistance

Technical assistance ensures that medical maintenance policies and procedures are interpreted properly and applied uniformly to improve operations. Technical assistance to MTOE units and fixed HCAs is available in accordance with the following:

a. *The AMEDD Maintenance Support Program (AR 740-1)*. This program normally is restricted to advice and assistance on technical problems through daily contact or liaison visits. It does not include on-site maintenance covered by this regulation.

b. *The medical LAP (AR 700-4)*. This program is available to using and supporting units through command channels.

c. *Telemaintenance*. This system provides desktop audiovisual help for technical maintenance support or maintenance management problem resolution.

6-17. Modification and alteration of medical equipment

Approved modifications of medical equipment will be designated as mandatory modifications or quality assurance, minor alteration, and other alterations as shown below. Modifications and alterations will be recorded in maintenance records in accordance with TB 38-750-2 or STAMIS user procedures. Minor alterations without manufacturer consent may negate any further manufacturer product liability.

a. A modification work order (MWO) is a mandatory modification that changes the function, performance, or capability of the medical equipment. MWOs are announced by USAMMA DOD MMQC messages.

b. A quality assurance alteration (QAA) is a change required to correct safety hazards, faults, or deficiencies in medical equipment. QAAs are announced by USAMMA DOD MMQC messages.

c. A minor alteration is any necessary change to medical equipment that will enhance or improve its safe operation without altering its basic characteristics. These alterations may be performed only when manufacturer representatives or qualified medical maintenance activities have the capabilities to do so and are approved by HCA commanders.

d. Component modernization is the upgrade of equipment by manufacturer-authorized changes. Qualified MERs only may conduct component modernization in accordance with manufacturer specifications.

6-18. Medical standby equipment program

a. MEDSTEP assets include end items, components, and assemblies used to provide supported activities with serviceable items for unserviceable, economically repairable items. These assets will be managed in accordance with MACOM and local procedures. MEDSTEP assets formerly were called "operational readiness float."

b. MEDSTEP assets—

(1) Maintain a high availability rate for critical patient care equipment.

(2) Will not be used to fill equipment shortages, replace uneconomically repairable items, expand operational missions, or satisfy temporary loan requirements. The appropriate HCA commander may authorize exceptions only under emergency conditions.

(3) Are established or authorized as follows:

(a) USAMMA/USAMMCE will establish MEDSTEP assets at their maintenance divisions to support HCAs and other DOD customers.

(b) MEDCOM may establish additional MEDSTEP assets at TDA HCAs and medical research organizations. Additional MEDSTEP assets for MEDLOG Bns may be approved by their MACOMs.

(c) OCONUS medical commands may establish MEDSTEP assets at MEDCENs, MEDDACs, and MEDLOG Bns to support MTOE units and HCAs.

(4) The criteria for MEDSTEP assets are as follows:

(a) Availability of the items from IMSAs/MEDLOG Bns, USAMMA/USAMMCE, DSCP, or the manufacturers.

(b) Criticality of items to the missions.

c. MEDSTEP procedures are as follows:

(1) MEDSTEP assets will be accounted for on property books in accordance with AR 710-2 and DA Pam 710-2-1.

(2) Loan of MEDSTEP assets to supported activities will be made as follows:

- (a) Normally, assemblies will be exchanged in their entirety.
- (b) Components will not be exchanged except when justified by activity requests or required by x-ray tubes. X-ray tube considerations include certification, physical configuration, and color.
- (c) Component items normally will not be exchanged if they are not replaced with identical model, condition, age (within 10 percent), and color.
- (3) MEDSTEP assets will be physically located in the maintenance activity in accordance with established hand-receipt procedures.
- (4) MEDSTEP assets will be loaned in accordance with local procedures, AR 710–2, and DA Pam 710–2–1. Reconciliation actions for loaned assets will be performed quarterly.

6–19. Maintenance performance measures and reports

Command surgeons and RMCs/MSCs/MEDCENS/MEDDACs will establish performance measures and reports to determine maintenance operation effectiveness.

6–20. Repair parts procedures

- a. Repair parts for medical equipment include components, supplies, and other materials necessary to facilitate unit and higher-level maintenance support of medical equipment. These parts, though normally Class VIII or Class IX (repair parts and components and items required for support of all equipment) items, can include all supply classes where such parts or materials are applicable to the services described in chapter 6, section II.
- b. AR 710–2, DA Pam 710–2–1, DA Pam 710–2–2, and TB MED 750–1 contain repair parts stockage and supply policies and procedures.
 - (1) DMLSS will be used by TDA medical operations to manage repair parts. AMEDDPAS will continue to be used by TDA activities where DMLSS has not been fielded.
 - (2) The TAMMIS MEDMAINT, TCAM, SAMS1, or ULLS–G, if available, will be used by MTOE medical maintenance operations to manage repair parts.
 - c. TDA HCAs can stock mission essential and minimum order repair parts.
 - d. HCA commanders or designees will approve mission essential parts list annually.
 - e. Mission essential repair parts must—
 - (1) Ensure the functioning of lifesaving equipment.
 - (2) Support equipment for which the manufacturer will no longer supply parts.
 - (3) Support new equipment until demand data can be established.

Section IV

Anesthetizing Locations in Health Care Activities

6–21. Anesthetizing locations policy

- a. NFPA 99 establishes requirements for specific types of flooring in anesthetizing locations. These standards require conductive flooring in all areas where flammable anesthetics are used. NFPA 99 also delineates testing criteria and frequency.
- b. The use of explosive or flammable anesthetics is prohibited in Army HCAs.
- c. Conductive flooring currently in anesthetizing locations will not be replaced with nonconductive flooring until normal deterioration dictates replacements.
- d. HCAs will post signs at the entrances to all anesthetizing locations in accordance with NFPA 99, chapter 3, paragraph 4. These signs will read "RESTRICTED TO NONFLAMMABLE INHALATION ANESTHETIC AGENTS."
- e. Electrostatic safeguard standards established in NFPA 99 do not apply to nonflammable anesthetizing locations. Antistatic clothing and testing furniture for conductivity is not required.

6–22. Conductive flooring policy

HCAs will have conductive flooring tested in accordance with NFPA 99. NFPA 99 no longer requires testing conductive flooring that is not in a flammable anesthetizing location.

Section V

Army Warranty Program

6–23. Overview

- a. Overall policies and procedures for the Army Warranty Program are contained in AR 700–139 and TB MED 750–1. Additional information is furnished in SB 8–75 MEDCASE for centrally purchased radiology equipment.
- b. In warranty applications, unit readiness and mission effectiveness will take priority. If the medical maintenance

activity is not able to get an effective response through the warranty process, then repair first and settle later through the acquisition support activity.

6–24. Warranty implementation

AR 700–139 provides procedures for administering warranties. HCAs or MTOE medical units will establish local warranty implementation procedures.

6–25. Warranty claim actions

Warranty claim actions for other than AAC “L” and nonstandard medical equipment will be reported to USAMMA on DA Form 2407 or its automated equivalent with all pertinent information. Copies of any maintenance records or histories will be provided in addition to copies of contract and receiving documents. Warranty claim actions for locally acquired medical equipment also may be forwarded to DA representatives for information or assistance to resolve warranty disputes.

Chapter 7 Environmental Services

Section I Environmental Services Management

7–1. Operations

MEDLOG environmental services include medical textile care, medical housekeeping, and disposition of regulated medical waste (RMW) and radioactive waste.

7–2. Management

a. Responsibilities of environmental services officers (EVSOs) include oversight and visibility of medical textile care services (see Glossary), medical housekeeping services, and RMW and radioactive waste disposition.

b. The Army Civilian Training, Education, and Development System (ACTEDS) plan for the General Schedule (GS)-673 occupational series provides the careerist and the manager with a guide to assist in career enhancement and progression. Training and development planning is essential in developing and enhancing the chief of environmental service’s knowledge, skills, and abilities. The ACTEDS, if followed, will provide all environmental services personnel the avenue to become more proficient in the field.

Section II Medical Textile Care Services

7–3. Medical textile care services management

This section outlines policy for the management of medical textile care services in both TDA HCAs and MTOE HCAs performing patient care missions.

a. HCA commanders have overall responsibility for the management of medical textile care services. This includes providing local policies and procedures that comply with the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard (29 CFR 1910.1030) and Regional Tri-Service Medical Logistics Support Program guidance.

b. Chiefs, logistics/directors of logistics have management responsibility for medical textile care services.

c. EVSOs are functionally responsible for daily management of textile care services. EVSOs are directly responsible to the chiefs, logistics/directors of logistics for—

(1) Supervising personnel assigned to textile care services.

(2) Maintaining accurate linen and laundry records.

(3) Providing textile services by actively identifying requirements, determining the best means of furnishing linen items and services, and maintaining close coordination with customers and sources of services.

d. Each commander will establish a Linen Management Committee (LMC) at his or her HCA. Each committee will—

(1) Recommend linen management policy and review program performance.

(2) Consist of the following appointed members:

(a) Deputy commander for administration.

(b) Deputy commander for clinical services.

(c) Chief, logistics/director of logistics.

(d) EVSO.

- (e) Chief, nursing services/deputy commander for nursing.
 - (f) Infection control officer (ICO).
 - (g) Chief, Department of Emergency Medicine
 - (h) Others, as required.
- (3) Issue a standing invitation to the supporting laundry manager/COR.
- e. Each LMC may be integrated with another HCA (parent) committee (for example, Environment of Care Committee), if approved by the commander. However, LMC responsibilities will be performed fully by the parent committee. The mission of each LMC is to—
- (1) Review existing linen inventory, ensuring each line item appropriately meets the needs of the end user.
 - (2) Ensure compliance with applicable JCAHO standards and the OSHA Bloodborne Pathogens Standard (29 CFR 1910.1030).
 - (3) Elevate performance, concerns, and suggested improvements to the commander.
 - (4) Implement the Regional Tri-Service Medical Logistics Support Program for Logistics Services.
- f. Each RMC EVSO will—
- (1) Implement uniform MTF reporting requirements to assess cost effectiveness and quality of laundry and linen distribution services.
 - (2) Provide regional statistical utilization management data as required by MEDCOM.

7-4. Medical textile care services operations

This program provides for—

- a. Establishment of economic stock levels at the user's location.
 - b. Review of linen use and correction of inappropriate patterns of use.
 - c. Reduction or prevention of the theft and misuse of linen.
 - d. Compliance with the HCA infection control program.
 - e. Establishment of textile repair and special fabrication procedures.
 - f. Implementation of JCAHO standards and the OSHA Bloodborne Pathogens Standard.
 - g. Provision of a documented continuing education program for textile services personnel.
 - h. A prescribed method for assessing the cost of laundry services.
 - i. Scrubs policy.
- (1) Each HCA will establish and approve a policy for the use of scrubs in the HCA and supported activities.
 - (2) Each Infection Control Committee (ICC) will prescribe scrubs policy, and subject to review by the LMC, recommend changes to the HCA commander.
 - (3) The HCA commander is the approving authority for the HCA scrubs policy.

7-5. Medical textile accounting

- a. HCA EVSOs informally will account for hospital textiles on DA Form 1296 or an automated system. DA Form 2064 (Document Register for Supply Actions) or an equivalent automated form and voucher files will be used to support all entries. See DA Pam 710-2-1 and DA Pam 710-2-2 for instructions regarding the use of these forms. Hold these informal records for 2 years after the last posting date, then destroy them.
- b. EVSO are responsible for conducting inventories for HCA-owned textiles at least annually. HCA commanders may require more frequent inventories based on EVSO evaluations of user stockage levels and other available data (for example, suspected laundry losses, wholesale theft, and widespread linen abuse). HCA commanders will use results of the inventories to evaluate the effectiveness of textile services and to determine the amount of unexplained losses. Inventory results will be reported through the LMCs to the executive committees for appropriate action. DA Form 444 (Inventory Adjustment Report) or an automated equivalent will be used to document inventory actions. HCA commanders will approve results of the inventories.
- c. Procedures will be established to account for increases and decreases of linen due to patient evacuation.

7-6. Textile stockage levels

- a. Each HCA EVSO will establish a par level for each item of linen stocked. This par level will be based on requirements to support user linen levels, turn around time for laundry service, safety level, and other factors that may, in the opinion of the EVSO, bear on the providing of adequate linen support. At a minimum, an eight-day par level is recommended. Par levels will be reflected by pencil entries on DA Form 1296 (Stock Accounting Record) or on automated records.
- b. Each using activity will compute user stockage levels for all clean linen used. These levels will constitute the maximum quantities to be stocked by each respective using activity.

7-7. Medical textile handling and storage

Each HCA EVSO will—

- a. Handle and store clean textiles in such a way as to minimize their exposure to airborne contaminants.
- b. Separate the storage and distribution of clean textiles from the collection and processing of soiled linen to prevent cross contamination.
- c. Exercise protective measures when handling soiled linen. Collect (bag) and process soiled linen in accordance with 29 CFR 1910.1030. Soiled (contaminated) textiles will not be sorted or rinsed at the HCA, except within an on-premise laundry facility.
- d. Transport clean textiles in covered vehicles or carts. Separate carts and vehicles, that are readily identifiable, will be used to maintain physical separation of clean and soiled textiles.
- e. Provide for the cleaning and decontamination of soiled textile transporters. The ICO will be consulted on procedures and cleaning products that comply with local infection control practices.

7-8. Textile marking

HCA-owned textiles will be distinctly marked with the name of the HCA. Contractor-owned and -provided textiles will be marked as prescribed in contracts.

7-9. Textile disposal

- a. HCA-owned textiles that cannot be repaired or reconditioned economically will be classified as salvage. Items designated for salvage will be—
 - (1) Turned in to the supporting DRMO. Soiled items will be laundered prior to turn in; or
 - (2) Converted to rags. List each item by stock number, nomenclature, and quantity on DA Form 3161. This form will be marked to show that the items were converted to rags and will be certified by a disinterested officer appointed on orders. Rags must be dyed or marked so that they can be distinguished from serviceable textiles. The LMC may approve other methods of marking.
- b. Unserviceable rented textiles will be returned to the vendors for replacement or credit as prescribed in the contracts.

7-10. Contract laundry and/or textile distribution services

- a. EVSOs will be designated as CORs at those medical treatment facilities that directly contract for laundry and/or textile distribution services. (See AR 5-20 for additional information on CORs.) This ensures that medical activity customers maintain quality assurance surveillance oversight of contractor performance.
- b. Each EVSO/COR will—
 - (1) Ensure the recommended practices provided in ANSI/Association for the Advancement of Medical Instrumentation (AAMI) ST65:2000 are included in contract specifications.
 - (2) Implement a quality assurance surveillance program, independent of the contractor's QC program, to evaluate quality, quantity, and timeliness of performance in accordance with contract specifications.

Section III

Medical Housekeeping Services

7-11. Medical housekeeping services management

This section outlines policy for the management of medical housekeeping services in both TDA HCAs and MTOE HCAs performing patient care missions.

- a. HCA commanders have overall responsibility for the management of medical housekeeping services. This includes providing local policies and procedures that comply with the OSHA Bloodborne Pathogens Standard (29 CFR 1910.1030) and Regional Tri-Service Medical Logistics Support Program guidance.
- b. Chiefs, logistics/directors of logistics have functional responsibility for the management of medical housekeeping services.
- c. HCA EVSOs are responsible for daily management of medical housekeeping services. EVSOs are directly responsible to chiefs, logistics/directors of logistics for supervising personnel assigned to medical housekeeping services.
- d. RMC EVSOs will implement MEDCOM management policy in conjunction with the Regional Tri-Service Medical Logistics Support Program for logistics services.
- e. At HCAs, EVSOs will oversee the performance of the medical housekeeping services.
- f. Logistics divisions in MTOE medical activities responsible for facility-wide housekeeping services will follow the procedures outlined in paragraphs 7-12 and 7-13 below.

7-12. Medical housekeeping services operations

- a. HCA commanders will ensure that EVSOs are qualified HCA housekeeping officers (GS-673 series). This will ensure that housekeeping officers are properly qualified for the positions as a result of education and/or certification, training, and experience.

- b.* Each HCA EVSO/housekeeping officer will—
 - (1) Manage daily housekeeping operations.
 - (2) Establish a quality assessment program to evaluate the performance of housekeeping services.
 - (3) Integrate the HCA housekeeping services program with the facility's infection control program.
 - (4) Obtain approval from the local ICC for cleaning procedures and cleaning supplies used in the HCA and supported activities. Cleaning products must comply with Environmental Protection Agency and OSHA guidelines as well as local infection control practices. To the maximum extent practicable, housekeeping will utilize the least hazardous and most efficacious and cost effective cleaning supplies.
 - (5) Ensure that all materiel safety data sheets for cleaning supplies are accessible to all housekeeping employees and HCA staff at all times. If transferring cleaning supplies from the original containers, housekeeping will ensure that new containers meet all OSHA labeling requirements under 29 CFR 1910.1200.
 - (6) Manage the collection, storage, transport, and disposal of RMW within the HCA in accordance with AR 40-5.
 - (7) Comply with JCAHO standards.
 - (8) Comply with the OSHA Bloodborne Pathogens Standard (29 CFR 1910.1030).

7-13. Contract medical housekeeping services

The following apply to HCAs with contracted housekeeping services:

- a.* The requirements, as appropriate, of paragraph 7-12*c* above will be included in contracts.
- b.* Each HCA EVSO/housekeeping officer will—
 - (1) Be designated as the COR to ensure contractor compliance with housekeeping contract requirements.
 - (2) Ensure the performance based work statement for the housekeeping contract clearly states the standards against which contract performance will be measured.
 - (3) Establish and maintain a quality assurance surveillance plan to assess and measure contractor performance.
 - (4) Ensure that contractors properly train all housekeeping employees and that this training is properly documented on each employee's training record.

Section IV

Medical Waste Disposition

7-14. Regulated medical waste

- a.* The collection, transportation, and disposal of RMW will be in accordance with AR 40-5.
- b.* EVSOs/CORs will be provided with initial and recurrent training in the proper waste collection and handling procedures, as specified in AR 40-5.
- c.* Transportation of RMW, both inside and outside HCAs, will be in accordance with AR 40-5.

7-15. Radioactive regulated medical waste

Radiation safety officers will control the disposition of radioactive RMW. Such disposition includes holding waste for radioactive decay to background levels before—

- a.* Returning to normal RMW channels.
- b.* Arranging for disposal by burial as radioactive waste. (See AR 11-9 and TM 3-261 for additional information on radioactive waste.)

Chapter 8

Facility Management in Health Care Activities

8-1. Facility management overview

- a.* This chapter describes the roles and responsibilities of facility managers in every aspect of the facility life cycle management (FLCM) process.
- b.* The objective of facility management is to provide a reliable inventory of facilities that meets specific codes and standards, maintains accreditation, and affords the best possible health care environment for soldiers, family members, and retired beneficiaries.
- c.* FLCM is the basis for meeting this objective and the foundation of the MEDCOM facility sustainment strategy. FLCM is a strategy of sustainment, restoration, modernization, and replacement of facilities and systems throughout their useful lives. FLCM includes the formal process of planning, programming, designing, constructing, commissioning, sustaining, restoring, modernizing, demolishing, and reusing to produce the most favorable return on capital and operating investments.

d. Facility managers are responsible for FLCM programs. They are supported by an array of technical and management support teams at RMCs, USAHFP, U.S. Army Corps of Engineers (USACE), and MEDCOM.

8-2. Facility management operations

Facility managers are responsible for—

- a.* Maintaining reliable facility inventories and ensuring medical facilities are accurately documented in installation real property inventory databases of records, as well as DMLSS.
- b.* Planning, programming, and budgeting of real property maintenance services.
- c.* Customer/inter-agency liaisons.
- d.* Execution of OMA, and repair projects.
- e.* Facility performance assessments and feedback.
- f.* Ensuring their facilities meet the objectives of MTF business operations plans and the facility-related issues under JCAHO.

8-3. Facility management functions

Facility management consists of planning, organizing, staffing, directing, and controlling all facility functions. Functions for these activities include—

- a.* Planning, organizing, staffing, directing, and controlling all facility-related activities, including conducting studies of the total facility maintenance and repair, construction, quality assurance, and oversight requirements to arrive at operations and maintenance management plans and staffing plans for current and future years. Reviews of all maintenance and construction activities planned inside and outside facilities must include impact assessments on occupying staff and patients and be coordinated with installation directors of public works.
- b.* Serving on key committees and boards including, but not limited to, safety committees, space management committees, security committees, master planning, minor construction review boards, pre-design and pre-construction review boards, installation review boards, energy councils, resource management and budget review boards, and medical equipment capital improvement boards.
- c.* Administrative approval and oversight of projects and programs to validate projects are in unison with master planning and facility life cycle management strategies and are coordinated with affected staff.
- d.* Financial programs oversight, including budgeting and managing funding obligations.
- e.* Ensuring that facilities meet all applicable requirements for accreditation.
- f.* Establishing and maintaining liaisons with the Installation Management Agency (IMA), regions, installation support divisions, military programs, USACE, and respective AMEDD major subordinate commands and headquarters.
- g.* Personnel administration and training.

8-4. Office administration functions

Office administration activities manage all administrative functions to support financial tracking and record keeping, engineering, operations and maintenance, and contract administration/quality assurance. Functions for these activities include—

- a.* Tracking disbursements to assure that all funds can be obligated in accordance with guidance or that sufficient time is allowed for reallocation of the funds.
- b.* Financial oversight of reimbursable accounts based on services.
- c.* Managing personnel timesheet input.
- d.* Maintaining confidential records.
- e.* Managing applicable sections of ISSAs and MOAs to validate services for quality, quantity and value. Services that are too costly will be reviewed for alternative sources of accomplishment.
- f.* Manning duty phones.
- g.* Collation and distribution of report information to all levels of management for the purpose of making decisions, providing status, and quantifying requirements.
- h.* Maintaining suspense dates and ensuring they are met for typical scheduled events such as repair maintenance operations programs, POM and budget estimate submissions, beneficial occupancy date (BOD) meetings, Minor Construction Review Board (MCRB), safety meetings, annual work plans, JCAHO, and command logistics review team.
- i.* General clerical support.

8-5. Automation function

Automation support activities are responsible for providing information management technical support to all facility management branch activities. Functions for these activities generally include—

- a.* Supporting computerized maintenance management systems and assuring that adequate effort is expended to maintain an accurate and up-to-date automated system.

- b.* Utilizing plant and energy management systems to the fullest extent possible.
- c.* Other systems that database, store, and report information electronically as automated methods of logging, tracking, and reporting requirements such as projects, ISSA, energy, JCAHO, drawings, and space utilization.

8-6. Project management and technical support functions

Engineering/technical support activities provide design and engineering services, programming of major construction, space utilization/space management, and engineering technical support. Functions for these activities include—

- a.* Maintaining inventories of all working drawings, design drawings, as-built drawings, and master drawings of facilities and components that can be made available to contractors that are developing scopes for new projects.
- b.* Performing project scope development for all major repair and minor construction projects that represent organizational staff in meeting their needs for the most reasonable costs.
- c.* Reviewing engineering designs and work plans and coordinating the design and execution of associated MILCON and major repair projects to represent customers and maintenance activities during all phases of projects.
- d.* Managing, tracking, and monitoring engineering work requests, execution, closeout, and warranty issues to decide which projects will be funded in a given year, to validate project requests, and to achieve project completion. Engineering/technical support activities will reference their facility master plans for appropriate project requests and ensure complete and comprehensive coordination is maintained with directorates of public works.
- e.* Performing facility condition assessments and maintaining records of current facility conditions related to reliability, function, and compliance reflecting all past work and future requirements.
- f.* Developing annual, intermediate, and long-range project work plans that reflect regional project requirements by fiscal year. MEDCOM will compile all regional integrated project lists into a MEDCOM-wide requirement by fiscal year for a 6-year period.
- g.* Managing minor construction projects and scheduling and coordinating project work with health care staff.
- h.* Assisting in space management and space utilization by maintaining space allocation records.
- i.* Facilitating facility master plans with local commands and in conjunction with USAHFPA.
- j.* Maintaining up-to-date facility inventories with condition assessment, project history, and future requirements.

8-7. Operations and maintenance functions

Operations and maintenance support activities manage maintenance and repair to buildings and structures. These elements typically are responsible for maintaining job order logs, inputting data into computerized maintenance management systems, and maintaining facility libraries. Functions for these activities include—

- a.* Planning and executing scheduled and unscheduled maintenance activities.
- b.* Identifying and executing maintenance procedures that increase efficiency and promote system reliability.
- c.* Managing storage and maintenance of spare parts, materials, and supplies.
- d.* Operating and maintaining dedicated utility plants and systems.
- e.* Maintaining all required accreditation documents, including critical system records, test reports, and emergency procedure plans.
- f.* Managing, monitoring, and operating energy management and control systems as well as plant management systems, including utility usage tracking systems.
- g.* Maintaining work order sections.
- h.* Maintaining up-to-date equipment component inventories.
- i.* Providing personnel management of managing maintenance work forces.
- j.* Scheduling and coordinating maintenance work with health care staff.
- k.* Coordinating maintenance-training activities.

8-8. Contract administration and quality assurance functions

Contract administration/quality assurance activities provide contract facilitation and support for facility operations and maintenance, engineering services, construction, and ancillary support contracts through outside agencies. Typical functions for these activities include administration of contracts within delegated authorities, including conduct of quality assurance, surveillance/evaluation of contractor performance, monitoring ISSA work completed by host installations, programming quality assurance requirements based on workload, and acquisition planning.

8-9. Regional medical command facility director responsibilities

Regional facility directors (FDs) are required to assist with the facility management process and provide information to MEDCOM for planning, programming, budget, and execution. FDs are tasked with providing information to MTF facility managers. FDs also are proponents for their regions, coordinating and ensuring appropriate funding to operate facilities at each site. At a minimum, each FD will—

- a.* Assure a reasonable level of maintenance and best practices that will result in reliable facilities and installation

infrastructure, and operate within budget. Develop the capability for fast and accurate analysis, forecasting, modeling, and planning.

b. Determine the best level of major repair projects for the region that will result in reliable facilities and installation infrastructure, and operate within budget. Develop the capability for fast and accurate analysis, forecasting, modeling, and planning of major repair requirements.

c. Determine the best level of restoration and modernization projects for the region that will result in improved access and health care best practices, and operate within budget. Develop the capability for fast and accurate analysis, forecasting, modeling, and planning of restoration and modernization requirements.

d. Promote and encourage smart business initiatives such as reliability centered maintenance programs to all FMs in the region.

Chapter 9 Medical Materiel Readiness

Section I Deployment and Mobilization

9-1. Readiness program overview

This chapter—

- a.* Provides direction and reporting requirements for managing medical materiel support and readiness programs.
- b.* Applies to the total force throughout all phases of planning, program, and execution.
- c.* Applies to all levels within the military health care system.

9-2. Readiness policies and responsibilities

The following are the specific responsibilities for organizations providing Class VIII materiel support to mobilizing and deploying units.

a. TSG or a designated official will—

- (1) Publish policy and guidance for the deployment and mobilization of the medical force.
- (2) Program for centrally managed medical materiel to reduce cost and ensure critical assets are available for deploying units.

(3) Centrally manage Class VIII materiel for readiness. Centrally managed Class VIII materiel is divided into two distinct categories based on funding and release authority:

(a) Materiel managed for DA.

(b) Materiel managed by OTSG, referred to as OTSG contingency stock programs. This category includes—

1. Medical Materiel Program for Defense against Nuclear, Biological, and Chemical Agents (MMPDANBC).
2. Centralized P&D programs.
3. Reserve Component Hospital Decrement (RCHD).

(4) Function as the responsible official. OTSG has delegated planning, programming, budgeting, managing responsibility, and release authority for OTSG contingency stock to USAMRMC/USAMMA for the annual update of these programs. (See SB 8-75-S7 for additional information on OTSG contingency stock.)

b. Commander, MEDCOM or a designated official will—

- (1) Develop plans and policies to support and execute readiness programs.
- (2) Execute programs as directed by the OTSG.
- (3) Coordinate pre-deployment, deployment mobilization requirements with other MACOMs.
- (4) Develop and deploy mobilization-planning tools for use by MEDCOM organizations for determining Class VIII materiel requirements in supported deploying units.

(5) Develop logistics plans and guidance to support the mobilization mission of subordinate organizations (RMCs, MTFs, AMEDD, and contracting activities).

(6) With FORSCOM and USARC, develop Class VIII acquisition strategies and a support structure to support mobilization deployment.

(7) Develop policies to support readiness.

c. Commanding General (CG), FORSCOM or a designated official will—

(1) Develop Class VIII readiness requirements and support plans for FORSCOM units and installation/power projection platforms.

(2) Validate requirements with MEDCOM to facilitate acquisition strategies that ensure availability of Class VIII materiel for the purpose of—

(a) Medical materiel readiness.

- (b) Medical maintenance readiness.
- (c) Unit compliance with existing policy.
- (3) Ensure units have Class VIII unit basic load (UBL) on hand upon deployment or mobilization, unless covered by a centrally managed program. The SB 8-75-S7 states which units are covered under the centrally managed Class VIII programs. CG, FORSCOM also may publish additional guidance for units based on the operation plans (OPLANs) and specific missions.
 - d. Commander, USAMRMC or a designated official will—
 - (1) Manage and execute DA and OTSG medical materiel readiness programs, as directed by CG, MEDCOM.
 - (2) Develop MEDLOG plans to provide mobilization and contingency operation support, including—
 - (a) Mobilization of subordinate organizations.
 - (b) Acquisition of materiel.
 - (c) Support the execution of MACOM/COCOM (combatant commander) OPLANs.
 - e. Commanders, RMCs or designated officials will—
 - (1) Manage and execute DA and OTSG medical materiel readiness programs, as directed by OTSG/CG, MEDCOM.
 - (2) Develop MEDLOG plans to provide mobilization and contingency operation support, including—
 - (a) Mobilization of subordinate organizations.
 - (b) Acquisition of Class VIII materiel.
 - (c) Support the execution of MACOM/COCOM OPLANs.
 - (3) Coordinate and develop plans to provide Class VIII support to mobilizing, deploying, and deployed units to include P&D materiel, CTA 8-100 items, field sanitation items, non-UA items, non-centrally managed items, unit generated shortages, soldier readiness processing (SRP)/POM materiel, and PV surge contracts.
 - (4) Develop contingency plans to support power projection platforms/power support platforms, and expand the MTF capability.
 - (5) Ensure all IMSAs validate, document, and template divisional medical unit Class VIII UBL requirements not covered by a centrally managed program.
 - f. Commander, USAMMA or a designated official will—
 - (1) Plan for mobilization and support to deploying and deployed units.
 - (2) Manage and execute assigned DA and OTSG materiel readiness programs, including centrally managed P&D programs, RCHD, and MMPDANBC.
 - (3) Lead and coordinate the development of materiel acquisition strategies and centrally managed contracts to support mobilization and contingency operations, and serve as the single POC to coordinate the execution of centrally managed contracts supporting mobilization and contingency operations.
 - (4) Provide personnel augmentation to Army Materiel Command—Logistics Support Element (AMC LSE) Medical Logistics Support Team to coordinate and execute Class VIII APS issue.
 - (5) Develop and program resources for materiel requirements required to support mobilization and COCOM OPLANS and contingency operations.
 - (6) Maintain accountability for AMEDD-owned PMI assets.
 - g. Overseas Class VIII distributor personnel will—
 - (1) Provide focused MEDLOG support to Army, Navy, Air Force, and Department of State customers located in their respective theaters. (USAMMCE and the 16th Medical Logistics Battalion in Korea will execute the mission as the SIMLMs in their respective theaters of operations.) These organizations will provide—
 - (a) Acquisition, storage, and distribution of Class VIII medical materiel.
 - (b) DS, GS, and depot-level clinical engineering services.
 - (c) Single and multi-vision optical fabrication support.
 - (2) In conjunction with USAMMA, manage and execute the DA and OTSG materiel readiness programs, as directed by CG, MEDCOM, that include—
 - (a) Centrally managed P&D programs.
 - (b) Class VIII APS and medical chemical defense materiel (CDM).
 - h. Commanders of FORSCOM units or designated officials will—
 - (1) Maintain authorized Class VIII UBL, unless otherwise exempted by FORSCOM policy.
 - (2) Coordinate annually with MEDLOG SSAs. Coordination includes establishing signature cards, assuming command orders on file at SSAs, and establishing customer accounts with SSAs.
 - (3) Develop plans to acquire unit generated shortages, SRP/POM requirements, and CTA 8-100 material for mobilization or deployment.
 - (4) Coordinate with USAMMA to acquire centrally managed materiel and equipment.
 - (5) Plan for and coordinate medical maintenance support prior to mobilization or deployment.
 - (6) Coordinate movement plans for medical materiel and equipment on hand and received prior to deployment.

Section II

Material Readiness Programs

9-3. Centrally managed Class VIII materiel

a. MACOMs, combatant commanders, and DLA provide COSIS for OTSG contingency stocks stored at their facilities under specific agreements and statements. In addition, these agreements also will provide for asset reporting and plans for materiel movement and issue.

b. When required, USAMMA will provide designated deploying echelons-above-division medical units in Force Packages 1 and 2 with a medical P&D unit deployment package (UDP) and initial re-supply package. These packages are required to maintain mission capability through the initial deployment periods of contingency or wartime operations. USAMMA will manage these P&D stocks centrally during peacetime in various UA listings (UALs) (excluding selected short shelf-life items and P&D requirements based on mission or command preference). UDP requirements are published in SB 8-75-S7.

9-4. Army prepositioned stock

a. The Deputy Chief of Staff, G-3 (DCS, G-3) programs funding for Class VIII APS materiel. USAMMA is responsible for the COSIS and management of Class VIII APS.

b. The DCS, G-3 will grant release authority to USAMMA for issue/release of APS materiel to designated units/multiple theaters of war (MTWs) in accordance with AR 710-1 and AR 700-131.

c. APS issue procedures are outlined in the FM 100-17 series. Issue procedures for land-based APS are outlined in FM 100-17-2. Issue procedures for APS-3 (afloat) are outlined in FM 100-17-1.

9-5. Medical policy for management of medical nuclear, biological, and chemical defense materiel

a. The purpose of the MNBCDM program for defense against nuclear, biological, and chemical agents is to—

(1) Provide for the procurement, stockpile, storage, maintenance, and distribution of a broad spectrum of—

(*a.*) Antibiotics.

(*b.*) Drugs.

(*c.*) Protectants.

(*d.*) Biological vaccines.

(*e.*) Toxoids.

(*f.*) Antitoxins.

(*g.*) Medical CDM.

(*h.*) Other related medical products for the prevention and treatment of diseases and effects of nuclear, biological, chemical (NBC) agents.

(2) Enhance medical NBC defense to Army forces during—

(*a.*) War operations.

(*b.*) Other than war operations.

(*c.*) Contingency operations (under HQDA and DCS, G-3 direction).

b. Medical CDM is managed by HQDA and the OTSG. The OTSG will program, budget, fund, and coordinate distribution of strategic stockpile materiel procured for individual Service member issue.

c. Service member initial issue of medical CDM will be—

(1) Centrally funded by OTSG.

(2) Stored at strategic locations worldwide and managed by USAMMA. These assets will be maintained as deployable force package (DFP) sets.

d. The DCS, G-3 is the release authority for DFP sets. The DCS, G-3 will coordinate with the AMEDD Operation Center (AOC) for the release of MNBCDM. The DCS, G-3 will provide release instruction to the AOC, in writing, then the AOC will provide written guidance to USAMRMC/USAMMA on MNBCDM release.

9-6. Army war reserve sustainment

Army war reserve sustainment (AWRS) is materiel intended to provide essential consumable materiel to sustain combat operations. USAMMA manages and performs COSIS on AWRS medical materiel.

9-7. Operational projects

a. OPs support special needs above normal allowances and consist of materiel used to satisfy one or multiple contingencies and OPLAN requirements.

b. FORSCOM, OCONUS MACOMs, and other designated agencies request, justify, and recommend amendments to medical materiel in OPs. The OTSG and the DCS, G-4 approve amendments to Class VIII portions of OPs.

c. USAMMA centrally manages and performs technical reviews of medical materiel requirements within OPs.

9–8. Programs directed by the Office of The Surgeon General

OTSG has developed additional contingency materiel programs targeted at specific areas of concern and Class VIII supply gaps not covered by APS. These programs include the OTSG RCHD program, which consists of DEPMEDS medical materiel sets (MMSs), ASIOE, and TMDE. RCHD is for the restored portion of Component 3 (U.S. Army Reserves) (COMPO 3) hospitals that are authorized to have only a MEET set at home station.

a. FORSCOM will develop deployment plans in conjunction with USARC for COMPO 3 units, and will provide guidance to USAMMA.

b. USAMMA will—

(1) Manage and prioritize RCHD stocks in accordance with the DA command plan.

(2) Manage, account for, resource, and conduct modernization and sustainment efforts for the RCHD.

(3) Provide unit status report (USR) feeder reports on a quarterly basis (1 October) to USARC, the applicable Regional Readiness Command, and the Reserve Component unit. Change reports will be provided if sustainment or modernization actions occur (that is, modernization that would impact readiness status). USR feeder reports reflect the required quantity based on the database used to build the modules. (Note: Depending on the database used to build the module, the requirements may differ from previous or subsequent databases.)

(4) Ensure the required COSIS is performed on the nonmedical ASIOE, and DEPMEDS MMSs are packed in long term storage.

c. USARC will—

(1) Ensure Regional Readiness Commands use the RCHD listing properly to calculate hospital unit readiness.

(2) Coordinate with USAMMA to identify Class VIII nonexpendable shortages when an Army Reserve unit is alerted for possible mobilization. Specifically, the Army Reserve Surgeon will be the focal point for all Reserve medical equipment coordination with USAMMA.

(3) Facilitate coordination with Continental U.S. Army Surgeon's Office and USAMMA upon mobilization.

Chapter 10 Managing Medical Assemblages

Section I Medical Assemblages Management Overview

10–1. Purpose

This chapter prescribes policy for the issue, turn-in, accounting, storage, and reporting of medical assemblages. AR 40–60 delineates specific responsibilities and procedures for the development and revision of medical assemblages. Unless otherwise indicated, “MES” is a generic term used to describe medical sets, kits, and outfits (SKOs) and may include the following items:

a. Medical equipment.

b. Veterinary equipment.

c. Dental equipment.

d. Optical equipment.

e. Laboratory equipment.

f. Medical materiel.

g. Dental materiel.

h. Preventive medicine materiel.

10–2. Operational policy

a. AMEDDC&S will design, develop, update, and recommend the composition of medical assemblages, except for medical supply planning modules and recommended stockage lists.

b. USAMMA performs staff management actions as delineated in AR 40–60. USAMMA develops funding requirements, based on the basis of issue provided by AMEDDC&S.

c. The OTSG will coordinate for programming and budgeting from the proper appropriation fund (OMA, OPA, or stock fund) for procurement of newly developed or significantly revised medical assemblages and ASIOE.

d. MACOMs (in addition to the Army Reserve and NGB) requisition, store, and maintain medical assemblages and equipment authorized to be on hand in MTOE units or TDA activities. MACOMs will- Use operations and maintenance funds for replacement components and other items not centrally managed. Not program or budget for components covered under DA centrally managed programs (for example, items with an MCSC of CQ, UDP materiel).

Section II Medical Equipment Sets

10-3. Identifying medical equipment sets

There are two categories of MESs:

a. Service-unique MESs. A Service-unique MES consists of a grouping of medical and nonmedical items under a single stock number managed by AMEDD and used primarily by the Army. A four-character numeric UA number identifies such assemblages.

b. Multi-Service MESs. A multi-Service MES consists of a grouping of medical and nonmedical items under a single stock number managed by DMSB and used by multiple Services. A four-character numeric MES UA number identifies such assemblages. For multi-service MESs, the first character in the UA number always will be "7."

10-4. Composition of medical equipment sets

a. AMEDDC&S, as the combat developer, determines the components of Service-unique MESs, including ASIOE.

b. UALs undergo two types of updates:

(1) *Maintenance catalog updates.* Maintenance catalog updates—

(a) Are published annually in the SB 8-75 series. Units will continue to use the UA lists initially fielded with their units until authorized for update by USAMMA. With the exception of maintenance charges, commanders will apply updates only when directed to do so by USAMMA as part of a materiel fielding action. This may result in the use of several UALs for the same line item number (LIN). Units will use UALs as specified based on the NSN listed when fielded, as detailed in unit property books.

(b) Are used to purge obsolete and/or terminal items. Units must research all possible interchangeability and substitutability relationships prior to replacement of obsolete/terminal items.

(c) Revise DMLSS assemblage management stand alone (AMSA) databases.

(d) Require MACOMs to budget operational and maintenance funding to support materiel acquisition programs.

(2) *Modernization updates.* Modernization updates—

(a) Are scheduled in accordance with AR 40-60.

(b) Are published in the SB 8-75 series by USAMMA.

(c) Reflect changes in doctrine, health care, and technology.

(d) Can have a material impact on programming and budgeting.

(e) Necessitate the OTSG to budget OPA funds.

c. Commanders can download current UALs from the USAMMA Web site at <http://www.usamma.army.mil/>. Users can search for UALs by unit identification code (UIC), UA code, NSN, LIN, or nomenclature. If Internet access is not available, commanders may request current UALs from Commander, USAMMA, ATTN: MCMR-MMO, 1423 Sultan Dr., Ste. 100, Fort Detrick, MD 21702-5001. Requests will identify the following:

(1) Unit UIC and UA number.

(2) Nomenclature.

(3) The NSN for each MES required.

d. Medical resupply set (MRS) development is determined by the following criteria:

(1) MRSs are intended to operationally sustain the MESs for which they were developed (that is, MRS, Trauma would resupply the MES, Trauma (2)). AMEDDC&S will develop these MRSs.

(2) USAMMA will develop MRSs that are intended for a given force type such as a division, armored cavalry regiment, or brigade. Known as "recommended stockage lists," these resupply sets are used for contingency planning. Units/MACOMs may add or delete items to provide mission-specific support and to adjust the allowances for existing items in recommended stockage lists. These recommended stockage lists will not have assigned LINs and therefore will not be authorized by TOE/MTOE. In addition, because these are planning SKOs and not authorizations, supply catalogs (SCs) will not be published for recommended stockage lists.

e. The DMSB monitors and approves components of multi-Service MESs. The DMSB will obtain multi-Service concurrence. Changes to these sets are published annually in the SB 8-75 series.

f. Activities may recommend changes to components of MESs. Submit recommendations on DA Form 2028 (Recommended Changes to Publications and Blank Forms), with justification for changes as follows:

(1) For Service-unique MES, submit through command channels to Commandant, AMEDDC&S, ATTN: MCCS-FCC, Fort Sam Houston, TX 78234-6100.

(2) For multi-Service MESs, submit through AMEDDC&S and USAMMA, to Director, DMSB, 1423 Sultan St., Frederick, MD 21702-5013.

g. The stated number of days of supply listed in the SC or UAL for an SKO constitutes the minimum basic load to sustain that SKO.

h. P&D materiel are components within MESs that possess a shelf life of 60 months or less.

i. USAMMA plans, budgets, acquires, and delivers P&D materiel with a shelf life between 12 and 60 months for

non-divisional medical units. This responsibility is part of a DA centrally managed program. All other units, to include combat units (that is, special operations forces (SOF), armored cavalry regiment (ACR), Stryker brigade combat team (SBCT), and other divisional units) must maintain P&D materiel either as on hand or on order unless directed otherwise by their MACOMs.

j. Unit commanders must plan, budget, and acquire the portion of P&D materiel that has a shelf life between 0 and 12 months.

k. Non-P&D materiel are those components having an indefinite shelf life or having a shelf life greater than 60 months. Unit commanders must maintain these components as either on hand or on order.

l. Army Reserve units will not stock P&D material.

10-5. Requisition, issue, and turn-in of medical equipment sets

a. Requisition authorized MESSs that are not Service-regulated through the supporting IMSAs/MEDLOG Bns.

b. The issue of MESSs to the ARNG/ARNGUS and Army Reserve will be as follows:

(1) The appropriate MACOM will authorize medical equipment and MESSs for MTOE units.

(2) Equipment for training will be issued to Army Reserve MTOE units organized at reduced authorized level organizations or to units not capable of storing and maintaining medical equipment.

(3) Whenever possible, equipment for training will be the portion of MTOE equipment that the unit can store and maintain and is required for training.

(4) AR 71-32 provides specific authorization policy for Army Reserve MTOE medical units. USAMMA will not issue controlled medical items (that is, scheduled drugs), shelf-life items, or refrigerated items with Service-regulated MESSs to units until those units are federally activated.

(5) The DLA may issue non-Service-regulated MESSs with controlled or deleted items. When non-Service-regulated MESSs are received locally, MTOE units must remove and turn in all controlled or deleted items.

c. The turn in of medical sets is as follows:

(1) Report excess Service-regulated MESSs to USAMMA. USAMMA will provide disposition instructions. ARNG/ARNGUS units will report excess Service-regulated MESSs to NGB, which will provide disposition instructions.

(2) Report serviceable multi-Service regulated MESSs to USAMMA for disposition. ARNG/ARNGUS units will report excess multi-Service-regulated MESSs to the NGB, which will provide disposition instructions.

(3) Turn sets in when directed by USAMMA.

(4) List and attach MES shortages to turn-in documents.

(5) Do not requisition components to fill shortages in excess MESSs to be turned-in for disposal.

(6) Include the following statement on turn-in documents: "Action required by AR 735-5 was initiated, where necessary. This materiel has been released by the appropriate authority." Commanders will sign and date these statements.

(7) Turn-in MESSs during redeployment in accordance with theater commanders/combatant commanders guidance.

Section III

Medical Materiel Sets

10-6. Identifying medical materiel sets

a. An MMS consists of a grouping of medical and nonmedical items under a single stock number. The DMSB manages the DEPMEDS database and uses it to develop modules for DEPMEDSs that are approved with multi-Service concurrence.

b. A four-character UA number identifies the MMS. The first character of the UA number is an alpha character, which determines the specific UA fielded to a unit.

10-7. Composition and support of medical materiel sets

a. Component authorizations are published as UALs and SCs (SC 6545-8 series) by USAMMA and follow the same maintenance and modernization updates as outlined for MESSs. Component revisions are published annually in the SB 8-75 series and are reflected in current year UALs.

b. Commanders, DEPMEDS units will continue to use the UA lists initially fielded with their units until authorized for update by USAMMA. Commanders will apply maintenance updates only unless directed otherwise by USAMMA due to materiel fielding actions. This may result in the use of several UALs with different dates for different assemblages until a single current year update is provided by USAMMA.

c. AMEDDC&S will develop DEPMEDS medical supply sets to support MMSs configured to Level 3 and 4 hospitals. AMEDDC&S will develop these supply sets using the patient stream/load identified in the task, time, treatment file for Level 3 & 4 hospitals.

d. AMEDDC&S manages Army-unique UALs for split-sets that are a part of corps-level, split-based Medical Reengineering Initiative (MRI) hospitals.

10–8. Requisition, issue, and turn-in of medical materiel sets and dental materiel sets

- a.* All MMSs and dental materiel sets are Service regulated.
- b.* DEPMEDS units will use the Army's total package fielding (TPF) method to requisition and issue MMSs.
- c.* All units will report excess through their chain of command to their MACOM. USARC will direct movement of Army Reserve equipment only after coordinating cross leveling and turn in disposition with USAMMA to ensure fielding plans are not disrupted or readiness eroded.

10–9. Accounting for components of medical materiel sets

Commanders, DEPMEDS units will establish and maintain accounting records. DEPMEDS units will inventory MMSs using the UALs fielded with their units (with maintenance changes applied), until USAMMA authorizes the use of the most current assemblage configuration.

10–10. Total package fielding

a. TPF (see AR 700–142 and DA Pam 700–142 for additional information on total package fielding) is the Army's method of fielding, in which the system or end item and all required support materiel is—

- (1) Identified.
- (2) Consolidated into a single package.
- (3) Funded.
- (4) Deprocessed by the fielding command responsible for fielding medical systems or end items under total package concepts.

b. USAMMA—

- (1) Fields MMSs.
- (2) Requisitions all major medical end items, medical ASIOE, and some nonmedical ASIOE required for the TPF of the medical system. Gaining units/MACOMs will requisition organizational support.

(3) Provides shortages recorded during the hand-off/fielding process. Shortages normally are in two categories:

(a) Category 1-major items of OPA-funded medical ASIOE and some nonmedical ASIOE.

(b) Category 2-other expendables, durables, and nonexpendables that are components of MMSs and MESs.

(4) Provides both categories 1 and 2 shortages either under the ship-short program or another alternative method, as determined by USAMMA.

c. Materiel fielding teams (MFTs) are established by USAMMA to accomplish specified tasks in conjunction with fielding of the medical system or end item using TPF techniques. (See DA Pam 700–142 for additional information on total package fielding.) Specific tasks of MFTs are to deprocess, conduct joint inventories, and complete customer documentation packages. MFTs will not perform gaining command functions but instead will help to ensure efficient and effective fielding operations.

d. Customer documentation packages are documents required by gaining units and support activities to post receipts or due-ins and to update SSA accountable records, property books, and financial records. As directed by USAMMA, MFTs will prepare and provide documentation to gaining units/MACOMs for each item of materiel to be handed off.

e. USAMMA will continue to support fielded units/MACOMs after initial fielding by providing materiel or an updated status for all due-ins after the fielding of medical systems or end items.

Section IV

Maintenance and Management of Medical Assemblages

10–11. Maintenance of medical assemblages

a. Commanders, MTOE units that are authorized MESs will—

(1) Maintain component equipment and supplies of such sets, less those items under DA centrally managed programs.

(2) Perform appropriate maintenance checks, services, and tests on MES component equipment items as specified in applicable TMs or manufacturer operating instructions.

b. Selected medical equipment items are reportable under USR procedures. (See AR 700–138 and AR 220–1 for additional information on unit status reports.) These items are not necessarily components of medical assemblages.

c. Army Reserve units will coordinate maintenance of their MEET sets with appropriate RTS–MEDs. RTS–MEDs will visit units semiannually to assist with the medical maintenance of all Class VIII and ASIOE.

10–12. Loan of modified table of organization and equipment materiel (equipment) in support of projects at health care activities

- a.* These loans apply to Active Army-owned/controlled assets only, not to Army Reserve or NGB-controlled assets.
- b.* Requesting HCAs must ensure that funding is available to cover all associated costs such as transportation, materiel fielding, travel, maintenance/repair, and site preparation. HCAs must identify and program for the loan of equipment early in their budget cycles to avoid delays.
- c.* Requesting HCAs will prepare and submit MOAs/MOUs through their supporting RMCs, MACOMs, USAMMA, USAHFPA, and OTSG for approval.
- d.* MOAs/MOUs will undergo the following approval process:
 - (1) RMCs and MACOMs will—
 - a.* Coordinate and validate information in the MOAs/MOUs.
 - b.* Ensure funding is available.
 - c.* Recommend approval and forward to USAMMA.
 - (2) USAMMA will—
 - a.* Review the MOAs/MOUs to determine whether the equipment is available or that the action will not impact fielding of equipment to MTOE units.
 - b.* Provide technical assistance to the HCAs.
 - c.* Recommend approval/disapproval.
 - d.* After final approval, field the equipment in the same manner as normal DEPMEDS unit fielding to include prebrief, hand-off, and displacement.
 - e.* Prepare loan agreements and provide disposition instructions. (See AR 700–131 for additional information on loan agreements.)
- f.* Forward approval to USAHFPA.
- (3) USAHFPA will—
 - a.* Assist HCAs in developing phasing plans and requirements for temporary facilities during the design and development process.
 - b.* Provide technical assistance on medically related space and utilities issues.
 - c.* Upon MACOM approval, review the MOAs/MOUs to confirm that they effectively support the MILCON projects.
 - d.* Recommend approval/disapproval.
 - e.* Forward approval to OTSG.
- (4) OTSG will—
 - a.* Resolve conflicts between offices.
 - b.* Provide final approval/disapproval.

10–13. Loan of medical equipment to civilian authorities

Army medical equipment may be loaned to civilian authorities. Loans, whether emergency or preplanned, must be processed in accordance with AR 700–131.

10–14. Newly developed medical assemblages

- a.* Newly developed or significantly revised medical assemblages will be issued to units in accordance with MFPs developed by USAMMA and coordinated with gaining MACOMs.
- b.* Turn-in procedures for assemblages becoming excess because of newly issued sets may be modified on a case-by-case basis by the individual assemblage's MFPs.
- c.* The provisions in MFPs will dictate the costs to gaining units.

Chapter 11 Optical Fabrication

11–1. Optical fabrication authority and overview

a. Optical fabrication has become a consolidated effort within DOD. In response to this consolidation, the Optical Fabrication Enterprise (OFE) was formed, with the Navy Surgeon General designated as the executive agent (EA). The OFE was created to manage DOD optical fabrication assets and meet optical fabrication requirements of all of the Services. The OFE charter includes all Defense Health Program supported laboratories. The EA designated the Commander of Naval Ophthalmic Support and Training Activity (NOSTRA) to provide daily oversight of the OFE. To manage and maintain DOD optical fabrication, the Optical Fabrication Advisory Board (OFAB) was established. The OFAB acts as the primary advisor to the EA. The OFAB operates with a combined staff consisting of two members

each from the Army, Air Force, and Navy, and one representative from the DOD Secretariat. The MEDCOM Assistant Chief of Staff for Logistics is chairperson of the OFAB.

b. Army optical fabrication laboratories (OFLs) and units fabricate prescription eyewear that includes spectacles, protective mask inserts, and similar ocular devices for eligible personnel under AR 40–63/NAVMEDCOMINST 6810.1/AFR 167–3.

c. This chapter identifies requirements used for the management of Army OFLs located at TDA and MTOE activities/units.

11–2. Optical fabrication laboratory production guidance

Army OFLs will prioritize daily workload as follows (in descending priority):

a. Standard Frame Program eyewear produced prior to the Frame of Choice (FOC) or Reimbursable Frame Programs.

b. FOC eyewear produced before that of the Reimbursable Frame Program.

c. Reimbursable Frame Program.

11–3. Optical fabrication contingency contracts

a. RMCs are responsible for optical fabrication contingency contracts. These contracts will provide optical fabrication support to TDA optical laboratories and units when optical requirements exceed laboratory capabilities and when the need for rapid fulfillment of these requirements exists.

b. Conditions for activating contingency contracts are:

(1) Unit mobilization.

(2) Projected surge requirement (that is, basic combat training/advanced individual training surges).

(3) Personnel shortages.

(4) Professional filler system training requirements.

(5) Non-projected surges.

(6) Command directed assessments.

11–4. Optical laboratory and unit operating supplies

a. Laboratory operating supply authorizations are:

(1) The initial supply of consumable items incorporated in optical fabrication assemblages for medical MTOE units. This initial supply consists of those items required under average conditions for a period of 30 days. The authorizations for individual items are listed in SC 6545–8–P01 and SC 6545–8–P03.

(2) The initial allowance of consumable optical items authorized in SC 6545–8–P02 for the optical division of MTOE 8–287H6. The above mentioned set consists of quantities required under average conditions for a period of 90 days.

b. Laboratory operating supply levels are as follows.

(1) OCONUS MTOE optical laboratories and units will maintain a 30-day level of operating supplies.

(2) CONUS TDA optical laboratories and units will maintain no more than a 15-day level.

11–5. Performance measures

An OFL's performance is measured by its ability to produce prescription eyewear in a timely manner. OFL managers will monitor their activities' performance using the indicators described below together with any additional performance indicators they consider relevant. Key indicators used to measure OFL performance are—

a. Eyewear for deployments/grounded pilots fabricated within 24 hours.

b. Basic trainee eyewear fabricated within 48 hours.

c. Standard frame eyewear fabricated within 3 days.

d. FOC eyewear produced within 5 to 10 days.

e. Reimbursable eyewear fabricated as stipulated in the agreement.

11–6. Optical fabrication enterprise report

Consolidated OFE Reports provide data on optical devices fabricated by optical laboratories and units. They are used for—

a. Planning mobilizations.

b. Preparing budgets.

c. Assigning opticians.

d. Analyzing inter-Service support.

e. Utilization of manpower.

f. Analyzing cost/production efficiency.

11-7. Completing optical fabrication enterprise report worksheets

a. General information and instructions for completing and submitting the OFE Report worksheets are available from MEDCOM ACSLOG, Logistics Plans and Readiness Division, or NOSTRA.

b. The report is located at <https://www.medlogspt.army.mil> and is a fully integrated online data-reporting tool. OFE reports consist of four different metrics, entitled production, financial, staff, and performance. These online reports have been developed to capture data and additional information required by OFE and MEDCOM.

c. To access <https://www.medlogspt.army.mil>, personnel must register on the site then contact MEDCOM ACSLOG, Logistics Plans and Readiness Division for access to the OFE optical Fabrication Web-tool.

d. Army optical laboratories and units, including those organized as elements of TDA and MTOE units, will—

(1) Submit consolidated OFE reports monthly at <https://www.medlogspt.army.mil>.

(2) Staff/review the submitted reports through command channels to the appropriate RMC or command surgeons. Reports then will be reviewed by MEDCOM by the 10th of each month.

(3) If additional information or guidance is required on these reports or optical issues, contact MEDCOM, AT-TN:MCLO-P, 2050 Worth Rd., Ste. 8, Fort Sam Houston, TX 78234-6008.

Appendix A References

Section I Required Publications

AR 1-75/SECNAVINST 4900.49/AFJI 16-104

Administrative and Logistical Support of Overseas Security Assistance Organizations (SAOs). (Cited in para 1-6*i*.)

AR 5-20

Commercial Activities Program. (Cited in paras 7-10*a* and 7-12*b*.)

AR 10-64/OPNAVINST 6700.2/AFR 160-29/MCO 5420.18A

Joint Field Operating Agencies of the Office of The Surgeon General of the Army. (Cited in para 1-19.)

AR 11-1

Command Logistics Review Program (CLRP). (Cited in para 1-9*a*.)

AR 11-9

The Army Radiation Safety Program. (Cited in paras 1-6*j* and 7-15*b*.)

AR 25-1

Army Knowledge Management and Information Technology Management. (Cited in paras 2-1, 5-2*a*, 5-12*a*, and 5-20*f*.)

AR 25-400-2

The Army Records Information Management System (ARIMS). (Cited in paras 3-22*b*(4) and 5-2*a*.)

AR 40-3

Medical, Dental, and Veterinary Care. (Cited in paras 3-18*a* and 3-20*b*(4).)

AR 40-5

Preventive Medicine. (Cited in paras 7-12*c*(6), 7-14*a*, 7-14*b*, and 7-14*c*.)

AR 40-10

Health Hazard Assessment Program in Support of the Army Material Acquisition Decision Process. (Cited in para 1-6*j*.)

AR 40-38

Clinical Investigation Program. (Cited in para 3-20*b*(1).)

AR 40-60

Policies and Procedures for the Acquisition of Medical Materiel. (Cited in paras 1-12*a*, 1-14*g*, 3-4, 5-23*f*, 6-2*j*, 10-1, 10-2*b*, and 10-4*b*(2)(*a*).)

AR 40-63/NAVMEDCOMINST 6810.1/AFR 167-3

Ophthalmic Services. (Cited in para 11-1*b*.)

AR 40-68

Quality Assurance Administration. (Cited in para 4-2*b*.)

AR 70-1

Army Acquisition Policy. (Cited in para 3-20*b*(2).)

AR 70-6

Management of the Research, Development, Test, and Evaluation, Army Appropriation. (Cited in para 5-20*f*.)

AR 70-25

Use of Volunteers as Subjects of Research. (Cited in para 3-22*b*(6).)

AR 70–65

Management of Controlled Substances, Ethyl Alcohol, and Hazardous Biological Substances in Army Research, Development, Test, and Evaluation Facilities. (Cited in para 3–23.)

AR 71–32

Force Development and Documentation-Consolidated Policies. (Cited in paras 5–17a, 5–27c, and 10–5b(3).)

AR 73–1

Test and Evaluation Policy. (Cited in para 3–20b(3).)

AR 190–51

Security of Unclassified Army Property (Sensitive and Nonsensitive). (Cited in paras 2–2d(1), 3–24f(2)(b), and 3–26a.)

AR 220–1

Unit Status Reporting. (Cited in paras 5–23j, 6–2b, and 10–11b.)

AR 700–4

Logistics Assistance. (Cited in paras 1–6i and 6–16b.)

AR 700–84

Issue and Sale of Personal Clothing. (Cited in para 5–8e.)

AR 700–127

Integrated Logistics Support. (Cited in para 6–2i.)

AR 700–131

Loan of Army Materiel. (Cited in paras 5–6, 5–7b, 9–4b, 10–12d(2)(d), and 10–13.)

AR 700–137

Logistics Civil Augmentation Program (LOGCAP). (Cited in para 1–6h.)

AR 700–138

Army Logistics Readiness and Sustainability. (Cited in paras 1–15e, 6–2b, and 10–11b.)

AR 700–139

Army Warranty Program Concepts and Policies. (Cited in paras 6–23a and 6–24.)

AR 700–142

Materiel Release, Fielding, and Transfer. (Cited in paras 5–2a and 10–10a.)

AR 702–18/DLAD 4155.37/ NAVSUPINST 4410.56A/AFJMAN 23–232/MCO 4450.13A

Materiel Quality Storage Standards Policy for Shelf-Life Materiel. (Cited in paras 4–6a(3), 4–6a(5), 4–6a(6), 4–7b, 4–8b(2), and 4–8c.)

AR 710–1

Centralized Inventory Management of the Army Supply System. (Cited in paras 5–23b(1) and 9–4b.)

AR 710–2

Inventory Management Supply Policy Below the National Level. (Cited in paras 1–15f, 1–21c, 2–2c, 3–3b(1), 3–12c, 5–2a, 5–2b(2), 5–8b, 5–14a, 5–23g, 5–23h, 5–25a, 6–15a(3), 6–18c(1), 6–18c(4), and 6–20b.)

AR 710–3

Asset and Transaction Reporting System. (Cited in para 5–13a.)

AR 725–50

Requisitioning, Receipt, and Issue System. (Cited in paras 3–10b, 3–15d(1), and 5–9a.)

AR 735–5

Policies and Procedures for Property Accountability. (Cited in paras 5–2a, 5–3a(9), and 10–5c(6).)

AR 740-1

Storage and Supply Activity Operations. (Cited in para 6-16a.)

AR 750-1

Army Materiel Maintenance Policy. (Cited in paras 1-14k, 6-3a(1), 6-3a(2)(d), 6-3a(2)(f), 6-9b, 6-13b, 6-15a(3), and 6-15b.)

AR 750-43

Army Test, Measurement, and Diagnostic Equipment Program. (Cited in para 6-14c(3).)

21 CFR

Food and Drugs. (Cited in 6-2e(1), 6-6d(1), and 6-10b). (Available at www.gpoaccess.gov/cfr/index.html.)

29 CFR

Labor. (Cited in paras 6-2e, 7-3a, 7-3e(2), 7-7c, 7-11a, 7-12c(5), and 7-12c(8).) (Available at www.gpoaccess.gov/cfr/index.html.)

CTA 8-100

Army Medical Department Expendable/Durable Items. (Cited in paras 9-2e(3) and 9-2h(3).) (Available at <https://webtaads.belvoir.army.mil/usafmsa>.)

CTA 50-909

Field and Garrison Furnishings and Equipment. (Cited in para 5-21b.) (Available at <https://webtaads.belvoir.army.mil/usafmsa>.)

DA Pam 5-20

Commercial Activities Study Guide. (Cited in para 7-12b.)

DA Pam 25-91

Visual Information Procedures. (Cited in para 5-2a.)

DA Pam 700-142

Instruction for Materiel Release, Fielding, and Transfer. (Cited in paras 5-2a, 10-10a, and 10-10c.)

DA Pam 710-2-1

Using Unit Supply System (Manual Procedures). (Cited in paras 5-2a, 5-2b(2), 5-8b, 5-23g, 5-25a, 6-18c(1), 6-18c(4), 6-20b, and 7-5a.)

DA Pam 710-2-2

Supply Support Activity Supply System: Manual Procedures. (Cited in paras 2-2c, 3-12c, 5-8b, 6-20b, and 7-5a.)

DFAS-IN Reg 37-1

Finance and Accounting Policy Implementation. (Cited in para 3-15d(3).) (Available at <https://dfas4dod.dfas.mil>.)

DOD 4160.21-M

Defense Materiel Disposition Manual. (Cited in paras 5-8c and 5-9a.) (Available at <http://www.dtic.mil/whs/directives>.)

FM 100-17 Series

Series Army Pre-positioned Stock. (Cited in para 9-4c.) (Available at <http://www.train.army.mil>.)

SB 8-75 series

Army Medical Department supply bulletins. (Cited in paras 1-14a, 3-24a, 3-24c, 4-2a(3), 4-8b(3), 4-8b(3), 6-2n(3), 6-3b(2)(e), 6-15a(2)(b), 10-4b(1)(a), 10-4b(2)(b), 10-4e, 10-7a.) (Available at <http://www.usamma.army.mil>.)

SB 8-75 MEDCASE

Army Medical Department Supply Information. (Cited in paras 1-15c, 5-2c, 5-17c, 5-18b, 5-19a, 5-19b(3), and 6-23a.) (Available at <http://www.usamma.army.mil>.)

SB 8-75-11

Army Medical Department Supply Information. (Cited in paras 3-6a, 3-12c, 3-12d, 3-22c(1), 3-24e(1), 3-33b, 3-38b, 4-4d, 4-9b, 4-10b, 4-12, 4-14b, 5-2b(2), 5-2f, 5-9a(3), and 10-12c.) (Available at <http://www.usamma.army.mil>.)

SB 8-75-S7

Army Medical Department Supply Information. (Cited in paras 9-2a(4), 9-2c(3), and 9-3b.) (Available at <http://www.usamma.army.mil>.)

SB 8-75-S10

Army Medical Department Supply Information. (Cited in para 3-36.) (Available at <http://www.usamma.army.mil>.)

SC 6545-8-CL-HR series

Sets, Kits, and Outfits Components List. (Cited in para 10-7a.) (Available through normal publications supply channels.)

SC 6545-8-P01

Optical Fabrication Unit Field 1, Semi Mobile. (Cited in para 11-4a(1).) (Available through normal publications supply channels.)

SC 6545-8-P02

Optical Fabrication Unit Field 2, Base With Laboratory. (Cited in para 11-4a(2).) (Available through normal publications supply channels.)

SC 6545-8-P03

Optical Fabrication Unit Field, Portable Field. (Cited in para 11-4a(1).) (Available through normal publications supply channels.)

TB 8-6515-001-35

Calibration and Repair of Audiometric Equipment. (Cited in paras 6-7a and 6-7b.) (Available through normal publishing channels.)

TB 38-750-2

Maintenance Management Procedures for Medical Equipment. (Cited in paras 6-2m(1), 6-5b, 6-6c, and 6-17.) (Available through normal publications supply channels.)

TB 43-180

Calibration and Repair Requirements for the Maintenance of Army Materiel. (Cited in paras 6-14b(2), 6-14b(3), 6-14d(2), 6-14e(2), and 6-14e(3).) (Available through normal publications supply channels.)

TB MED 1

Storage, Preservation, Packaging, Packing, Maintenance, and Surveillance of Materiel-Medical Activities. (Cited in paras 6-11b and 6-2l.) (Available at <http://chppm-www.apgea.army.mil/tbm.htm>.)

TB MED 7

Maintenance Expenditure Limits for Medical Materiel. (Cited in paras 6-8a, 6-8b, 6-9d, 6-10c, 6-13b, and 6-13d.) (Available at <http://chppm-www.apgea.army.mil/tbm.htm>.)

TB MED 521

Occupational and Environmental Health: Management and Control of Diagnostic, Therapeutic, and Medical Research X-Ray Systems and Facilities. (Cited in para 6-6b.) (Available at <http://chppm-www.apgea.army.mil/tbm.htm>.)

TB MED 750-1

Operating Guide for Medical Equipment Maintenance. (Cited in paras 6-1d, 6-3a(1), 6-4, 6-6a, 6-8, 6-20b, and 6-23a.) (Available at <http://chppm-www.apgea.army.mil/tbm.htm>.)

Section II**Related Publications**

A related publication is a source of additional information. The user does not have to read a related publication to understand this regulation.

ANSI/AAMI ST65:2000

Processing of reusable surgical textiles for use in health care facilities, first edition. (Cited in para 7–10b(1).)
(Available at <http://webstore.ansi.org/ansidocstore/default.asp>.)

AR 1–100

Gifts and Donations

AR 1–101

Gifts for Distribution to Individuals

AR 11–27

Army Energy Program

AR 12–12/AFR 67–7/SECNAVINST 4355.17A/Defense Logistics Agency Regulation (DLAR) 4140.60

Processing Discrepancy Reports Against Foreign Military Sales Shipments

AR 32–4/DLAR 4235.18/AFR 67–125/NAVSUPINST 4400.70C/MCO 4400.137A

Special Measurement Clothing and Footwear, Orthopedic Footwear, Guidons, Streamers, and Flags

AR 40–7

Use of Investigational Drugs and Devices in Humans and the Use of Schedule I Controlled Drug Substances

AR 40–35

Dental Readiness and Community Oral Health Protection

AR 40–65/NAVMEDCOMINST 6700.4/AFR 167–13

Review Procedures for High Cost Medical Equipment

AR 40–538/BUMEDINST 6700.2B/AFR 167–5

Property Management During Patient Evacuation

AR 190–40

Serious Incident Report

AR 200–1

Environmental Protection and Enhancement

AR 210–20

Master Planning for Army Installations

AR 210–130

Laundry and Dry Cleaning Operations

AR 335–15

Management Information Control System

AR 380–5

Department of the Army Information Security Program

AR 385–10

The Army Safety Program

AR 385–40

Accident Reporting and Records

AR 420–49

Utility Services

AR 700–49/DLAR 4140.27/AFR 400–52/MCO 4443.10

Loan of DLA Stock Fund Materiel

AR 700–68/DLAI 4145.25/NAVSUPINST 4440.128D/AFJMAN 23–227(I)/MCO10330.2 D
Storage and Handling of Liquefied and Gaseous Compressed Gasses and Their Full and Empty Cylinders

AR 708–1
Logistics Management Data and Cataloging of Supplies and Equipment

AR 735–11–2/DLAI 4140.55/ SECNAVIST 4355.18A/AFJMAN 23–215
Reporting of Supply Discrepancies

AR 840–10
Flags, Guidons, Streamers, Tabards, and Automobile and Aircraft Plates

40 CFR
Environmental Protection Agency: Protection of Environment. (Available at www.gpoaccess.gov/cfr/index.html.)

Comprehensive Accreditation Manual for Hospitals: The Official Handbook (CAMH)
Joint Commission on Accreditation of Healthcare Organizations. (The current edition of this publication may be obtained from the Joint Commission on Accreditation of Healthcare Organizations, 1 Renaissance Blvd., Oakbrook Terrace, IL 60181, and from www.jcaho.org.)

CTA 50–900
Clothing and Individual Equipment. (Available at <https://webtaads.belvoir.army.mil/usafmsa>.)

DFAR Supplement
Subpart 217.70, Exchange of Personal Property. (Available at <http://deskbook.dau.mil/jsp/default.jsp>.)

DOD 4145.19–R–1
Storage and Materials Handling. (Available at <http://www.dtic.mil/whs/directives/>.)

DOD 4500.9–R
Defense Transportation Regulation (Available at <http://www.dtic.mil/whs/directives/>.)

DOD 6010.8–R
Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). (Available at <http://www.dtic.mil/whs/directives/>.)

DODI 6050.5
DOD Hazard Communication Program. (Available at <http://www.dtic.mil/whs/directives/>.)

DOD Medical Catalog, Volume II
Sets, Kits, and Outfits. (Available at https://dmmonline.dscp.dla.mil/homepages/dodva_medcat.asp.)

DOD Medical Catalog, Volume III
Master Cross-Reference List (Available at https://dmmonline.dscp.dla.mil/homepages/dodva_medcat.asp.)

FAR
Federal Acquisition Regulation. (Available at <http://deskbook.dau.mil/jsp/default.jsp>.)

FM 100–17
Mobilization, Deployment, Redeployment, Demobilization. (Available at <http://www.train.army.mil>.)

FM 100–17–1
Army Pre-positioned Afloat Operations. (Available at <http://www.train.army.mil>.)

JP 4–02.2
Joint Tactics Techniques and Procedures for Patient Movement in Joint Operations. (Available at <http://www.dtic.mil/doctrine/index.html>.)

MIL-STD-1691F

Construction and Material Schedule for Military Medical and Dental Facilities. (Available at <http://dodssp.daps.dla.mil/adodssp.htm>.)

PL 94-580

Solid Waste Utilization Act. (Available at <http://thomas.loc.gov>.)

NFPA 99

Standard for Health Care Facilities. (This publication may be obtained from the National Fire Prevention Association, 1 Batterymarch Park, Quincy, MA 02169-7471, and at <http://www.nfpa.org>.)

NFPA 101

Life Safety Code. (This publication may be obtained from the National Fire Prevention Association, 1 Batterymarch Park, Quincy, MA 02169-7471, and at <http://www.nfpa.org>.)

PL 102-486

Energy Policy Act of 1992. (Available at <http://thomas.loc.gov>.)

QSTAG 287 ED.3

Procedure for Reporting and Initial Disposition of Unsatisfactory Medical Materiel. (This publication may be obtained from the Document Automation and Production Service, Building 4/D, 700 Robbins Ave., Philadelphia, PA 19111-5094, and at <http://dodssp.daps.dla.mil/>.)

QSTAG 291

Interface of Medical Supply Procedures. (This publication may be obtained from the Document Automation and Production Service, Building 4/D, 700 Robbins Ave., Philadelphia, PA 19111-5094, and at <http://dodssp.daps.dla.mil/>.)

TB MED 525

Control of Hazards to Health from Ionizing Radiation Used by the Army Medical Department. (Available at <http://chppm-www.apgea.army.mil>.)

TM 3-261

Handling and Disposal of Unwanted Radioactive Material. (Available at <https://www.logsa.army.mil>.)

TM 5-609/NAVFAC MO-125/AFM 91-2

Military Custodial Services Manual. (Available at <http://www.usace.army.mil/publications/>.)

TM 38-410/DLAM 4145.11/NAVSUP PUB 573/AFR 69-9/MCO 4450.12

Storage and Handling of Hazardous Materials. (Available at <https://www.logsa.army.mil>.)

Section III**Prescribed Forms**

Except where indicated otherwise below, the following forms are available as follows: DA forms are available on the Army Electronic Library CD-ROM (EM 0001) and the Army Publishing Directorate Web site (<http://www.apd.army.mil>). DD forms are available from the Office of the Secretary of Defense Web site (<http://www.dtic.mil>).

SF 380

Reporting and Processing Medical Materiel Complaints/Quality Improvement Report (Prescribed in 4-13a, 4-14a.) (This form is available through normal forms supply channels.)

Section IV**Referenced Forms****DA Form 11-2-R**

Management Control Evaluation Certification Statement

DA Form 444

Inventory Adjustment Report (IAR)

DA Form 1296
Stock Accounting Record

DA Form 2028
Recommendation Changes to Publications and Blank Forms

DA Form 2064
Document Register for Supply Actions

DA Form 2407
Maintenance Request

DA Form 3161
Request for Issue or Turn in

DA Form 5624-R
DC Defibrillator Inspection Record

DA Label 175
Defibrillator Energy Output Certification

DD Form 1149
Requisition and Invoice Shipping Document

DD Form 1391
FY, Military Construction Project Data

DD Form 2163
Medical Equipment Verification/Certification

FDA Form 2579
Report of Assembly of a Diagnostic X-Ray System. (This form may be requested over the phone from the U.S. Food and Drug Administration.)

Appendix B

Management Control Evaluation Checklist

B-1. Function

The functions covered by this checklist are medical logistics policies.

B-2. Purpose

The purpose of this checklist is to assist units in evaluating the key management controls listed below. It is not intended to cover all controls. This checklist will be used at the Headquarters, Department of the Army, field operating agency, major Army command, installation, and table of organization and equipment levels. The checks in this section represent the minimum requirements that will be included in Command Logistics Review Programs; they are not considered to be all inclusive and do not preclude the evaluation of all other provisions within AR 40-61 under the appropriate Command Logistics Review Program, Command Supply Discipline Program, or end user.

B-3. Instructions

Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, sampling, and simulation). Answers that indicate deficiencies must be explained and corrective action indicated in supporting documentation. These management controls must be evaluated at least every five years. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2-R (Management Control Evaluation Certification Statement).

B-4. Test questions

a. Medical logistics policy and systems

(1) Does the regional medical command/major subordinate command commander provide assistance to subordinate activities and installations by conducting reviews every 12 months concerning the logistics programs at his or her

subordinate activities, then provide the results of these reviews to U.S. Army Medical Command, Assistant Chief of Staff for Logistics within 30 days of the visit?

(2) When standard systems do not provide the functionality to support a required medical logistics business practice, are nonstandard automated information systems authorized only after approval through the Army Medical Department Director of Logistics/Assistant Chief of Staff for Logistics?

b. Army medical materiel management Are medical items without national stock numbers identified by either medical item identification numbers or locally assigned management control numbers?

(1) Has the installation medical supply activity/medical logistics battalion/U.S. Army Medical Materiel Center, Europe established a suspense system for walk-through transactions to ensure that they are posted to the accountable record?

(2) Are written agreements established between the Government and the vendor for materiel examinations/evaluations being completed?

(3) When a commander determines that an examination is necessary, is a written agreement between the activity and the vendor prepared in coordination with the supporting property management officer/medical supply officer and the supporting contracting officer?

(4) When an examination item is delivered, does the property management officer enter the item and all major components in the property records and establish a separate record for each examination agreement?

(5) Is the U.S. Army Medical Department Board preparing an evaluation plan and a milestone schedule in coordination with the designated evaluation activity?

(6) Is the health care activity commander or command surgeon appointing the medical supply officer, and at least one alternate, to serve as the custodian of the activities' stocks on controlled medical items?

(7) Is a disinterested officer, appointed by the health care activity commander or command surgeon, conducting an inventory of all symbols "R" and "Q" controlled items monthly?

(8) Does the command surgeon determine the peacetime stockage objective for modified table of organization and equipment medical supply operations that does not exceed 30 days?

c. Quality control of medical materiel

(1) Do the Medical logistics activities (installation medical supply activity/medical logistics battalion/U.S. Army Medical Materiel Center, Europe) and pharmacies establishing and operating medical materiel surveillance programs provide for the scheduled inspection of medical materiel?

(2) Are activities initiating extension requests for materiel that meet extension criteria?

(3) Are complaints involving medical materiel that is found to be injurious or unsatisfactory reported on SF 380 (Reporting and Processing Medical Materiel Complaints/Quality Improvement Report) and, when necessary, in accordance with American, British, Canadian, and Australian Quadripartite Standardization Agreement (QSTAG) 287 ED.3?

d. Medical equipment management

(1) Are all items on property books identified with bar coded labels to improve inventory accuracy?

(2) Is equipment furnished by contractors listed in their contracts and are copies of the contracts furnished to the property book officer for review and applicable equipment accountability?

(3) Does the property book officer ensure that hand-receipt holders/custodians have current records for assigned accountable property?

(4) Is an automated or manual hand receipt prepared in duplicate and used to issue property loaned to other Army or Department of Defense health care activities?

(5) Is the property book officer maintaining a record of all materiel on loan?

(6) Has the health care activity commander established issue procedures using a local standing operating procedure?

(7) Has the health care activity safety officer/manager established a policy for the introduction, use, inspection, and documentation of patient-owned, nonmedical comfort equipment within the medical treatment facility?

(8) Is the property book officer preparing a DD Form 1149 or, when authorized, a DA Form 3161 to document the posting of the property book for all equipment transferred with patients?

(9) Do all requests for excess investment equipment have an approved medical care support equipment requirement?

(10) Has the health care activity commander or designated representative identified individuals to provide information and assistance to customers making acquisition decisions and establish controls on expenditures for furniture?

(11) Does the health care activity authorize the rental, lease, or loan of equipment when it is advantageous or cost effective to the Government?

(12) Does the property book officer keep a separate file for each rental/lease/loan contract containing the approved authorization and a copy of the rental/lease/loan contract, applicable amendments, and receipt/return documentation?

(13) Does the medical treatment facility commander serve as the initial review authority for item requirements that clinicians or care providers have justified detailing the impact on the health services mission if the equipment is not obtained?

(14) Have requirements approved by the health care activity commander been forwarded through staff channels to the command surgeon for final action?

e. Medical equipment maintenance

(1) Does the commander provide for the maintenance of medical materiel issued to each activity under his or her responsibility?

(2) Do medical maintenance activities organic to medical centers, medical department activities, medical logistics battalions, U.S. Army Center for Health Promotion and Preventive Medicine, Armed Forces Institute of Pathology, regional training sites-medical, and U.S. Army Medical Materiel Agency maintenance divisions publish external maintenance support procedures for use by their customers?

(3) Is each item of medical equipment tested for serviceability and electrical safety prior to initial use and at least annually thereafter, unless otherwise recommended by original manufacturer guidelines?

(4) Does each activity commander with a medical equipment maintenance mission publish a directive emphasizing the responsibilities of supervisors and equipment operators for the care and maintenance of medical equipment?

(5) Are labor rates computed locally in accordance with major Army command/U.S. Army Medical Command guidance?

(6) Are Medical Standby Equipment Program assets physically located in the maintenance activity in accordance with established hand-receipt procedures and are they accounted for on property books?

(7) Is Army Medical Department Property Accounting System or Defense Medical Logistics Standard Support used by table of distribution and allowances medical operations to manage repair parts?

(8) Does the health care activity commander or designee approve the mission essential parts list annually?

f. Environmental services management

(1) Do the responsibilities of the environmental services officer include oversight and visibility of medical textile care services, medical housekeeping services, regulated medical waste, and radioactive waste disposition?

(2) Has the commander established a linen management committee at each health care activity?

(3) Is the environmental services officer designated as the contracting officer's representative at medical treatment facilities that directly contract for laundry and/or textile distribution services?

(4) Has the health care activity commander ensured that the environmental services officer is a qualified health care activity housekeeping officer (General Schedule-673 series)?

g. Facility management in health care activities

(1) Are inventories and maintenance of medical facilities accurately documented in the installation real property inventory database of record, as well as Defense Medical Logistics Standard Support?

(2) Is administrative approval for the oversight and validation of projects/programs in unison with master planning and facility life cycle management strategies to include coordination with affected staff members?

(3) Is there a mechanism in place to track disbursements to insure that all funds can be obligated in accordance with guidance or that sufficient time is allowed for reallocation of the funds?

(4) Is financial oversight of reimbursable accounts based on services?

h. Medical materiel readiness and managing medical assemblages

(1) Do U.S. Army Forces Command units maintain authorized Class VIII UBL unless otherwise exempted by U.S. Army Forces Command policy?

(2) Do U.S. Army Forces Command units coordinate annually with medical logistics supply support activities to include establishing signature cards, assumption of command orders, and establishing a customer account with the supporting supply support activity?

(3) Do unit commanders plan, budget, and acquire the portion of potency and dated materiel that has a shelf life between 0 and 12 months?

(4) Do units report excess Service-regulated medical equipment sets to the U.S. Army Medical Materiel Agency?

(5) Do commanders ensure that deployable medical systems units continue to use the unit assemblage lists that were initially fielded with their units until they are authorized for update by the U.S. Army Medical Materiel Agency?

(6) Are deployable medical systems units establishing and maintaining accounting records?

(7) Is the medical treatment facility preparing and providing documentation to the gaining unit/major Army command for each item of materiel to be handed off as directed by the U.S. Army Medical Materiel Agency?

i. Optical fabrication

(1) Is the initial supply of consumable items incorporated in optical fabrication assemblages for medical modified table of organization and equipment units?

(2) Are modified table of organization and equipment optical laboratories and units maintaining a 30-day level of operating supplies and table of distribution and allowances optical laboratories and units maintaining no more than a 15-day level?

(3) Are general information and instructions for completing and submitting Optical Fabrication Enterprise Report

worksheets available from the U.S. Army Medical Command, Assistant Chief of Staff for Logistics, Logistics Plans and Readiness Division, or the Naval Ophthalmic Support and Training Activity?

B-5. Comments

Help make this a better tool for evaluating management controls. Submit comments to Commander, U.S. Army Medical Command, ATTN: MCLO, 2050 Worth Rd., Ste. 10, Fort Sam Houston, TX 78234-6010.

Glossary

Section I Abbreviations

AAC

acquisition advice code

ACSLOG

Assistant Chief of Staff for Logistics

ACTEDS

Army Civilian Training, Education, and Development System

AE

aeromedical evacuation

AFIP

Armed Forces Institute of Pathology

AFJI

Air Force joint instruction

AFM

Air Force manual

AFR

Air Force regulation

AIT

automatic identification technology

AMC—LSE

Army Materiel Command—Logistics Support Element

AMDF

Army Master Data File

AMSA

assemblage management stand alone

AMEDD

Army Medical Department

AMEDDC&S

Army Medical Department Center and School

AMEDDPAS

Army Medical Department Property Accounting System

AMSA

assemblage management stand alone

ANSI

American National Standards Institute

AOC

Army Medical Department Operation Center

APDE

automated data processing equipment

APS

Army prepositioned stock

AR

Army regulation

ARNG

Army National Guard

ARNGUS

Army National Guard of the United States

ASIOE

associated support items of equipment

ASL

authorized stockage list

AVF

asset visibility file

AWRS

Army war reserve sustainment

BLIC-NF

budget line item code—new facilities (Defense Health Program funded)

BLIC-MB

budget line item code—new facilities (military construction (MILCON) funded)

BMET

biomedical equipment technician

BOD

beneficial occupancy date

BPA

Blanket Purchase Agreement

C&RS

calibration and repair support

CAIM

customer area inventory management

CDM

chemical defense materiel

CEEP

Capital Equipment Expense Program

CFR

Code of Federal Regulations

CG

commanding general

CHAMPUS

Civilian Health and Medical Program of the Uniformed Services

CIIC

controlled inventory item code

Compo 3

Component 3 (U.S. Army Reserves)

CNGB

Chief, National Guard Bureau

CONUS

continental United States

COR

contracting officer's representative

COSIS

care of supplies in storage

CPT

clinical product team

CTA

Common Table of Allowances

CVC

calibration, verification, and certification

DA Pam

Department of the Army Pamphlet

DA

Department of the Army

DAPA

Distribution and Pricing Agreement

DBBS

Defense Blood Bank System

DBPA

Decentralized Blanket Purchase Agreement

DCS, G-3

Deputy Chief of Staff, G-3

DEA

Drug Enforcement Administration

DEPMEDS

deployable medical system

DFARS

Defense Federal Acquisition Regulations Supplement

DFAS

Defense Finance and Accounting Service

DFP

deployable force package

DLA

Defense Logistics Agency

DLAM

Defense Logistics Agency Manual

DLAR

Defense Logistics Agency Regulation

DLIS

Defense Logistics Information Service

DMLSS

Defense Medical Logistics Standard Support

DMSB

Defense Medical Standardization Board

DOD

Department of Defense

DODAAC

Department of Defense activity address code

DODD

Department of Defense Directive

DOL

Director of Logistics

DOL/C Log

Director of Logistics/Chief, Logistics Division

DRMO

Defense Reutilization and Marketing Office

DS/GS

direct support/general support

DSCP

Defense Supply Center Philadelphia

DVA

Department of Veterans Affairs

DWWCF

Defense Wide Working Capital Fund

EA

executive agent

EAC

echelons above corps

ECAT

Electronic Catalog

EVSO

environmental services officer

FAR

Federal Acquisition Regulation

FD

facility director

FDA

Food and Drug Administration

FEDLOG

Federal Logistics Data on Compact Disc

FLCM

facility life cycle management

FORSCOM

U.S. Army Forces Command

FM

field manual

FOC

Frame of Choice

FSC

Federal Supply Catalog

FSMC

forward support medical company

FSS

Federal Supply Schedule

GCSS-A

Global Combat Support System-Army

GCSS-A-MNT

Global Combat Support System-Army-Maintenance

GCSS-A-SPR

Global Combat Support System-Army-Supply and Property

GS

General Schedule

HCA

health care activity

HDV

high dollar value

HQDA

Headquarters, Department of the Army

ICC

Infection Control Committee

ICO

infection control officer

IDIQ

indefinite delivery indefinite quantity

IMA

Installation Management Agency

IMPAC

International Merchant Purchase Authorization Card

IMSA

installation medical supply activity

IS

automated information system

ISSA

inter-Service support agreement

JCAHO

Joint Commission on Accreditation of Healthcare Organizations

LAP

Logistics Assistance Program

LAV

logistics assistance visit

LIN

Line item number

LMC

Linen Management Committee

LOGCAP

Logistics Civilian Augmentation Program

MAC

maintenance allocation chart

MACOM

major Army command

MCMR–MMI

U.S. Army Medical Materiel Agency medical materiel information

MCO

Marine Corps order

MCRB

Minor Construction Review Board

MCSC

materiel category structure code

MEDASM

Medical assemblage management

MEDCASE

medical care support equipment

MEDCEN

U.S. Army Medical Center

MEDCOM

U.S. Army Medical Command

MEDDAC

U.S. Army Medical Department Activity

MEDLOG

medical logistics

MEDLOG Bn

medical logistics battalion

MEDMAINT

medical maintenance

MEDSTEP

Medical Standby Equipment Program

MEDSURG

medical surgical

MEDSUP

medical supply

MEET

minimum essential equipment for training

MEL

maintenance expenditure limit

MER

medical equipment repairer

MES

medical equipment set

MFP

materiel fielding plan

MFT

materiel fielding team

MHS

Military Health System

MIDI

Military Item Disposal Instructions

MIL-STD

Military Standard

MIIN

medical item identification number

MILCON

military construction

MILSTRIP

Military Standard Requisitioning and Issue Procedures

MLSC

medical logistics support company

MMBP

military medical benefits property

MMPDANBC

Medical Materiel Program for Defense Against Nuclear, Biological, and Chemical Agents

MMQC

medical materiel quality control

MMS

medical materiel set

MNBCDM

medical nuclear, biological and chemical defense materiel

MOA

memorandum of agreement

MOS

military occupational specialty

MOU

memorandum of understanding

MRS

medical resupply set

MSA

medical supply activity

MSC

major subordinate command

MSMC

main support medial company

MSO

medical supply officer

MTF

medical treatment facility

MTOE

modified table of organization and equipment

MU

military-unique

MWO

modification work order

NAC

National Acquisition Center

NAVSUPINST

Navy Supply Instruction

NBC

nuclear, biological, chemical

NFPA

National Fire Protection Association

NGB

National Guard Bureau

NMP

national maintenance point

NOSTRA

Naval Ophthalmic Support and Training Activity

NSN

national stock number

OCIE

organizational clothing and individual equipment

OCONUS

outside continental United States

OFAB

Optical Fabrication Advisory Board

OFE

Optical Fabrication Enterprise

OFL

optical fabrication laboratory

OMA

Operations and Maintenance, Army

OMD

Operations and Maintenance, Defense

OP

operational project

OPA

Other Procurement, Army

OPD

Other Procurement, Defense

OPLAN

operation plan

OPNAVINST

operations Naval instruction

OSHA

Occupational Safety and Health Administration

OTSG

Office of the Surgeon General

P&D

potency and dated

PBO

property book officer

PMCS

preventive maintenance checks and services

PMI

patient movement item

POC

point of contact

POM

program objective memorandum

PPP

power projection platform

PR

purchase request

PRWeb

Purchase Request Web

PSP

power support platform

PV

Prime Vendor

QAA

quality assurance alteration

QSTAG

Quadripartite Standardization Agreement

RCHD

Reserve Component Hospital Decrement

RDTE

research, development, test, and evaluation

RIA

Regional Incentive Agreement

RMC

regional medical command

RMW

regulated medical waste

RTS-MED

regional training site-medical

SAMS1

Standard Army Maintenance System 1

SB

supply bulletin

SC

supply catalog

SECNAVINST

Secretary of the Navy Instruction

SICC

service item control center

SIMLM

Single Integrated Medical Logistics Manager

SKO

sets, kits, and outfit

SLC

shelf-life code

SLEP

shelf-life extension program

SOF

Special Operations Forces

SPBS-R

Standard Property Book System-Redesigned

SRP

soldier readiness processing

SRTS

Spectacle Request Transmission System

SSA

supply support activity

STAMIS

Standard Army Management Information System

STARC

state area command

TAMMIS

Theater Army Medical Management Information System

TB

technical bulletin

TB MED

technical bulletin, medical

TCAM

TAMMIS customer support module

TDA

table of distribution and allowances

TI

technical inspection

TM

technical manual

TMC

Troop Medical Clinic

TMDE

test, measurement, and diagnostic equipment

TMDE–GP

general purpose test, measurement, and diagnostic equipment

TMDE–SP

special purpose test, measurement, and diagnostic equipment

TOE

table of organization and equipment

TPF

total package fielding

TRADOC

U.S. Army Training and Doctrine Command

TSG

The Surgeon General

UA

unit assemblage

UAL

unit assemblage listing

UBL

unit basic load

UDP

unit deployment package

UDR

Universal Data Repository

UIC

unit identification code

ULLS–G

Unit Level Logistics System—Ground

ULLS–S-4

Unit Level Logistics System (Staff Level Logistics)

USAARL

U.S. Army Aeromedical Research Laboratory

USACE

U.S. Army Corps of Engineers

USACHPPM

U.S. Army Center for Health Promotion and Preventive Medicine

USAHFPA

U.S. Army Health Facility Planning Agency

USAMEDDBD

U.S. Army Medical Department Board

USAMMA

U.S. Army Medical Materiel Agency

USAMMCE

U.S. Army Medical Materiel Center, Europe

USAMRMC

U.S. Army Medical Research and Materiel Command

USAR

U.S. Army Reserve

USARC

U.S. Army Reserve Command

USPFO

U.S. Property and Fiscal Office

USR

unit status report

VI

verification inspection

Section II**Terms****Accountability**

Obligation to keep records of property, documents, or funds such as item identification data, gains, losses, dues-in, dues-out, and balances on hand or in use.

Accountable officer

Person officially appointed, in writing, to maintain a formal set of accounting records of property or funds. This person may or may not have physical possession of the property or funds. Two types of accountability most common to medical facilities or organizations are formal and property book: formal-stock record accounting for supplies being held for issue from time of receipt until, issued, shipped, or dropped from accountability; property book-accounting for nonexpendable organization property upon receipt and until subsequently turned-in, used (consumed) for authorized purposes, or dropped from accountability.

Appointing authority

An officer or civilian designated by the approving authority with responsibility for appointing report of survey investigating officers.

Army Master Data File (AMDF)

An official source of supply management data used in medical logistics. It is published monthly by the U.S. Army Materiel Command.

Army Medical Command

An organization that has command over one or more U.S. Army medical centers, medical department activities, or

medical research activities. Includes U.S. Army Medical Command, U.S. Army Medical Research and Materiel Command, and 18th Medical Command.

Calibration, verification, and certification (CVC)

Services to determine compliance of medical equipment with applicable specifications or standards and to make the necessary corrections or to compare items with certified device, tool, or test equipment standards.

Capital expense equipment program (CEEP)

Equipment having a unit price less than the current Other Procurement, Defense threshold.

Command surgeon

Senior medical corps officer who is part of the division/corps/theater/major Army command special staff. The command surgeon keeps the commander informed regarding medical aspects of operations.

Deployable Medical Systems (DEPMEDS)

Standard Department of Defense modular medical and dental materiel sets that are configured into hospitals for use in wartime theaters of operations or as fixed contingency hospitals in peacetime.

Durable item

An item of Army property coded with an accounting requirements code of "D" in the Army Master Data File or Universal Data Repository. Durable items do not require property book accountability. Commercial and fabricated items similar to items coded "D" in the Army Master Data File or Universal Data Repository are considered durable items.

Exchange of equipment

Equipment furnished and upgraded by vendors while under contract for their reagents or software applications. Exchange requires legal confirmation by the contracting officer and accountability by the property book officer before exchange with no exceptions.

Expendable

An item that is consumed or loses its identity in use. Expendable items are identified with accounting requirements codes of "X" in the Army Master Data File or Universal Data Repository.

Health Care Activity (HCA)

All table of organization and equipment and table of distribution and allowances facilities that provide medical care and support. Hospitals, clinics, dental activities, veterinary activities, combat stress, preventive medicine, logistics, and evacuation are health care activities.

Hospital linen management

A unique system for managing linen in health care activities. It is based on the need for responsive, sanitary, and economic linen operations. It consists of all actions involved in the requisitioning, storage, accounting, distribution, repair, cleaning, and safeguarding of hospital linen.

Hospital linen

Linen used in direct patient care or in support of direct patient care. It normally includes selected hospital and surgical clothing and hospital bedding and linen items in the Federal Supply Catalog (Department of Defense Section, Medical Materiel (Federal Supply Catalog 6530, 6532, and 7210)) and similar nonstandard items.

Installation medical supply activity (IMSA)

In the continental United States, the supply support activity for medical materiel for an installation or geographic area. Outside the continental United States, it normally is the primary supply support activity for medical materiel for a designated geographic area.

Leased equipment

Leased equipment requires legal agreement (contract) and accountability. Files will contain authorization, lease agreement with applicable amendments, and receipt of turn-in/return documentation.

Loaned equipment

Equipment provided "free of charge" while using vendors' software applications and reagents in the medical arena. This includes vendor equipment furnished with established blanket purchase agreements.

Major subordinate commands (MSCs)

Major subordinate commands under U.S. Army Medical Command. Includes regional medical commands, U.S. Army Center for Health Promotion and Preventive Medicine, U.S. Army Veterinary Command, U.S. Army Dental Command, Army Medical Department Center and School, and U.S. Army Medical Research and Materiel Command.

Materiel demonstration

Showing, use, or application of an item by the vendor. A materiel demonstration does not involve any action by Army personnel beyond observing the operation of the product by the vendor.

Materiel evaluation

Formal investigation by an activity of materiel that may have U.S. Army Medical Department-wide potential to improve health care or efficiency.

Materiel examination

Use of an item by an activity to determine whether the item or a similar item will be purchased. The materiel examination generally does not exceed 30 days.

Medical Care Support Equipment (MEDCASE)

Equipment required in U.S. Army Medical Department table of distribution and allowances fixed health care activities that is authorized for acquisition through Other Procurement, Defense and medical military construction funding programs.

Medical equipment (including dental and veterinary items)

Consists of devices used in the medical diagnosis, therapy, and treatment of injury or disease. This equipment consists primarily of Federal Supply Catalog 6500 items that are standardized by the Defense Medical Standardization Board and are procured by the appropriate acquisition agency for the Surgeon General to implement health service support for the Army. It also consists of similar commercial, nonstandard items, approved by the Food and Drug Administration and marketed as medical devices, used primarily in fixed treatment facilities to provide state-of-the-art patient care. The equipment is maintained and repaired by medical equipment repairers organic to the medical unit or treatment facility, or maintenance is provided under contract.

Medical materiel

Medical materiel includes nonexpendable, durable, and expendable supplies used in health care activities, medical research and laboratory facilities and other medical related institutions and units in the U.S. Army Medical Department.

Medical Standby Equipment Program (MEDSTEP)

Includes end items, components, or assemblies used to support activities with serviceable items when the primary item is unserviceable and is economically repairable (previously called "operational readiness float").

Medical equipment sets (MES)

Grouping of medical and other items under a single national stock number, with Defense Logistics Agency- or Defense Supply Center Philadelphia-managed (may be Service regulated) components.

Nonexpendable item

An item of Army property that retains its original identity, is not consumed in use, and is coded with an accounting requirements code of "N" in the Army Master Data File or Universal Data Repository. Nonexpendable items require property book accountability.

Regional medical commands

Command-and-control headquarters that allocates resources, oversees day-to-day management, and fosters readiness among HCAs in their area.

Regulated medical items

Materiel identified in the Army Master Data File, Federal Logistics Data on Compact Disc, or Universal Data Repository with an acquisition advice code "A." Examples of regulated medical items include medical equipment sets, patient movement items, and associated support items of equipment.

Regulated medical waste

Includes liquid or semi-liquid blood or other potentially infectious materials, contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed, items that are caked with

dried blood or other potential infectious materials during handling, contaminated sharps, and pathological and microbiological waste containing blood or other potentially infectious materials.

Rented equipment

Requires legal documentation and accountability. Coordination with the contracting officer and property book officer is mandatory.

Service-unique medical equipment sets

A grouping of medical and other items under a single NSN, with components Service managed.

Soiled linen

Consists of laundry that is considered contaminated and has been soiled with blood or other potentially infectious materials or contains sharps. Soiled linen is handled in accordance with Occupational Safety and Health Administration Bloodborne Pathogens Standard (29 CFR 1910.1030).

Total package fielding

The Army's method of fielding a system, end items, and all required support materiel identified, consolidated into a single package, and funded by the fielding command responsible for fielding medical systems or end items under total package concepts.

Textile services management

The inventory management, handling, transportation, laundering, infection control, and occupational safety considerations applicable to the management of textile services in U.S. Army Medical Department patient care facilities.

Type I complaint

Initiated when materiel (including equipment items) is determined by use or test to be harmful or defective to the extent that its use has caused or may cause death, injury, or illness. Immediate action will be taken to report such items and suspend them from use.

Type II complaint

Initiated when medical materiel other than equipment is suspected of being harmful, defective, deteriorated, or otherwise unsuitable for use. Expeditious action will be taken to report these items and suspend them from use.

Type III complaint

Initiated when equipment is determined to be unsatisfactory because of malfunction, design, or defects (attributable to faulty materiel workmanship and/or quality inspection or performance). Type III complaints do not necessarily require suspension of the items.

Section III

Special Abbreviations and Terms

This section contains no entries.

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