SB 8-75-11

DEPARTMENT OF THE ARMY SUPPLY BULLETIN

Army Medical Department Supply Information

Headquarters, Department of the Army, Washington, DC 20310-2300 30 November 2006

Effective until rescinded or superseded

DISTRIBUTION STATEMENT A: Approval for public release; distribution is unlimited

Printing of this information does not constitute endorsement of the product, manufacturer, or the use of any related item thereof by the U. S. Army.

REPORTING ERRORS AND RECOMMENDING IMPROVEMENTS

You can improve this publication. If you find any mistakes, or you know a way to improve it, please let us know. Mail your letter or DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to the U. S. Army Medical Materiel Agency, ATTN: MCMR-MMA, Fort Detrick, MD 21702-5001. If you prefer using email, please address it to **usammacrm@amedd.army.mil**.

This Supply Bulletin contains procedural guidance to augment the policies published in the revised AR 40-61, *Medical Logistics Policies and Prodcedures.*

Table of Contents Page

Errata Sheet - i
Overview - ii
CHAPTER 1 - Introduction 1-1
CHAPTER 2 - Medical Logistics Systems 2-1
CHAPTER 3 - Medical Materiel Management 3-1
CHAPTER 4 - Quality Control Information 4-1
CHAPTER 5 - Medical Equipment Management 5-1
CHAPTER 6 - Medical Equipment Maintenance 6-1
CHAPTER 7 - Environmental Services Management In Healthcare Organizations 7-1
CHAPTER 8 - Facility Life-Cycle Management 8-1
CHAPTER 9 - Medical Materiel Readiness 9-1
CHAPTER 10 - Procedures for Management of Medical Assemblages 10-1
CHAPTER 11 - Optical Fabrication 11-1

Appendix A - Similar Asset/Estimated FMV Worksheet A-1
Appendix B - Instructions for Recording DIN-PACS Medical Systems on Activity Property Books for Sites Using DMLSS B-1
Appendix C - Draft Copy of *TB MED 750-1* C-1

GLOSSARY - GL-1
CUMULATIVE INDEX FOR 2006 - IN-1

NOTICE

This is the last issue of the DA SB 8-75 Series to be published for 2006

Errata Sheet For SB 8-75-S7 dated 20 July 2006

Cover page: Chapter 5 title: Change the word Chemical to read Chemical

Chap. 1

P. 1-1, para 1-1b: **Delete** have established on line b(1).

Chap 5

P. 5-2, para 5-2a, Table 5-1, for NSN 6505-01-529-6640: **Delete** the entire ANTIBIOTICS: Note

p. 5-5, Table 5-3, Correct the following NSNs in Table 5-3 as shown below:

NSN	NOMENCLATURE	BASIS OF ISSUE	AAC
6505-01-457-8901	Antidote Treatment Kit - Cyanide) – **This kit is being phased out for project code DH5. Use until depleted. See future replacements below:**		A
---	---	---	---
6505-01-533-4408	Sodium Nitrite Injection, 30 MG, 2s	15 per set	L
6505-01-533-4417	Sodium Thiosulfate Injection, 25%, 50ml	30 per set	L

P 5-9, para 5-10d, line 1: **DELETE** the word "your" before MCDM

OVERVIEW

This supply bulletin contains medical materiel management procedures and guidance. It is designed to augment the policies published in the current *AR 40-61, Medical Logistics Policies and Procedures* (28 January 2005). Both *AR 40-61* and *SB 8-75-11* are required to have complete medical logistics polices and procedures explained.

Where and if there is a conflict between the procedures and guidance contained in the *SB 8-75-11* and the *AR 40-61,* **this *SB 8-75-11* will take precedence**.

Due to the dynamic nature of medical logistics, particularly since 11 September 2001, *the SB 8-75-11* will be updated and published each year to keep the procedural guidance current and to facilitate the changes that are necessary in providing timely medical logistics support.

CHAPTER 1. INTRODUCTION

1.1 PURPOSE

This Supply Bulletin (SB) provides procedures and guidance for operating a uniform supply system for all medical logistical units, both Table of Distribution and Allowances (TDA) and Modified Table of Organization and Equipment (MTOE) organizations.

1.2 ABBREVIATIONS

Explanation of abbreviations and terms are contained in the Glossary Section of this Supply Bulletin.

1.3 REQUESTING CLARIFICATION

a. The chain of command will be used to request clarification of the provisions and requirements in this publication.

b. A memorandum will be used when making a clarification request. The memorandum will include the following:

(1) Page and paragraph in question.
(2) Requester's name and Defense Switching Network (DSN) phone number.

c. Each element in the chain of command receiving a clarification request will try to answer it. The clarification request will be sent to the next higher staff element when it cannot be answered. This procedure will assure that available knowledge and skills are used and the quickest possible answer is given. Requests received outside of command channels will be returned through channels.

1.4 REQUESTING DEVIATION AUTHORITY

Deviations from procedures in this SB will be made only with prior approval from Headquarters, U.S. Army Medical Command (USAMEDCOM). The *Defense Finance and Accounting Service - Indianapolis (DFAS-IN) Regulation 37-1* will be used to prepare and process request for deviation from accounting procedures. Requests for deviation or waivers should explain the need for the waiver, how long it will last, how the waiver will help accomplish the mission, and how the end results will be measured. The request should include an opinion by the United States Army Medical Command legal officer.

CHAPTER 2. MEDICAL LOGISTICS SYSTEMS

2-1. FUNCTIONAL PROPONENT

The Assistant Surgeon General for Force Sustainment, in accordance with (IAW) *Army Regulation* (*AR*) *5-22,* is the functional proponent for Medical Logistics. The Office of the Surgeon General (OTSG) Director of Logistics and the U.S. Army Medical Command Assistant Chief of Staff for Logistics serve as the functional proponent representative for medical logistics Information Management/Information Technologies (IM/IT).

2-2. THE ARMY MEDICAL DEPARTMENT (AMEDD) LOGISTICS SYSTEMS DIVISION

a. The Division asserts functional proponent responsibilities by ensuring AMEDD logistics IM/IT is consistent with existing and evolving health care management business practices as well as procurement and financial management policies. The Division is responsible for planning and coordinating the development of operational requirements for logistics IM/IT and the acquisition strategy to satisfy those requirements. The Division provides executive level oversight for the integration and life-cycle management of medical logistics systems to ensure viable medical logistics support to sustaining base and deployed force logistics elements Army wide.

b. The AMEDD Logistics Systems Division provides guidance to subordinate commands and Military Health Systems (MHS) proponent groups, as well as conceptualizes and implements new and emerging technologies to enhance medical logistics business processes and automated medical logistics systems.

2-3. MEDICAL LOGISTICS INFORMATION MANAGEMENT/INFORMATION TECHNOLOGIES (IM/IT)

This paragraph applies to medical logistics IM/IT at automated medical logistics operations, medical fixed facilities, division, and corps level units (Echelon II-V). This paragraph is IAW *AR 25-1* and *USAMEDCOM Regulation 25-1*.

a. Medical logistics IM/IT supports the following core business functions:

(1) Acquisition, accountability, 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 medical logistics operations will use existing Department of Defense (DoD)/Army standard medical logistics IM/IT.

c. Medical fixed facilities and units conducting medical logistics operations will not use locally developed or procured non-standard medical logistics systems when either a DoD or Standard Army Management Information System is available.

d. Units and supply activities at all levels will promote the use of electronic ordering for all Class VIII transactions through the available and approved Medical Logistics IM/IT. Specifically, the Installation Medical Supply Activities (IMSA) located at the USAMEDCOM fixed facilities will mandate the use of Medical IM/IT to establish electronic ordering with all customers. Hardcopy or manual requisitions will be the exception. The habitual use of electronic ordering will improve efficiency and effectiveness for both peacetime and wartime operations. Ongoing guidance from the USAMEDCOM to the IMSA will establish electronic ordering procedures.

2-4. MEDICAL LOGISTICS INFORMATION SYSTEMS (IS) DESCRIPTIONS

a. The following systems are authorized as standard DoD and Medical Logistics ISs:

(1) Theater Army Medical Management Information System (TAMMIS). TAMMIS is maintained by the:

U. S. Army Medical Information Technology Center
ATTN: Logistics Systems Branch
2710 Howitzer Street, BLDG 2372
Fort Sam Houston, TX 78234

(a) Medical Supply (MEDSUP): Automated and comprehensive inventory management of medical materiel. TAMMIS MEDSUP provides automated support for inventory management functions at deployable medical units. Functions supported include ordering, receiving, storing, accounting for, and issuing medical supplies and equipment. TAMMIS MEDSUP also provides financial transactions through interfaces with Army/DoD financial systems.

(b) TAMMIS Customer Assistance Module (TCAM): TCAM allows remote customers who have no other medical logistics automation to create automated Class VIII requests with minimal hardware requirements (Personal Computer (PC) or laptop with a network connection). TCAM customers can connect to the designated TAMMIS site and select files from the TAMMIS database. Once the files are downloaded, the customer can break the connection and use the TAMMIS data to place orders, check status, review the stockage catalog, and research substitutions. Then, customers can reconnect and send the file containing Military Standard Requisitioning and Issue Procedures (MILSTRIP) transactions to the TAMMIS source of supply. TCAM has been successfully used in garrison and in deployments. Units are strongly encouraged to use TCAM in order to establish electronic Class VIII ordering with the designated source of supply. TCAM is an approved part of the TAMMIS baseline. Medical Supply Support Activities will assist units in obtaining the TCAM application, setting up the user environment, connection to the Supply Support Activity (SSA) server and providing user training. If TCAM problems occur beyond the capability of the medical SSA units will contact the TAMMIS Project Office Customer Support Office at 210-295-3600, 888-567-2514 or DSN 421-3600. TCAM will be replaced by the Defense Medical Logistics Standard Support (DMLSS) Customer Assistance Module (DCAM) beginning in FY07.

(c) Communications: TAMMIS can relay information between Table of Organization and Equipment (TO&E) units in various ways. The preferred method uses Local Area Networks (LAN). This method relies on the use of the Mobile Subscriber Equipment (MSE) military communications system. Because communications cannot be assured in wartime, units can also pass information by standard telephone lines, Terminal Services Access Controller System, satellite communications, over a stand-alone LAN (without MSE), by Tactical Terminal

Adapter, or by external magnetic/electronic media (floppy disks, flash drives, tape, etc.) delivered by courier. All methods preclude re-entering data at the receiving TO&E unit. Examples of transactions and files that are moved include medical logistics MILSTRIP transactions (requisitions, supply status, shipment status, financial transactions, follow-up transactions, requisition modifiers, and cancellation requests). TAMMIS logistics systems also exchange electronic commerce transactions with vendors. The system is designed to utilize all forms of communications available to a unit in garrison and in a deployed environment.

(d) Theater Enterprise Wide Logistics System (TEWLS) will replace TAMMIS in the interim at medical distribution centers and DMLSS will be used in the deployable hospitals. DMLSS Joint Enterprise Wide Logistics is the system of the future that will integrate TEWLS and DMLSS into a MHS enterprise solution.

(2) Defense Medical Logistics Standard Support (DMLSS): DoD migration IS to replace TAMMIS (at deployable hospitals) and AMEDDPAS. TDA activities with DMLSS servers will use DMLSS Functionality

DMLSS functions include:

- Inventory Management (IM)
- Customer Area Inventory Management (CAIM)
- DMLSS Customer Assistance Module (DCAM)
- CAIM Source of Supply (SOS)
- Customer Support /Customer Support on the Web
- Equipment and Technology Management (ETM)
- Facilities Management (FM)
- Systems Services and
- Business Objects.

(a) Inventory Management (IM): The IM module provides users with a standardized, integrated management system, which will provide formal accountability and facilitate materiel management and administration. Functions of this module include assemblage management, excess reporting, cataloging, credit card ordering, credit card reconciliation physical inventory, online and offline ordering, transaction history, location management, and delivery/pick lists. IM will also implement a simple automated quality assurance program covering recalls, suspensions, hazard alerts, destructions, and the safe medical devices act. This module also supports electronic commerce (ANSI X12) requisitioning capabilities as well as the standard MILSTRIP/FEDSTRIP (Federal Standard Requisitioning and Issue Procedures) interfaces and Internet ordering capability.

(b) Customer Area Inventory Management (CAIM)/CAIM SOS):

(1) CAIM is designed to give all internal customers the ability to manage an individual stockroom or area. CAIM assists the customer in identifying materiel items required in patient care and clinical support; providing an automated tool for requesting materiel items; physical inventory, credit card ordering, credit card reconciliation location management, receipt, and tracking of patient care related materiel to the point of use. CAIM acts as an individual logistics operation allowing users to go directly to a DoD prime vendor or to the Logistics Division.

(2) CAIM SOS gives the customer the ability to sell items to other customer areas as well as managing its own inventory. As with CAIM, the CAIM SOS assists the customer in identifying materiel items required in patient care

and clinical support. It provides an automated tool for requesting materiel items; performing a physical inventory; location management; receipts; and tracking of patient care related materiel to the point of use. It also gives the user the capability to issue (sell) to its customers. The following are examples of departments that should be considered for conversion to CAIM or CAIM SOS:

- Pharmacy
- Central Material Service
- Operating Room
- Department of Pathology/LAB
- Optical Fabrication Lab
- Materiel Distribution Branch.

(c) DMLSS Customer Assistance Module (DCAM): The DMLSS program manager is reprogramming and replacing TCAM with updated software that complies with the DMLSS Common Operating Environment. As with TCAM, DCAM allows remote customers who have no other medical logistics automation to create automated Class VIII requests with minimal hardware requirements (PC or laptop with a network connection). DCAM customers can connect to the designated DMLSS or TAMMIS site and select files from the DMLSS or TAMMIS database. Once the files are downloaded, the customer can break the connection and use the DMLSS or TAMMIS data to place orders, check status, review the stockage catalog, and research substitutions. Then, customers can reconnect and send the file containing MILSTRIP transactions to the DMLSS or TAMMIS source of supply. New features in DCAM that did not exist in TCAM include secure data transfers using secure File Transfer Protocol (FTP) with TAMMIS and HTTPS with DMLSS. Also, a DCAM level 2 has been added to allow Class VIII supply support activities, such as brigade medical supply offices (BMSO), to receive and process electronic DCAM requisitions from subordinate customers. DCAM is an approved part of the DMLSS baseline. DCAM will be part of the Theater Medical Information Program (TMIP) Block 2, Release 1 software suite and will be distributed to some units by the Medical Communication for Combat Casualty Care (MC4) deployment teams. Other customers requiring DCAM will request the application from their medical SSA. The SSA will provide the application, assist the customer in setting up the DCAM account on the SSA server and provide training for the customer. Should DCAM problems occur beyond the capability of the medical SSA, contact the MHS Help Desk.

(d) Customer Support: Provides internal customers with the automated capability to research information from commercial and DoD sources and stocked items from the Medical Treatment Facility (MTF). Manages/transfers New Item Requests electronically through the levels of approving authorities, create Work Requests to the Facility Manager, medical maintenance manager and provides an automated replenishment process for restocking customer supply areas.

(e) Customer Support on the Web: Encompasses catalog research and item request capabilities and provides users with the capability to submit and review the status of new item requests as well as facility and medical maintenance work requests. It provides non-logisticians, such as clinicians, ancillary and administrative personnel with an automated, user-friendly method of researching and requesting supplies and support services from Medical Logistics.

(f) Equipment and Technology Management (ETM):

(1) Equipment Management: Enables customers and equipment managers to manage equipment assets from the time a customer starts researching an equipment item to the point at which the equipment is processed for redistribution or disposal. It also enables the logistician to acquire equipment, track inventory, and dispose of assets through an automated and integrated process.

(2) Equipment Maintenance: Provides the user with a systematic approach to equipment maintenance, simplifying the maintenance request process and tracking the progress of requested work. The work order system schedules maintenance procedures and facilitates collection of historical maintenance data, which support the equipment management and budgeting processes. A repair parts module interfaces to the supporting supply activity and the work order system.

(g) Facilities Management (FM): The Defense Medical Logistics Standard Support automated information system Facility Management Module (DMLSS-FM) provides a powerful Computer-Aided Facility Management tool for standardizing facility management programs throughout the DoD healthcare industry. It provides comprehensive automated management capabilities ranging from scheduled maintenance and project tracking to regulatory compliance and space management.

(h) System Services (SS): This module manages the Supported Customer data, DMLSS Communication Manager (DCM), and Table Maintenance Utility (TMU).

(i) Business Objects: This module allows the user to access the DMLSS database and provide managerial information through the use of queries. This powerful software can be used to develop daily, monthly and quarterly reports. While many reports are already preformatted, the module provides the capability to develop and format ad-hoc reports as required.

(3) Theater Enterprise Wide Logistics System (TEWLS): TEWLS is the initiative to migrate the capability for theater level Class VIII Supply Chain Management (SCM) from TAMMIS into a Systems Applications and Products (SAP)-based, enterprise architecture. TEWLS will build upon the SAP Enterprise Resource Planning (ERP) initiative that has been 'live' at the US Army Medical Materiel Agency (USAMMA) since May 2002, and would bring theater Class VIII management into the same system architecture that is used for the production of Army Medical Equipment Sets (MES) and Medical Materiel Sets (MMS). TEWLS will migrate as an Army sponsored initiative into the DMLSS program at some point in the future.

(4) The Medical Logistics Support Web Portal (https://medlogspt.army.mil) is developed and maintained by the AMEDD Logistics Systems Division. It is integrated with the Army Knowledge Online (AKO) through the use of the AKO single sign on. Additionally, the AKO Medical Logistics Group Page in the Medical Knowledge Online community is maintained by the division. The web portal is a collaborative environment for information relevant to the medical logistics community regarding policies, missions, current events, conferences, etc., and also to automate certain business practices making their processes more cost-effective. The medical logistics web applications include: the Optical Fabrication Enterprise application; the Environmental Services Application; Command Logistics Review Program (CLRP) application; the Issue Status Review application; the Medical Logistics eHelp portal; and the medical logistics lessons learned application. The portal provides a web-based tool to track and route medical logistics related questions to the proper subject matter experts.

(5) eZ SAVe: Provides a web based service that uses data synchronization techniques to compare site logistics data to a centralized authoritative database and make recommendations for changes in three categories.

-Opportunities for better product pricing (current product price is higher than "best available")

- Opportunities for better sourcing (an e-Commerce source of supply is available but not being used)
- Opportunities for site record improvement and/or contract coverage improvement (critical product data missing or does not match authoritative data).

b. The following systems are authorized as standard DoD and Army Logistics Management ISs:

(1) Purchase Request Web (PRweb): Web-enabled application between a customer and their servicing contracting office for the processing and acceptance of requirements for local purchase. From their desktop Web browsers, customers can create and route purchase requests, with attachments, to other PRweb users for approval and fund certification. Approved requirements are transmitted directly to the Procurement Desktop-Defense (PD^2) database of the supporting contracting office. PRweb is utilized when TAMMIS or DMLSS is not available or requirements require attachments and extended descriptions.

(2) Defense Blood Bank System (DBBS): The DBBS automates the blood bank operations and is currently fielded to Medical Logistics (MEDLOG) units, deployable and fixed hospitals with a blood bank/donor center support mission. This application will be integrated as part of the TMIP 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.

(3) 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.

(4) 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 will be used in all FSMC, Brigade Support Medical Company, MSMC, and Sustainment Support Medical Company at Echelon II and III units. It also replaces the Standard Army Maintenance System Levels 1 and 2 (SAMS-1 and SAMS-2) and the Army Reserve Supply and Maintenance System (ARSAMS) that are used in selected Medical Logistics Companies, Logistics Support Companies , Medical Brigades, and USAMEDCOM units. ULLS-G, SAMS-1, SAMS-2, and ARSAMS are the migration systems for all MEDLOG units using TAMMIS MEDMAINT, as well as deployable hospitals in Corps and EAC levels. GCSS-A-MNT will be used in all medical units authorized a company or battalion level motor maintenance operation in the division, corps, and EAC levels.

(5) Joint Medical Asset Repository (JMAR): JMAR Asset Visibility is an important decision support database. The vision of JMAR is to provide Global Access to Joint Medical Logistics Information for any user, any time on any government machine. It is recognized by the Department of Defense as the single source to acquire, manage, and provide timely and accurate Joint Medical Asset Visibility Information. JMAR daily receives data from a multitude of government legacy systems including DMLSS and TAMMIS/TEWLS.

JMAR is constantly evolving and currently has report and ad hoc asset query capability for Assemblages, Blood, Facility, Inventory, Prime Vendor (PV), Global Transportation Visibility and Materiel and asset visibility that can be queried.

The JMAR website can be located at: https://jmar.detrick.army.mil/.

(6) GCSS-A Property Book Unit Supply Enhancement (PBUSE):

GCSS-A-PBUSE is the replacement for the Unit Level Logistics System S4 Module (ULLS-S4) and Standard Property Book System-Redesigned systems that will be used in all medical units at the battalion level and higher that maintain their own property books in the corps and EAC levels.

c. When standard MTF medical logistics systems do not provide the functionality to support a required medical logistics business practice, non-standard IM/IT are authorized only after approval through the AMEDD Directorate of Logistics/Assistant Chief of Staff for Logistics (DOL/ACSLOG), with final approval authority at AMEDD CIO. MTFs shall submit a request for waiver through their respective Regional Medical Command (RMC) to the:

Commander, USAMEDCOM
ATTN: MCLO-LS
2050 Worth Road, Suite 8
Fort Sam Houston TX 78234-6008

d. Army medical activities and units operating a manual medical accounting system will follow this supply bulletin and procedures in *AR 40-61*, *AR 710-2*, and Department of the Army Pamphlet *(DA PAM) 710-2-2*.

e. Army medical fixed facilities are authorized to use commercial automated medication and supply distribution systems, known as Point of Use (POU).

(1) Coordination with USAMEDCOM is required to purchase or lease POU systems in order to apply the numerous system interfaces that maximize the benefits of POU cabinets. Requests to purchase or lease POU systems will be submitted through the respective RMC to:

Commander, USAMEDCOM
ATTN: MCLO-LS
2050 Worth RD, Suite 8
Fort Sam Houston TX 78234-6008

Requesting activities must submit justification that includes projected economic and clinical benefits.

(2) 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.

f. Army medical activities with Automatic Identification Technology (AIT) equipment that includes Radio Frequency devices, such as base radio units, repeaters, hand-held 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 MHS helpdesk IAW procedures described in paragraph 2-6.

2-5. HELP DESK

a. Trouble calls for in support of TAMMIS will be submitted to the U.S. Army Medical Information Technology Center (USAMITC), TAMMIS Project Office Customer Support Office at 888-567-2514, DSN 421-3600, or 210-295-3600. E-mail help requests may be submitted to Cust.Spt.TAMMIS@amedd.army.mil.

b. Trouble calls for support of DMLSS or TEWLS will be submitted to the MHS Help Desk at any of the following numbers:

800-600-9332 Continental United States (CONUS)
210-767-5250 (Direct/Commercial)
866-637-8725 Outside CONUS (OCONUS)

Digital Help requests can be made at: **http://www.mhs-helpdesk.com**.

c. Requests for information on TEWLS may be submitted to the TEWLS Competency Center Director at TEWLSCC@amedd.army.mil

2-6. SYSTEM CHANGE PROCESS

The System Change Request (SCR) is an official recommendation to correct or enhance the functionality of IS. In a formal process, the SCR is validated and accepted by the program manager and USAMEDCOM. Units or activities that have identified a significant problem or possible improvement that may warrant an SCR, will submit their ideas to the appropriate project office and USAMEDCOM through the MHS help-desk.

CHAPTER 3. MEDICAL MATERIEL MANAGEMENT

This Chapter provides the procedures for a Supply Support Activity (SSA) and other supply operation for medical materiel to: Operate, stock, requisition, issue, dispose of excess, and measure its operations.

3-1. MEDICAL SUPPLY SUPPORT ACTIVITY (SSA) OPERATIONS

a. The SSAs for medical materiel are distinguished from other medical supply operations in that they:

(1) Operate a stock record account per *AR 710-2*

(2) Perform the full range of supply functions identified for SSAs in *AR 710-2*

(3) Appoint an accountable officer per *AR 735-5*

(4) Requisition materiel directly from the wholesale system or from a major, intermediate level medical materiel SSA

b. The SSAs for medical materiel include:

(1) Installation Medical Supply Activity (IMSA)

(2) Medical Logistics Battalion (MEDLOG Bn): In peacetime, MEDLOG Bns may perform the full functions of, may have a training mission, or may have an area supply mission. Upon mobilization and/or deployment, the MEDLOG Bn will normally perform all SSA functions.

(3) U.S. Army Medical Materiel Center Europe (USAMMCE)

c. Other supply operations for medical materiel maintain informal stock control records in support of a direct support or area supply mission. These operations do not normally requisition directly from the Defense Logistics Agency (DLA) system and do not perform the full range of supply and Financial Inventory Accounting (FIA) functions.

d. Other supply operations for medical materiel include:

(1) Combat Division level medical supply support provided by the Division Medical Supply Office (DMSO).

(2) Medical supply detachments.

(3) MTOE hospital units with an area supply mission.

(4) Other medical units with an area supply mission.

(5) Medical Logistics Management Center (MLMC). The MLMC is a unique organization that currently has a comprehensive and evolving role in Reach Logistics.

3-2. SUPPLY SUPPORT ACTIVITIES

The SSAs for medical materiel provide direct, general, and/or installation support to units and activities within a designated command or area. The unit's or activity's MTOE, TDA, or Major Command (U.S. Army) (MACOM) directive will state the mission for providing this support. The SSA:

a. Maintains accountability and manages medical supply stocks that are stored for issue to authorized supply customers.

b. Operates a stock record account per AR 710-2;
c. Operates with a standard logistics Information System (IS);
d. Conducts prescribed FIA and financial management of the:
(1) Defense Working Capital Fund (DWCF), which finances acquisition of SSA stocks at selected activities.
(2) Army fund, or Operation and Maintenance, Army (OMA) fund.
(3) Defense Health Program (DHP) fund, which finances acquisition and distribution of SSA stocks at selected activities.

e. Establishes an electronic ordering process with all external deployable units/customers.
(1) Electronic ordering implies that a remote connection is established and data is transferred from the customer to the supporting SSA.
(2) All medical SSAs and their supported customers may use only an approved Class VIII IS to accept and transmit requisitions.
(3) The electronic ordering processes will be used during peacetime and wartime operations.

3-3. INSTALLATION MEDICAL SUPPLY ACTIVITY (IMSA)

a. The IMSA is normally the SSA for medical materiel for a designated installation and/or geographical area and is under the control of the Medical Center (MEDCEN) or Medical Department Activity (MEDDAC) commander. The IMSA is normally separate from the installation's consolidated supply operation.

b. The MEDCEN or MEDDAC commander provides medical supply support to designated units and activities on the installation and within the assigned geographical support area (see *AR 5-9*).
c. The Medical Supply Officer (MSO) is responsible to the MEDCEN or MEDDAC commander for operation of the IMSA.

d. The IMSA accountable officer (and/or MSO) directs the operations of the IMSA. The MSO provides total medical supply support to all supported units and activities. The MSO is responsible for security of materiel per *AR 190-51*.

e. The IMSAs are authorized direct contact with customers, the USAMMA, Defense Supply Center Philadelphia (DSCP), other government agencies, supporting medical supply, and local purchase activities on medical supply matters.

f. The USAMEDCOM IMSAs, under the direction of their RMC, will meet with all supported active and United States Army Reserve Command (USARC) units at least annually to determine mobilization and deployment requirements.

3-4. MEDICAL LOGISTICS BATTALIONS/U.S. ARMY MEDICAL MATERIEL CENTER EUROPE

a. The MEDLOG Bn/USAMMCE is assigned a medical SSA mission that supports all customers according to the logistics support plan developed for their command or area of operation. The plan outlines the relationship between the MEDLOG Bn/USAMMCE and their supply support. The CONUS MEDLOG Bns supporting command shall coordinate the logistics support plan with the supporting RMC.

b. The MEDLOG Bn supported by an IMSA must conduct all interfaces electronically with the wholesale system (such as, submission of MILSTRIP replenishment requisitions) through the IMSA unless directed by the IMSA/RMC.

3-5. CONSOLIDATED SUPPLY ACTIVITIES ON ARMY MEDICAL DEPARTMENT INSTALLATIONS

a. On Installations under AMEDD control, other supply commodities may be consolidated with medical into a single activity.

b. The AMEDD installation consolidated supply activities:

(1) Operate under a structure similar to that of the IMSA.

(2) Are authorized, by The Surgeon General (TSG), direct contact with nonmedical supply activities, Service Item Control Centers, and National Inventory Control Points (NICPs), as appropriate.

3-6. U.S. ARMY NATIONAL GUARD UNITS

U.S. Property and Fiscal Officers (USPFOs) may provide IMSA-type support to Army National Guard (ARNG) units. The USPFOs and ARNG MTOE units assigned a medical supply support mission will operate per SB-8-75-10 and this SB.

3-7. MEDICAL MATERIEL MANAGEMENT PROCEDURES BY UNITED STATES ARMY RESERVE (USAR) AND ARNG PERSONNEL ASSIGNED A PATIENT-CARE MISSION

a. The USAR and ARNG units may requisition and use controlled, shelf life refrigerated materiel when they provide patient care to military personnel authorized such care by *AR 40-3*. During use, ARNG and USAR units will control and account for those items according to this chapter, *AR 40-2* and comply with pharmaceutical management procedures in the *SB 8-75 series*.

b. When the patient-care mission has been completed:

(1) The USAR units will coordinate the turn-in of all unused stocks to the supporting IMSA/MEDLOG Bn/USAMMCE.

(2) The ARNG units will:

(a) Return all controlled items per this SB.

(b) Return as directed by the United States Property and Fiscal Officer (USPFO) unit of issue quantities of all other items unlikely to be consumed prior to their expiration date. Return these items within 60 days of the completion of the patient care mission.

(c) Return Federal Supply Class (FSC) 6505 items that are on the IMSA/MEDLOG Bn/USAMMCE stockage list and unlikely to be consumed within 12 months.

(d) Manage remaining stocks as specified in applicable regulations and the *SB 8-75 series*.

(e) Account and Report all on hand Medical Chemical Biological Radiological and Nuclear (CBRN) Defense Materiel (MCDM) thru the DoD/Food and Drug Administration (FDA) Shelf Life Extension Program System (SLEP), see chapter 4 of this SB, *SB-8-75-7 and SB-8-75-10*.

3-8. STOCKAGE

a. The SSAs identified in this Supply Bulletin, may stock:

(1) Standard items; which are catalogued items listed in the Army Master Data File (AMDF), Federal Logistics Record (FEDLOG) or. Universal Data Repository (UDR) Medical Catalog (MEDCAT).

(2) Nonstandard items are items not listed in the above catalogs; however, they are required to support the health-care mission.

b. The MTOE medical supply operations may stock:

(1) Consumable items authorized in the supported Medical Sets, Kits, and Outfits (SKOs).

(2) Consumable items authorized in the resupply module for supported MTOE hospitals.

(3) Items used to meet contingency missions, training requirements, or used to provide garrison medical support, if approved by the command surgeon. These units will maintain command surgeon approved Authorized Stockage Lists (ASLs) that reflect both wartime and peacetime requirements.

c. The ARNG units maintain State Surgeon-approved formularies.

3-9. STOCKAGE CRITERIA

(1) The IMSA/MEDLOG Bn/USAMMCE will follow these guidelines when determining stockage.

(a) When six recurring demands have been recorded within a 360-day period, establish an initial stockage for the item.

(b) If less than six recurring demands have been recorded, a customer may request in writing that an item be stocked.

(c) For emergencies, the Unit's senior logistics officer can approve stockage of items.

(d) There must be at least three recorded demands within a 360-day period, to maintain stockage.

* NOTE: In the event that the item the customer requested to be stocked is no longer required, the customer may be charged for the unused quantities left in stock.

(2) The MTOE medical supply operations will follow these guidelines.

(a) When six recurring demands have been recorded within a 360-day period, establish an initial stockage for the item.

(b) There must be at least three recorded demands within a 360-day period, to maintain stockage.

(c) Follow MACOM guidance when establishing stockage criteria for items that support:

- Authorized Stockage List (ASL)
- Mandatory Parts List
- Resupply of medical assemblage components.

3-10. STOCKAGE LISTS

a. The IMSA/MEDLOG Bn/USAMMCE will provide copies of the stockage list to supported activities. Local policy will govern frequency and recipients.

b. The MTOE medical supply operations must maintain ASLs. Local policy will govern the distribution of the ASLs.

3-11. CRITICAL ITEMS

a. The Defense Medical Standardization Board (DMSB), Fort Detrick, Maryland, maintains a list of critical items needed for patient care during contingencies. The contents of this list are based on input from the military services and other DoD agencies that manage medical materiel. Periodic analysis of quantities of these critical items held by the military services and other DoD agencies is requested by the Assistant Secretary of Defense for Health Affairs to ensure DoD capabilities will meet contingency requirements.

b. The various Tri-Service Regional materiel standardization committees will review products included on the critical items list to ensure they are considered for standardization at their regional MTFs. The Health Care Activity (HCA) materiel standardization committee works in concert with the RMC to ensure the Tri-Service Region has these items for review and incorporation into the activities' stockage lists.

3-12. JOINT DEPLOYMENT FORMULARY

a. The DMSB, Fort Detrick, Maryland, maintains the Joint Deployment Formulary (JDF). The JDF's purpose is to establish a baseline deployment formulary to treat the most common wounds or diseases that may affect a US Armed Forces member. Inclusion must balance transportation and inventory management capabilities. It is assumed that Service members will deploy with 180 day supply of medications with resupply through Tricare Mail Order Pharmacy (TMOP).

b. The JDF is the pharmaceutical items that have been approved by all four Services for use in a Deployed Theater. The JDF is sourced against the Prime Vendors and the manufacturer's current availability to decrease the number of back orders and rejected requisitions an activity will receive while ordering in a deployed location. The USAMMA uses the JDF when updating and refilling medical assemblages.

c. The JDF is updated quarterly and is available on the DMSB Web site, https://www.dmsb.army.mil.

3-13. STOCKAGE LEVELS

a. Computing reorder points

(1) Compute reorder points with a safety level not exceeding 5 days (15 days for OCONUS) and the actual Order and Shipping Time (OST) for each item. The OTSG is the approval authority for requesting safety level modifications in DMLSS or TAMMIS. The OST for nonstandard items will include the average time used for processing a procurement request.

(2) The preferred method to compute reorder point is the Days Of Supply (DOS) procedures. This is used for distributed/PV/Electronic Catalog (ECAT) items and for all items in a deployed theater.

(3) You may use the Economic Order Quantity (EOQ) procedures to compute the reorder point, see *DA PAM 710-2-2*, Appendix D, for EOQ Reorder Point with appropriate Safety Level.

b. Computing Requisition Objectives (RO)/levels

(1) DOS is the preferred method for PV/ECAT items.

(2) Use *DA PAM 710-2-2* when computing EOQ.

(3) The operating level is a maximum of 15 days CONUS (30 days OCONUS) or as determined by the MACOM/command surgeon when establishing the days-of-supply method. Operating levels for nonstandard items acquired under vendor service are based on quantities needed to sustain operations between resupply cycles.

c. Calculating retention levels. When stock on-hand exceeds the RO/level, medical activities will calculate retention levels using provisions of *AR 710-2* and *DA PAM 710-2-2*. Process stocks exceeding authorized retention levels using the excess materiel guidance in this chapter.

d. Calculating stockage levels for MTOE Medical Supply Operations

(1) The Command Surgeon determines the peacetime stockage objective for the MTOE medical supply operations. The stockage objective should not exceed 90 days.

(2) The MTOE medical supply operations will use the DOS method or the inventory management module of an approved IS to compute the RO/level. Logistics support plans should establish days of supply needed to support designated unit operations when mobilized.

3-14. REQUISITION PROCEDURES

a. The IMSA/MEDLOG Bn/USAMMCE must provide responsive support to customers for medical items. Ways of providing this support are:

(1) The preferred method is through a commercial contract service, such as the DoD PV/ECAT.

(2) Local stockage of selected items will be used when:

(a) The distance between the IMSA/MEDLOG Bn/USAMMCE and the supporting commercial distributors warrants stocking items to preclude interrupting supply support.

(b) Items are not available through supporting commercial distributors.

(c) When item are ordered in unit of issue and sold by unit of measure.

(3) When the commercial distribution contracts cannot fill routine supply requirements, CONUS IMSAs/MEDLOG Bn will submit requisitions to DSCP using MILSTRIP procedures delineated in *AR 725-50*.

(4) Local purchase procedures (Decentralized Blanket Purchase Agreements (DBPA)/Blanket Purchase Agreement (BPA)/Credit Card) program

b. IMSA/MEDLOG Bn/USAMMCE will enter all purchases and receipts in DMLSS/TAMMIS for retrospective review by the Accountable Officer, to capture

demands for standardization, analyze procurement costs, and to ensure items are purchased using the most efficient acquisition methodology.

c. To requisition regulated medical items and/or provisioned medical equipment items, follow procedures in this chapter.

d. Requisition Medical Care Support Equipment (MEDCASE) items by following guidance in *SB 8-75-MEDCASE*, the USAMMA, and local command publications. The supporting property account will forward MEDCASE requisitions directly to the USAMMA. These requisitions will not be processed through the IMSA/USAMMCE. Capital Expense Equipment Program (CEEP) will be direct-fund cited when requisitioned through the medical supply account.

3-15. REQUISITIONING STANDARD AND NONSTANDARD MEDICAL MATERIEL

a. Standard stocked items: The OCONUS IMSA/MEDLOG Bn/USAMMCE may transceive an "A01" (request for standard stocked item), "A0A" for CONUS IMSA/MEDLOG Bn, requisitions through the Defense Automatic Addressing System (DAAS) to the supply source if the requisitions:

(1) Comply with local policies and procedures.

(2) Are in MILSTRIP format (See *AR 725-50*).

(3) Are for medical materiel centrally cataloged by DSCP and listed in one of the following publications:

- AMDF or FEDLOG.
- UDR MEDCAT
- Medical Services Information Logistics Systems (MEDSILS), http://www.usamma.army.mil/apps/qbca_medsils/

b. Nonstandard nonstocked items: The OCONUS IMSA/MEDLOG Bn/USAMMCE may transceive Document Identifier Code (DIC) "A05" (nonstandard nonstocked items) requisitions through DAAS to the supply source if the requisitions:

(1) Comply with local policies and procedures.

(2) Are for medical materiel not listed in either the:

- AMDF, MEDSILS, FEDLOG,
- UDR MEDCAT
- Medical Services Information Logistics Systems (MEDSILS), http://www.usamma.army.mil/apps/qbca_medsils/

(3) Are accompanied by all applicable exception data.

(4) Are prepared per procedures in *AR 725-50*.

c. Nonstandard medical materiel:

(1) The CONUS IMSA/MEDLOG Bns will purchase nonstandard medical materiel locally. However, when the item cannot be locally obtained, requisitions may be submitted to DSCP citing:

- DIC "AOE".
- Pertinent exception data.
- Advice code "2A".

(2) The MTOE medical supply operations will submit requisitions to their supporting IMSA/MEDLOG Bn/USAMMCE.

3-16. EMERGENCY REQUISITIONS

a. When emergency or urgent medical materiel requirements exist (to save lives or to prevent suffering or distress), IMSA/MEDLOG Bn/USAMMCE will expeditiously process requisitions from supported HCAs using the issue priority designator “03” (life or death) requisitions. Life or death requisitions will be submitted to DSCP only when the item is not available locally. The quantity ordered should reflect the minimum requirements for the particular emergency. Particular attention should be given to customer’s requests for in-vitro diagnostics and reagents. Because of the type of materiel involved, activities should be certain that a life or death situation is involved before submitting the requisition on that basis. Non-receipt of incremental shipments is not in itself a justification for submitting a life or death requisition. Submit requisitions telephonically to the Emergency Supply Operations Center (ESOC) at DSCP. Normal duty hour numbers are commercial 215 737-2112 or DSN 444-2112. After duty hour numbers are commercial 215 737-2341 or DSN 444-2341.

b. The following information, at a minimum, is required on the requisitions:
- Name of the physician administering to the patient.
- Diagnosis and prognosis of patient(s).
- Preferred mode of shipment.
- Requisitioner’s telephone numbers (on & after duty) and points of contact.

c. The commander or designated representative will personally review and document all requisitions with an urgency of need designator “A” or “B” per the *DA Pam 710-2 series*. The IMSA/MEDLOG Bn/USAMMCE will perpetuate all urgency of need designator “A” requisitions from supported activities.

d. Valid exception data for urgency of need designator “A” and “B” requisitions are requests for shipment using:

(1) The fastest traceable means.

(2) Shipments by specific mode (i.e., commercial air). If commercial air is requested, IMSA/MEDLOG Bn/USAMMCE will provide an appropriate transportation fund citation. Do not delay life or death “03” requisitions to verify or determine the appropriate fund cite.

e. When MTOE medical supply operations submit emergency urgency of need designator “A” and “B” requisitions to their supporting IMSA/MEDLOG Bn/USAMMCE, the unit commander will authenticate the priority assigned to the requisition per the *DA PAM 710-2 series.* The MTOE medical supply operation will process emergency requisitions from supported units. The requisition must be properly authenticated, provided the requisitions cannot be filled from on-hand stocks.

3-37. PRIME VENDOR AND ELECTRONIC CATALOG AS A SOURCE OF SUPPLY

a. The overall goal for materiel acquisition is to migrate to greater use of electronic commerce alternatives and decrease reliance on manual, labor-intensive procurements, such as credit cards. Two programs that maximize use of e-commerce methodologies and provide greater system-wide economies are the DSCP PV and the ECAT programs.

b. The DSCP pharmaceutical and medical/surgical PV/ECATs are the commercial distributors for items, which include:

- Distribution and Pricing Agreement (DAPA) items
- Federal Supply Schedule items
- PV/ECAT non-usage items
- PV/ECAT committed volume/Regional Incentive Agreements (RIA) items, and
- Other e-tool sources.

This program is mandatory for USAMEDCOM activities for products available under the program and serves as the primary acquisition method for pharmaceuticals and medical/surgical materiel.

c. Actions to be taken by the activity to increase PV utilization:

(1) Communicate weekly with the PV representative.
(2) Ensure all non-usage items are ordered under a specific Routing Identifier Code (RIC).
(3) Request items that can be provided by the PV to be stocked if they are not in the PV distribution center.
(4) Review and adjust usage levels with the PV representative monthly.
(5) Continuously review local purchase and credit card purchases with the PV representative for PV eligible items.
(6) Consider utilizing DOS versus EOQ for inventory management.
(7) Order smaller quantities more frequently.

d. The activity should ensure the PV is accomplishing the following tasks to increase utilization:

(1) Weekly communication with the activity.
(2) Notify the activity when usage items are stocked.
(3) Notify the activity when backordered items are received.
(4) Furnish the activity listings of items stocked by the distribution center.
(5) Minimize temporary out of stock. Address the temporary out of stock items routinely (minimum at the weekly meeting) with the activity.
(6) Capture demands on kills/cancellations.

e. Actions to be taken by the activity to increase PV fill rate of usage items:

(1) Work rejects daily. Some rejects can be caused or affected by the activity:

R1 – Not on Contract
R2 – Invalid Item Identification
R3 – Invalid Unit of Issue
R6 – Not on Customer Usage List
R7- Reorder as Drop Shipment
AR – Quantity Exceeds Allocation
AA – Customer Exceeded Forecasted Demand Quantity
The PV should work the other rejects.

(2) Reconcile usage versus non-usage items on a monthly basis with the PV representative.
(3) Order more frequently for smaller quantities.
(4) Do not permit the logistics IS to automatically reorder temporary out of stock or backordered items on a daily basis, if the item cannot be filled by the PV in a

reasonable period of time. Such continuous reordering does nothing to obtain the item and increases the number of unfilled/cancelled requisitions, thereby lowering the fill rate.

f. The activity should ensure that the PV accomplishes the following tasks to increase the fill rate:

(1) Notify activity when usage items are restocked (removed from backorder status).

(2) Notify activity when usage candidate is entered as usage in the PV system.

(3) Work with the activity on a daily basis to address rejects that are not caused by the activity (e.g., temporary out of stock, R4 – Manufacturer/National Backorder).

(4) Notify activity when a non-usage item has enough demands to convert to usage.

g. The DSCP ECAT program continues to expand and is used for laboratory, optical, dental, medical equipment, manufacturer direct and general MEDSURG items (available under ECAT Joint Venture Program). The program minimizes administrative workload, overhead costs and interest payments by streamlining electronic ordering and financial processes through the Military Standard Billing System (MILSBILLS). This program is mandatory for USAMEDCOM activities for products available under the program. A full description of the functionality and features of the DSCP ECAT system can be found at the ECAT webpage:
https://dmmonline.dscp.dla.mil/ECAT_Nonsecure/ecat_home.asp

3-18. VENDOR INVENTORY SERVICE

a. The IMSA/MEDLOG Bn/USAMMCE will use direct-order and other electronic vendor (INTERNET) inventory services provided by commercial medical materiel distribution organizations PV. The DSCP Pharmaceutical and MEDSURG PV's provide on-demand shipment of materiel.

b. The IMSA/MEDLOG Bn/USAMMCE will use these services to augment in-house capabilities for standard and nonstandard items and services. This augmentation provides significant benefits for managing short shelf life items.

c. The IMSA/USAMMCE will use PV inventory services as an alternative to stocking and a means to reducing inventory at the installation level.

d. Where appropriate, the IMSA/MEDLOG Bn/USAMMCE may authorize other SSAs and customers to use direct order and other electronic vendor-inventory services to satisfy supply requirements. All authorizations of adding other customers must be coordinated and approved by higher commands and the MEDCOM (MCLO-O). The DSCP PV and ECAT systems are the AMEDD number one means of acquisition. All materiel must be bought through these systems when the products are available. ECAT prices can be higher at times and the activity needs to make a judgment call to acquire it if it makes economic sense. The activity needs to challenge the higher price with the DSCP ECAT Help Desk at 800-290-8201 or dscpecathelp@dla.mil.

3-19. DEPARTMENT OF VETERANS AFFAIRS (DVA) AS A SOURCE OF MEDICAL MATERIEL

The DVA is a source of medical materiel that is authorized for local purchase. The DVA contracts with firms for common use supplies and services, and these contracts are summarized in the *Federal Supply Schedule (*FSS). When making local purchases from the *FSS* source, follow the provisions in the Federal Acquisition Regulation (FAR).

3-20. LOCAL PURCHASE FOR MEDICAL MATERIEL AND SERVICES

The preferred purchasing methodology is the contracted DSCP commercial distributor/PV/ECAT. When the PV/ECAT is unable to meet the requirement, local purchase may be utilized. The IMSA/MEDLOG Bn/USAMMCE should consider the following when local acquisition of materiel is appropriate.

a. The IMSA/MEDLOG Bn/USAMMCE will use local purchase procedures to satisfy supply requirements of supported customers. Methods of local purchase include:

(1) Direct-order and other electronic (INTERNET) vendor-inventory services.

(2) Decentralized Blanket Purchase Agreements (DBPAs). DSCP DBPAs are restricted to the 16th MEDLOG Bn, Ft Wainwright and USAMMCE.

(3) Supporting contracting office where deemed appropriate by the MSO.

(4) International Merchant Purchase Authorization Card (IMPAC) program/government purchase card/credit card.

b. The MTOE medical supply operations will obtain local purchase support through their supporting IMSA/MEDLOG Bn/USAMMCE. The activities should comply with IMSA/MEDLOG Bn/USAMMCE procedures when submitting Purchase Requests (PRs).

c. The PRs must:

(1) Be made on a competitive basis to the maximum extent possible.

(2) Establish and describe requirements for products and services based on actual needs of the government, not personal preference, and on the minimum essential characteristics required to perform the mission.

d. When government needs are such that only a particular product is acceptable, the customer will attach a justification for other-than-full-and-open competition to the PR. Activities should consider equipment compatibility and other conditions or circumstances that may necessitate sole source procurement. Additional to the factual statement, PRs will include facts concerning test and evaluation of potential products and will identify competitive products to the maximum extent possible. The factual statement should:

(1) Cite the physical, functional, or other characteristics essential to the needs of the government.

(2) Identify the physical and functional characteristics peculiar to the requested product or service.

e. The PRs must include all available information needed to receive the desired materiel. Complete information will prevent unneeded correspondence and will reduce lead-time.

f. USAMEDCOM activities will attach the properly completed Contract Data Distribution Form, USAMEDCOM Form 757-R (MCRM) dated Jun 05 to all purchase requests (DA Form 3953, DD 1348-6 or PR Web), except for acquisition to be paid by credit card. This action will assist DFAS – Vendor Pay in prompt payments of goods and services. The Group Administration Manager or Contracting Officer's Representative (COR) will ensure this data is kept current and accurate at all times by notifying the Wide Area Work Flow (WAWF) POC at the contracting office.

g. Coordination between the customer, supporting medical maintenance activity, and the facility engineer must be accomplished during the planning stage to determine structural and utility requirements for equipment requiring installation.

h. The MSO or designated representative will review all PRs to:
(1) Identify maintenance significant equipment
(2) Determine maintenance requirements
(3) Assist the customer in procurement specifications.

i. The PRs for maintenance significant equipment must include a request for two copies of operator and maintenance manuals. The ordering activity can adjust this figure to meet local requirements. Digital or electronic manuals may be provided instead of hard copy manuals.
(1) Operator manuals should include instructions on the following:
(a) Assembly
(b) Operation
(c) Services
(d) Accessories
(e) Calibration, if applicable

(2) Maintenance manuals should include instructions on the:
(a) Assembly
(b) Installation
(c) Troubleshooting
(d) Calibration requirements
(e) Utility schematics/wiring diagrams
(f) Applicable parts requirements

j. The Principle Assistant Responsible for Contracting (PARC) is the proponent for the IMPAC credit card program. The USAMEDCOM activities will use only IMPAC cards issued by the USAMEDCOM contracting offices. The USAMEDCOM contracting offices will provide the following types of guidance.
(1) Clarification of advise from the Assistant Secretary of the Army for Research, Development, and Acquisition (ASARDA), to include providing interpretations, clarification, and resolution of conflict between implementing activities and ASARDA.
(2) The USAMEDCOM policies and responsibilities regarding the IMPAC program.
(3) Monitoring and reporting USAMEDCOM progress to ASARDA.

k. Logistical responsibilities are identified in PARC memorandums and implementation plan for purchasing of supplies, equipment, and services.

3-21. LOCAL PURCHASE OF SELECTED ITEMS OF MEDICAL MATERIEL

The following medical materiel and equipment can be purchased locally:

a. ITEMS, INCLUDING REPAIR PARTS REQUIRED IMMEDIATELY: These items are needed to save lives or prevent suffering and can be purchased by following normal supply and financial procedures. The *DFAS-IN Regulation 37-1* authorizes that these purchases, if necessary, be made in the absence of funds. *AR 40-2* outlines the standards for purchasing drugs and immunizing agents.

b. OCCUPATIONAL THERAPY SUPPLIES AND EQUIPMENT: These items are authorized for use by occupational therapists.

c. PROFESSIONAL BOOKS AND PERIODICALS: These include all library material required by health care personnel involved in direct or indirect patient care.

(1) The OCONUS activities may order medical books and periodicals through DBPAs awarded by DSCP. If the required materiel is not available through DBPAs, send requisition to DSCP at MEDESOC@DLA.Mil. Telephones: Commercial 215-737-2112, Option 1; DSN 444-1212.

(2) Subscriptions for periodicals and journals may exceed one (1) year when it is more cost effective.

(3) To obtain a limited number of books, the FSS for Federal Supply Group 76 may be used.

d. WIGS (cranial prostheses): These can be supplied to:

(1) Females with alopecia (hair loss) or

(2) Males with alopecia under the following conditions:

(a) Secondary to specialized medical treatment

(b) Along with disfiguring scars

(c) Resulting in psychiatric disorders, and in the medical authority's opinion, the wig would be beneficial therapy.

e. POST-MASTECTOMY PROSTHESES AND BRASSIERES. The HCA commander must authorize the post-mastectomy prostheses, brassieres, and wigs as part of the overall course of treatment.

f. MEDICINAL GASES: These can be purchased only when available in satisfactory quality and volume per U.S. Pharmacopoeia standards. Available from:

U.S. Pharmacopoeia
12601 Twinbrook Parkway
Rockville MD 20852
Telephone 800-822-8772

g. Furniture and furnishings for clinical, waiting, and lounge areas.

h. CONTACT LENSES when authorized by *AR 40-63/Navy Medical Command Instruction (NAVMEDCOMINST) 6810.1/* Air Force Regulation (*AFR) 167-3*.

i. PROSTHETIC DEVICES, IMPLANTS, APPLIANCES, AND ACCESSORIES (*see AR 40-3*).

j. THE MEDCASE REQUIREMENTS: See *SB 8-75-MEDCASE*.

k. PRESCRIPTION SAFETY GLASSES: Prescription safety glasses are authorized solely for a specific job assignment per *AR 40-63*, *Technical Bulletin Medical 506 (TB MED 506*) and *Common Table of Allowances (CTA) 50-900*. Prescription safety glasses are authorized to members of the uniformed services only on a non-reimbursable basis. Procedures to obtain safety glasses for Federal civilian employees are contained in *TB MED 506*.

l. MEDICAL RESEARCH MISSION OR ENVIRONMENTAL LABORATORY MATERIEL: The laboratory commander must authorize this materiel.

3-22. LOCAL PURCHASE RESTRICTIONS

a. Purchase only Food and Drug Administration (FDA)-approved drugs; exceptions are listed *in AR 40-2* and *AR 40-7.*

b. Do not purchase vaccines and immunizing agents locally unless one or more of the following conditions have been met:

(1) The item is listed in the AMDF, FEDLOG UDR MEDCAT or MEDSILS
(2) The Army has approved or recommended the item for use
(3) The Surgeon General has specifically approved the item

c. Do not purchase nonstandard equipment, for which a standard comparable item is available, unless it provides features that are clearly needed in the health care service.

d. Do not purchase standard or nonstandard items needed for facility alterations, additions, expansions, or minor new construction before approval and funding of the construction project.

e. Follow the restrictions contained in the FAR and any supplements to purchase items of foreign origin.

f. Purchase infant transport under these conditions:

(1) When transport incubators or bassinets are used solely for ground transport. These items must be FDA approved.

(2) When infant incubators are used for air transport, The items must have been previously approved by the

U.S. Air Force Aeromedical Testing Branch
311 Human Systems Wing/YAML
Bldg. 160, Room 134
2485 Gillingham Drive
Brooks Air Force Base
San Antonio TX 78235-5105

g. Do not purchase or use investigational drugs without the prior written approval from TSG. Submit requests for approval to the U.S. Army Medical Materiel Development Activity (USAMMDA):

Commander, USAMMDA
ATTN: MCMR-UMZ
622 Neiman Street
Fort Detrick MD 21702-5009

AR 40-7 contains additional guidance on investigational drugs.

h. Do not purchase or issue drugs classified “ineffective 1A” by the FDA.

i. Do not purchase regulated medical items (see Glossary) and those authorized in major medical assemblages (SB 8-75 series) without approval of TSG.

j. Purchase orthopedic footwear for authorized individuals using guidance in *AR 32-4/DLAR 4235.18/AFR 67-125/Navy Supply Instruction (NAVSUPINST) 4400.70C/Marine Corps Order (MCO) 4400.137A, AR 700-84,* and *AR 40-3.*

k. Purchase hearing aids, batteries, and replacement ear molds through the medical supply channels from the DVA acquisition sources.

l. Do not purchase diagnostic imaging systems unless authorized by the USAMMA.

m. Purchase infant feeding formula using purchase orders, PRs, or BPAs. The IMSA/MEDLOG Bns/USAMMCE may receive formula at no cost as long as the authorized purchase order, PRs, or BPAs call numbers have been processed using prescribed procurement procedures established by the supporting contracting office.

n. Do not purchase investigational equipment not yet certified by the FDA without TSG approval. Submit requests for approval through command channels to

Commander, USAMEDCOM
ATTN: MCLO-O
2050 Worth Road, Suite 8
Fort Sam Houston TX 78234-6100

o. The installation’s preventive medicine service, in coordination with the safety committee, will define, develop, and/or review approval procedures for purchasing medical materiel locally. These procedures must mitigate potential harmful health and environmental effects. The MSO will request the Materiel Safety data Sheet(s) (MSDS) from the manufacturer.

p. Any equipment, supplies, or services offered to the U.S. Government by a contractor on a “no cost” basis will follow the procedures and regulations that are in:

(1) *AR 1-100* and *AR 1-101.*

(2) *FAR* and *DoD Federal Acquisition Regulation* (DFAR) Supplement (contract or purchase order).

q. The term “no cost” includes:

(1) Equipment, supplies, or services provided as a gift or donation to the government.

(2) Equipment or supplies provided to the U.S. Government for determining suitability for future purchases by the government, whether or not the items are consumed through use.

(3) Equipment temporarily loaned to the government.

(4) Equipment or supplies provided to the government either on a temporary or permanent basis, but conditioned upon purchase.

r. An evaluation must be made to determine total cost to the government under any of the methods described above. The evaluation should include all applicable costs

(i.e., consumable supplies, transportation, maintenance, training, site preparation, installation, and associated equipment).

s. If the contracting method is chosen as the most appropriate means of acquiring materiel or services, the following applies:

(1) A valid requirement must exist for the materiel or service.

(2) A provision will be included in the contract concerning the ownership and disposition of the “no cost” equipment and/or supplies in the event the contract is terminated or not renewed.

(3) Administrative or regulatory approvals required for automatic data processing, word processing, office automation system equipment, or MEDCASE will be obtained prior to submission of PRs to the contracting office, whether or not these items are offered at “no cost” to the government.

(4) A PR will be submitted per local procedures to the supporting contracting office. The PR will detail all known costs determined by the evaluation.

t. Property accountability will be established upon receipt of the property for all equipment items either as government owned or other-than-government owned, depending on the status of the equipment.

3-23. REQUISITIONING ITEMS IN SUPPORT OF MEDICAL EVACUATION

a. Annually the USAMMA will publish a list of items required in the medical evacuation system in the *SB 8-75 series*. This list includes a project code to be used when requisitioning these items for use in medical evacuation. During wartime, the USAMMA may announce additional items through messages as well as subsequent publications of the *SB 8-75 series*.

b. Submit requisitions citing the appropriate project code to DSCP. Only requisitions for medical evacuation purposes may cite this project code. The DSCP will fill the requisition from a special pool of assets, when available. The DSCP will also provide the appropriate MILSTRIP supply status. Materiel issued from this pool will consist of used, serviceable stocks rather than new, unused stocks. The DSCP will bill at:

(1) Ten percent (10%) of the standard unit price for those requisitions filled from the special asset pool and for issues of used, serviceable items made to support activities by IMSA/MEDLOG Bns/USAMMCE.

(2) Only ten percent (10%) of the standard unit price for issues of used, serviceable items made to support activities by IMSA/MEDLOG Bns/USAMMCE.

(3) The standard unit price for those requisitions not filled from the special asset pool.

3-24. PURCHASING SERVICES AND RENTALS

a. The *FAR*, as supplemented, provides guidance concerning contracting for personal and non-personal services. Non-personal services may be locally purchased. Examples of non-personal services are as follows:

(1) Repairs to medical equipment when in-house maintenance capability is inadequate

(2) Installation of equipment when not included with the original contract

(3) Consultation services.

b. Rent or lease equipment when:
(1) Needed to satisfy an emergency medical requirement
(2) Available only through lease
(3) The lease is more cost effective than purchasing

c. Follow property accountability guidelines for all rented or leased equipment.

3-25. PURCHASING SPECIAL DENTAL MATERIEL

a. The DSCP has established indefinite requirements contracts and DBPAs with various companies to purchase prosthodontic supplies, to include:
(1) Artificial teeth
(2) Facings
(3) Backings
(4) Mold guides
(5) Orthodontic supplies
(6) Partial denture casting alloys and accessories
(7) Other dental accessories and materiel

b. Purchase procedures for dental materiel are as follows:
(1) Use of the commercial distribution contracts or DSCP's ECAT program.
(2) Use of DBPAs by activities that provide orthodontic care.

3-26. MEDICAL EQUIPMENT AND PROVISIONED ITEMS

a. Medical equipment end items purchased for field use and requiring unique support and maintenance will be procured with the following provisioned items:
(1) Transportation/carrying case0
(2) Accessories and consumables required for item to be functional when received (3-day start-up kit)
(3) Operator and maintenance manuals (1 hard copy, 1 electronic copy)
(4) Training material, to include Operator & Maintenance materials
(5) Consumables and accessories item list

b. Medical equipment and provisioned items will be assigned a model-specific Acquisition Advice Code (AAC) "J" National Stock Number (NSN). The AAC "J" NSN will be used for procurement of the equipment items. The items to support and maintain the make/model specific medical equipment and provisioned items will be requisitioned using an AAC of "L."

c. Medical equipment and provisioned items can be Other Procurement, Army (OPA) or OMA funded as determined by the appropriation and budget activity account code of the Materiel Category Structure Code (MCSC) in the AMDF or FEDLOG.

d. The USAMMA will centrally fund all new components, both OPA and OMA, identified to a Unit Assemblage (UA) for Units being sustained. All other units are to keep their sets maintained to the as fielded UA listing. If a Unit Commander determines they are procuring the updates, notification to the USAMMA is requested.

e. The USAMMA messages will announce provisioned medical items, which are available on the USAMMA website (http://www.usamma.army.mil/).

f. Basic requisitioning procedures for all procurement appropriation provisioned medical equipment items are as follows:

(1) Prepare standard MILSTRIP requisitions per *AR 725-50*.

(2) Forward requisitions through appropriate Class VIII supply channels to the USAMMA for funding and requirement validation review.

(3) Use “AOE” or “AO5” as the DIC for all requisitions.

(4) Use “B69” as the RIC for all requisitions for AAC “J” end items to the USAMMA.

(5) Include a valid sole source justification with requisitions for AAC “J” NSNs. If not included, the requisition will be canceled and returned to the requesting unit.

(6) Use the requesting Unit’s Department of Defense Activity Address Code (DODAAC) in the requisition’s document number. If the supporting automated system requires the DODACC SSA in the document number, then identify the requesting unit in the supplementary address field. All requisitions will contain the original requester’s complete document number and the in-the-clear name of the unit, i.e., 228th Combat Support Hospital (CSH), in the EXCEPTION DATA accompanying the requisition.

(7) Submit the requisition to the USAMMA by message with an information copy to the appropriate MACOM. Mail may be used as an alternative submission method. Do not submit requests for Procurement Appropriations provisioned medical equipment items through the DAAS.

(8) Include the following information in the exception data for each requisition (the requesting unit must furnish this information).

(a) Current authorization (MTOE and effective date).

(b) Unit Identity Code (UIC).

(c) Reason for shortage (that is, initial issue or replacement).

g. The USAMMA will forward all validated and funded requisitions to the appropriate contract vehicle for procurement.

3-27. PURCHASING REFERENCE BOOK SETS FOR MEDICAL MTOE UNITS

a. The MTOE and other Army authorization documents authorize the book sets for MTOE units. The Army Medical Department Center & School (AMEDDC&S) will:

(1) Determine the components of book sets.

(2) Review book sets annually.

(3) Publish through the USAMMA and USAPD, the revised component listings in the *SB 8-75-S9* (20 September 2005).

b. To obtain individual books for book sets:

(1) Use local purchase procedures (see instructions in *SB 8-75-S9* dated 20 September 2005).

(2) Use current general services, administration FSS, and FSG 76.

3-28. INVENTORY ACCOUNTING

Use the following accounting methods for stocks. These procedures apply to manual systems and logistics ISs.

a. The IMSA/USAMMCE/MEDLOG Bn maintains accountable records using guidance in *AR 710-2*, *DA PAM 710-2-2*, and this *SB*.

b. Other MTOE medical supply operations will maintain informal inventory accounting records. These records should be maintained per *AR 710-2* and *DA PAM 710-2-2*. Accurate maintenance of these records will maximize efficiency and accuracy of records and effectiveness of training.

c. Medical MTOE units will account for items stocked and for components of medical assemblages.

3-29. INVENTORY AND ADJUSTMENT

a. The IMSAs, MEDLOG Bn, USAMMCE, and other medical supply operations must follow procedures in *AR 710-2* and *AR 735-5*, *DA PAM 710-2-2* and *DFAS-IN Reg. 37-1*, when inventorying and adjusting medical stocks.

b. The HCA commanders (Lieutenant Colonel or above) will approve inventory adjustments for IMSAs. Delegation of this authority must follow the guidance set forth in *AR 735-5*. This authority cannot be delegated to the Chief of Logistics at a medical activity.

c. The goal for inventory adjustment (gains and losses) is to keep the adjustment below five percent of the RO/level dollar value per fiscal year (*AR 735-5*).

d. A disinterested officer appointed on orders will inventory controlled medical items monthly, to account for the items.

e. The MSO must conduct causative research on all lines having a dollar value adjustment of $1,000, and on all controlled item discrepancies regardless of value.

3-30. REQUISITION SUPPORT PROCEDURES FOR MEDICAL ACTIVITIES ORDERING EXPENDABLE, DURABLE AND NON-EXPENDABLE MATERIEL

a. Organizational elements of TDA HCAs will submit requests for;

(1) **Non-Medical Durable and all Non-Expendable** materiel to the supporting Property Management division/branch.

(2) **Medical Durable and all Expendable** materiel to the supporting Materiel division/branch.

Note: **Self Service Supplies** available through E-Mall will be ordered through established channels.

b. Units and activities having an assigned DODAAC will submit requests for expendable, durable, and non-expendable medical items to the IMSA/MEDLOG Bn/USAMMCE per *AR 710-2*, *DA PAMs 710-2-1* and *710-2-2*, and MACOM/Command Surgeon guidance. The IMSA/MEDLOG Bn/USAMMCE will arrange for the technical acceptance inspection of maintenance significant equipment before issuing to the requesting activity.

c. Requesting activities will designate personnel authorized to request and receive medical supplies and equipment. A DA Form 1687 (Notice of Delegation of Authority - Receipt for Supplies) will be used for this purpose. Distinction will be made between

those authorized to order and receive controlled and sensitive items and other medical materiel. The IMSA/MEDLOG Bn/USAMMCE and other medical supply operations will maintain a current file of completed DA Form 1687s on customers. These procedures are outlined in *DA PAM 710-2-1*.

3-31. MATERIEL OBLIGATION VALIDATION

a. The IMSA/MEDLOG Bn/USAMMCE will:

(1) Conduct monthly customer due-out reconciliation [Materiel Obligation Validation (MOV)] with supported customers. The customers must complete a local reconciliation before the quarterly NICP MOV process begins (see *AR 725-50*).

(2) Review MOV requests with the customers to ensure proper use of funds and the need for continued supply action. Timely response in validating requests from supply sources is essential to ensure ongoing supply action and to prevent cancellation of the request.

b. The MTOE medical supply operations will validate requisitions per local IMSA/MEDLOG Bn/USAMMCE procedures for reconciliation. These MTOE medical supply operations will respond to IMSA/MEDLOG Bn/USAMMCE requests for MOV.

3-32. CONTROLLED MEDICAL ITEMS

a. Identification: The Drug Enforcement Administration (DEA) identifies drugs as controlled substances. The Federal Register and the *SB 8-75 series* contain 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 identify these substances as Controlled Inventory Item Codes (CIICs) “R” and “Q.”

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

(1) Schedule I - Substances/drugs having no accepted medical use in the U.S.

(2) Schedule II - Substances/drugs having a high abuse potential with severe psychic or physical dependence liability, identified as:

(a) Note “R” in the FSC.

(b) Controlled inventory item code “R” in the AMDF or FEDLOG.

(3) Schedule III - Substances/drugs having an abuse potential less than Schedules I and II substances, identified as:

(a) Note “Q” in the FSC.

(b) Controlled inventory item code “Q” in the AMDF or FEDLOG.

(4) Schedule IV - Substances/drugs having an abuse potential less than Schedule III substance, identified as:

(a) Note “Q” in the FSC.

(b) Controlled inventory item code “Q” in the AMDF or FEDLOG.

(5) Schedule V - Substances/drugs having an abuse potential less than Schedule IV substances, identified as:

(a) Note “Q” in the FSC.

(b) Controlled inventory item code “Q” in the AMDF or FEDLOG.

3-33. SECURITY PRECAUTIONS FOR CONTROLLED MEDICAL ITEMS

a. Controlled medical items such as controlled substances, tax-free alcohol, precious metals, and other items designated by the HCA commander, require security precautions and must follow the guidelines in AR 190-51 "Security of Unclassified Army Property". Research, development, test, and evaluation facilities will follow the policies and procedures in *AR 70-65* when managing controlled substances, ethyl alcohol, and hazardous biological substances.

b. Only those Army Activities identified in the SB 8-75 series can requisition controlled substances from DSCP. The DLA system will ship only to those DODAACs cited.

3-34. REQUISITIONING CONTROLLED MEDICAL ITEMS

a. The MACOMs should submit requests for additions and deletions to the list of authorized requisitioners, with justification, through command channels to

Commander, USAMEDCOM
ATTN: MCLO-O
2050 Worth Road, Suite 8
FT Sam Houston TX 78234-6100

b. The USAMEDCOM Commander will:

(1) Advise the submitting command of approved and disapproved requests.

(2) Notify the USAMMA (MCMR-MMB-R) of all approved changes, who in turn, will coordinate with the DSCP. The USAMMA is the originator of the data and is the Service Item Control Center.

(3) Authorized requisitioners will:

(a) Establish procedures that ensure adequate supply support of controlled substances for satellite medical activities.

(b) Ensure that supported activities demonstrate a valid need for controlled substances before issuing.

(4) Unauthorized units should, if controlled substances are needed, contact the nearest authorized requisitioner for supply support.

(5) The DSCP will reject requisitions from unauthorized activities.

(6) Each month, the DSCP will provide MACOMs with a list of controlled substances issued to their subordinate units. The MACOMs will establish procedures with subordinate activities to reconcile the lists with local supply account records on a timely basis. Subordinate activities must report any discrepancies to MACOMs and the DSCP. In addition, the IMSA/MEDLOG Bn/USAMMCE will establish local procedures to reconcile orders from commercial distributors with actual quantities received.

3-35. LOCAL PURCHASE OF CONTROLLED MEDICAL ITEMS

a. All local purchases of controlled medical items must comply with DEA instructions.

b. The HCA commanders 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. TDA activities utilizing DMLSS will enter schedules I and II in DMLSS as Off-Line Non Submit and utilize PO call number generated by DMLSS on DEA Form 225

(1) These designated individuals must be registered with the nearest DEA regional office by completing DEA Form 225 DEA Application Form. After registration, the DEA will furnish exempt officials the needed order forms (DEA Form 222, U.S. Official Order Form Schedules I and II) and instructions. Store order forms in a locked container. Each certificate must be renewed every 3 years.

(2) When a registered individual is replaced, the HCA will forward the registration and any unused order blanks to

DEA
ATTN: Registration
600 Army Navy Dr., 6th Floor-ODOC
Arlington VA 22202

(3) The OCONUS activities may submit requests to DSCP for their assistance in procuring controlled items.

3-36. 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.

(1) Store stocks of controlled medical items in a security storage device commensurate with the type and quantity of materiel. The IMSA/MEDLOG Bns/ USAMMCE's Accountable Officer will request the local Provost Marshal to survey and document the adequacy of the security per *AR 190-51*.

(2) Safeguard note "R" controlled medical items at each storage location. As a minimum, the security storage device should be a vault of substantial construction with a steel door and combination or key lock. Where small quantities permit, use a safe or steel cabinet (General Services Administration (GSA) Class 5 or equivalent). If the safe or cabinet weighs less than 750 pounds, attach it to a permanent structure to prevent easy removal. New vault construction will meet the DEA's minimum-security standards of non-practitioner handling of Schedule I and II controlled medical items. Existing storage vaults should also include the following:

(a) An electronic alarm system, which, upon unauthorized entry, transmits a signal directly to the appropriate military or civilian law enforcement agency.

(b) A self-closing and self-locking device to be used during normal hours when the vault door is open (frequently called a "day gate").

(3) Store note "Q" controlled medical items in safes or vaults. Where space limitations preclude, store items in a locked cage or secure room that has limited access. New construction of cage storage areas will meet the DEA's security standards. Existing cage storage areas should also include the additional features listed above.

(4) Ethyl alcohol is classified as a Code "R" item. **The guidelines established in this SB for bulk storage of ethyl alcohol take precedence over *AR 190-51***

***and AR 40-3* until either is superseded**. Store ethyl alcohol in a flameproof container/cabinet or storage area that meets National Fire Protection Association (NFPA) and Occupational Safety and Health Administration (OSHA) standards for storage of a flammable product. To the maximum extent practical, meet the standards in *AR 190-51* for the storage of Code "R" items. However, NFPA and OSHA fire protection standards will take precedence over security requirements. As a minimum, keep the container/cabinet locked or in a secure storage area that has a limited access.

b. Managing controlled medical items.

(1) The HCA Commanders or Command Surgeons will appoint the MSO and at least one alternate to serve as the custodian of the activities' stocks of controlled medical items. The custodians/alternates will:

(a) Post all gain and loss transactions on a DA Form 1296 (Stock Accounting Record) for both stocked and nonstocked items.

(b) Maintain current security container designations and records, to include Standard Form (SF) 700 (Security Container Information), SF 702 (Security Container Check sheet), and reversible "OPEN-CLOSED" signs per *AR 380-5*.

(c) Maintain a record of receipts, issues, and stock balances on DA Form 1296 at the storage site. These records are in addition to the IS accountable stock records that are maintained by the appropriate materiel manager.

(d) Sign for registered mail, parcels, and expressed packages addressed to the IMSA/MEDLOG Bn/USAMMCE.

(e) Issue controlled medical items directly to an authorized recipient, preferably at the security storage site. The custodian must obtain a full signature of the recipient.

(f) Complete the stock record accounting at the storage site immediately after a transaction.

(g) Retain accountable records and supporting documents for three years after the date of the last transaction.

(h) Authorize all issues by editing the requisitions before issue.

(i) Analyze the transactions once each month.

(j) Investigate shortages and unusual requisitions or expenditures immediately; consult with supported activities when necessary; and take corrective action if needed.

(2) The MSO will restrict the issue of all controlled medical items by:

(a) Issuing DEA-designated controlled medical items to the HCA pharmacies for dispersal to patients, wards, clinics, and other areas of the hospital. Hospitals must maintain records of these items per *AR 40-2*.

(b) Issuing DEA-designed controlled medical items to other activities only when authorized by the HCA commander or Command Surgeon.

(c) Issuing tax-free alcohol to hospital pharmacy and laboratory activities and other activities authorized by the commander.

(d) Issuing precious metal, Precious Metal Bearing Scrap (PMBS), and chrome-based metals for dental use to the precious metals coordinators of supported Dental Activities. The coordinator is the only one who can turn in precious metals, PMBS, and chrome-based metals.

(e) Issuing instructions containing precious metals to supported activities authorized such items.

(f) Issuing controlled medical items to authorized Active and Reserve Component MTOE units with written approval from the unit commander.

(3) The local Provost Marshal will complete a local files check on vault custodians/alternates, warehouse personnel, and other personnel having access to controlled medical items or medically sensitive items per *AR 190-51*.

3-37. PERIODIC INVENTORIES OF CONTROLLED MEDICAL ITEMS

a. The HCA Commander or Command Surgeon will:
(1) Change disinterested inventory officer assignments each month.
(2) Provide written inventory procedures based on current Army regulations.

b. The aviation life-support equipment technician will inventory controlled medical items in aviation survival kits when the periodic inspection of the complete kit is completed.

c. The Dental Command and all activities will conduct an inventory of precious metals annually to coincide with the annual quality assurance statement.

d. The inventories and corrective action consist of the following:
(1) Agreement between all stock balances on accountable records at storage locations and the quantities on-hand and the accountable stock record. If these do not agree, they must be reconciled.
(2) Authentication of the balance on stock accounting records at storage locations for each line item inventoried. The inventory officer will:
(a) Make a separate line entry on DA Form 1296 to include the date, abbreviation "INV", quantity on hand, and legible payroll signature.
(b) Submit a report of the inventory to the HCA Commander or Command Surgeon and provide a copy to the IMSA/MEDLOG Bn/USAMMCE.
(3) Corrective actions to clear all discrepancies before the next inventory. The HCA Commander or Command Surgeon will report all irreconcilable shortages immediately to the local Provost Marshal for investigation to establish a basis for subsequent action.

3-38. SHIPMENT OF CONTROLLED MEDICAL ITEMS

a. The custodian of controlled medical items will select and prepare the controlled items for shipment. Items will be held in secure facilities until transferred to a carrier.

b. Separate shipping documents and packing lists will cover the shipments. Both should clearly indicate quantities shipped. For individual controlled substances, the shipping documents and packing lists should indicate "medical supplies." Obliterate all markings from external containers and remark with the term "medical supplies."

c. Ship the controlled medical items by registered parcel post (request return receipt) when securely packed for safe transit. All shipments must comply with weight and size limitations of the U.S. Postal Service.

d. A customs declaration tag is not required for shipments that have been addressed to a military organization by title (for example, Commander or Supply Officer) at U.S. military Post Offices OCONUS.

e. If controlled medical items cannot be shipped by parcel post because of weight or size restrictions, refer to *AR 55-355/NAVSUPINST 4600.70/ AFR 75-2/ MCO P4600.14B/DLAR 4500.3*.

f. Shipping documents for controlled medical items sent to or from any OCONUS destination will be marked as indicated in the following statement:

"SPECIAL CARGO - PLACE IN CUSTODY OF CARGO SECURITY OFFICER."

3-39. CONTROLLING NEEDLES AND SYRINGES

The HCA activities will maintain adequate control of needles to prevent misuse or access by unauthorized persons. The storage and security of needles are outlined in *AR 190-51*. Disposable syringes that do not have needles are exempt from this requirement.

3-40. OTHER ITEMS REQUIRING CONTROL

a. The MSO will keep a record of controlled medical items on a DA Form 3862 (Controlled Substances Stock Record). Units with a resupply mission will use DA Form 1296. A disinterested officer, appointed by the commander, will inventory and inspect the items monthly.

b. Where unit storage security is inadequate and operational and readiness is not unduly compromised, store controlled medical item components at the lowest supply level having adequate storage facilities. The supporting IMSA/MEDLOG Bn/USAMMCE may also store these items; however, using unit personnel will inventory the stocks monthly.

(1) When stored at an IMSA/MEDLOG Bn/USAMMCE, commingled with IMSA/MEDLOG Bn/USAMMCE stocks, controlled medical item components are:

(a) Considered contingency stocks.

(b) Assigned a unique project code, if applicable to automated systems.

(c) Inventoried by the IMSA/MEDLOG Bn/USAMMCE.

(2) When stored at an IMSA/MEDLOG Bn/USAMMCE in a container secured by the owning unit, the owning unit will inventory and survey the items.

(3) A Memorandum of Agreement (MOA) between the MTOE medical unit and the IMSA/MEDLOG Bn/USAMMCE will be established to ensure issue procedures of stored controlled medical item components are available when required for mission accomplishment.

3-41. REGULATED MEDICAL ITEMS

a. Medical materiel is a regulated medical item when one or more of the following conditions apply:

(1) The item affects the readiness of MTOE units.

(2) A centrally DA-managed funding program funds the item.

(3) Distribution and redistribution is controlled due to:

(a) Critical supply availability

(b) Unique physical properties of the item and/or its specialized use

b. For management and requisition processing purposes, identify regulated medical items as one of the following types:

(1) Procurement appropriation-funded medical equipment for MTOE units

(2) Medical Assemblages (see SB 8-75 series)

(3) Other specialized medical items whose distribution is centrally managed and controlled.

c. The AMDF or FEDLOG identifies regulated medical items as AAC "A".

d. Certain medical items may receive a temporary regulated medical item designation due to special distribution requirements. The USAMMA messages will announce the temporary regulated medical item status. These messages are available on the USAMMA website at: **www.usamma.army.mil**

e. Basic requisitioning procedures for all regulated medical items are as follows:

(1) Prepare requisitions per *AR 725-50*. Each year one issue of the *SB 8-75 series* will also describe the prescribed military standard requisitioning and issue procedures format. This issue will also contain any current, updated information on requisitioning procedures.

(2) Use "AOE" or "A05" as the DIC for all requisitions.

(3) Use "B69" as the routing identifier code for all requisitions to the USAMMA.

(4) Use the requesting unit's DODAAC in the requisition document number. If the supporting automated system requires the DODAAC be used in the document number, then identify the requesting unit in the supplementary address field.

(5) Place the original requester's complete document number and the in-the-clear name of the unit in the exception data accompanying the requisition.

(6) Transmit the requisition to the USAMMA by message with an information copy to the appropriate MACOM. Mail may be used as an alternative submission method. Do not submit requests for regulated medical items through the DAAS.

(7) Exception data is required for any requisitions for the following MCDM items:

- Doxycycline BT of 30s;
- Ciprofloxacin BT. of 30; and
- Pyridostigmine Bromide Tablets (PBT)

The required exception data is:

(a) Unit Identification Code (UIC); and

(b) Reason for the order, i.e., Individual Service Member initial issue requirement for deployment, component of MES - need Line Item Number s (LIN) of the set and quantity on-hand, other missions). Please refer to *SB 8-75-S7*, dated 2006.

(c) Submit to MCMR-MMO-PM, fax COMM 301-619-4404 or DSN 343-4404.

f. Special requisition procedures are as follows:

(1) Submit requisitions for OPA funded MTOE equipment as follows:

(a) Enter code "GA" as the fund code.

(b) Enter a type requirement code (see *AR 725-50*).

(c) Identify the MES that the regulated medical item is a component of or related to in the exception data accompanying the requisition (for example, MES that comprises a unit's primary equipment authorization).

(d) Format and transmit ARNG requisitions per the *SB 8-75 series*

(2) Submit requisitions for MESs as follows:

(a) If funded by the requester, the requester will commit the appropriate OMA funds with stock fund code obligation from the requisitioner (for example, SSA).

(b) Enter a type requirement code (see *AR 725-50*).

(c) Include the following statement as exception data to USAR and ARNG requisitions: "Unit is authorized MESs by MTOE (provide MTOE number) and has capability to store and maintain the MESs."

(d) Include the current authorization, UIC, and reason for shortage, initial issue, or replacement as exception data with each requisition.

(3) Requisition other regulated medical items as follows:

(a) The requester will fund the items if a USAMMA message identifies the item for a special or centrally funded program.

(b) The USAMMA will identify special exception data in a message series.

g. Requisitions for MCDM require exception data as listed in e. above and in *SB 8-75-S7,* To route requisitions for regulated medical items (AAC "A"), follow these procedures:

(1) For CONUS and OCONUS active duty units:

(a) The requester submits requisitions to the supporting IMSA/MEDLOG Bn/USAMMCE.

(b) The IMSA/MEDLOG Bn/USAMMCE sends the requisition to the USAMMA with an information copy to the requester's MACOM.

(c) The USAMMA validates the requirement with the appropriate MACOM as required.

(2) For USAR units:

(a) The requester submits a requisition through normal channels, in accordance with supporting command's procedures.

(b) The Major Subordinate Command (MSC) validates the requirement and assigns funds for OMA Reserve-funded items.

(c) The MSC forwards the requisitions to the supporting IMSA/MEDLOG Bn/USAMMCE.

(d) The IMSA/MEDLOG Bn/USAMMCE sends the requisition to the USAMMA for validation.

(3) For ARNG units:

(a) The requester submits a requisition to the USPFO.

(b) The USPFO assigns funds for operations and maintenance, NG-funded items and forwards the requisition with a transmittal letter through

Chief, National Guard Bureau ATTN: NGB-ARS 111 South George Mason Drive Arlington VA 22204-1382	To	Commander, USAMMA ATTN: MCMR-MMO-PM Fort Detrick MD 21702-5001

h. The USAMMA procures and issues all regulated medical items.

i. The supplier will provide the shipping status to the USAMMA and requesting unit *per AR 725-50*. Requesting units should submit follow-ups to the USAMMA.

3-42. PRECIOUS METALS RECOVERY PROGRAM

a. The Precious Metals Recovery Program (PMRP) provides DoD activities with guidance and the requirements for the identification, accumulation, recovery, and refinement of precious metals from excess and surplus end item, scrap, hypo-solution, and other PMBS. The program's purpose is three-fold:

(1) To promote the economic recovery of precious metals.

(2) To use recovered precious metals for internal DoD purposes or as Government Furnished Materiel.

(3) To protect the environment from excess discharges of silver concentrations in waste effluent.

b. The PMRP recovers gold, silver, and platinum family metals from excess and surplus property. The platinum family includes platinum, palladium, iridium, rhodium, osmium, and ruthenium.

c. The DLA is responsible for administering and monitoring the PMRP. DoD activities are responsible for program participation, to include the identification and the transfer of PMBS to the local Defense Reutilization and Marketing Office (DRMO). The DRMO accumulates and ships PMBS to a recovery contractor for refining. The recovery contractor deposits the refined precious metal to the Defense Industrial Supply Center (DISC) account. The DISC issues the precious metal as government furnished material to government contractors at a minimal charge in return for an equal reduction in cost for manufacture of government products that use these metals.

d. The U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) will insure that MTFs have procedures in place to properly characterize wastes from photo processing (x-ray).

e. The RMC and Command Surgeons will:

(1) Develop a program for the recovery of precious metals by following the guidance in *DoD 4160.21-M*.

(2) Establish program procedures either as a supplement to *SB 8-75-11* or as a separate command regulation for:

(a) Recovering PMBS
(b) Safeguarding recovery equipment and reclaimed scrap
(c) Training using activity personnel
(d) Turn-in of scrap to collection points
(e) Control of the program
(f) Testing of equipment for effectiveness and safety
(g) Disposal of PMBS
(h) Documenting the quantities recovered and their disposition.

(3) Establish central collection points at HCAs. These activities will accumulate, report, and ship precious metals and PMBS.

f. Each HCA commander will appoint a Precious Metals Coordinator (PMC) to manage an internal PMRP. At the generator level, at least one Precious Metals Monitor (PMM) will be appointed to ensure the recovery of PMBS within the assigned area of responsibility.

g. Each PMM will assign a document number for each turn in of PMBS, based on local HCA procedures.

h. All high purity gold and silver PMBS will be managed as controlled substances. DA Form 3949 (Controlled Substances Record) will be maintained at the user level to record receipt, issues, and turn-in of PMBS except for fixer solution and scrap film.

i. Each MEDDAC/MEDCEN PMC will maintain a DA Form 1296 for each precious metal and PMBS item.

j. The recovery of silver from spent x-ray film developing solutions is an important element of the program; in some cases the costs to comply with applicable environmental regulations can make recovering the silver uneconomical. Activities may use commercial sources for silver recovery as long as these commercial sources comply with applicable Federal, State, and local environmental laws and regulations.

k. Spent fixer solution should not be discharged to the sanitary sewer system, even after silver recovery processing, unless the silver content of the effluent is less than limits prescribed by the Federal, State, and local laws.

3-43. RADIOACTIVE MATERIEL

a. Commanders of HCAs using radioactive materiel will designate, in writing, a radiation safety officer (See *AR 40-14*/*DLAR 1000.28* and *TB MED 525*). This officer will:

(1) Control, receive, issue, store, and dispose of radioactive materiel

(2) Comply with Nuclear Regulatory Commission licenses and Army authorizations

(3) Advise local fire authorities of the type, quantity, and locations of concentrations of radioactive materiel that may pose a hazard in an emergency.

b. The HCA will acquire and control radioactive materiel per *TB MED 525*, *AR 385-11*, *10 Code of Federal Regulations (CFR)*, and the conditions of the activity's NRC license or Department of the Army Radiation Authorization.

3-44. HAZARDOUS MATERIAL/WASTE MANAGEMENT PROGRAM

a. The AMEDD develops and procures hazardous material in such a way that minimizes potential hazards to public health and the environment. The applicable functions included in this development and procurement are:

(1) Research
(2) Development
(3) Testing
(4) Production
(5) Handling
(6) Use
(7) Storage
(8) Transportation
(9) Disposal

b. The *AR 200-1* addresses responsibilities and procedures of the hazardous material/waste management program. The *DoD 4160.21-M*, *AR 420-49,* and *AR 40-5* and *SB 8-75 series* define responsibilities and procedures for managing hazardous

materials and waste. The Military Item Disposition Instructions (MIDI) and Military Environmental Information Source (MEIS) contain technical guidance for disposal of small, unused quantities of medical materiel, hazardous waste, non-regulated special waste, Regulated Medical Waste (RMW), and excess medical materiel. To obtain this guidance, contact

Commander, USACHPPM
ATTN: MCHB-TS-EHM
5158 Blackhawk Road
Aberdeen Proving Ground MD 21010-5403

If any of these publications contain conflicting guidelines, follow the most stringent.

c. The unit's radiation safety officer will control and manage the disposition of all radioactive waste.

d. The HCA commanders must dispose of non-Resource Conservation and Recovery Act medical, dental, and veterinary supplies, hazardous waste, non-regulated special waste, and RMW (See *ARs 200-1* and *40-5* and *SB 8-75 series*). Commanders must dispose of all materiel and wastes in a manner that:

(1) Protects human health and the environment.

(2) Complies with appropriate Federal, state, local, U.S. Army, and host-nation regulations.

e. The HCA commanders will implement the pollution prevention program to the maximum extent possible. The Army's goal is to reduce the quantity or volume and toxicity of pollution whenever economically possible. The pollution prevention program's goals are to minimize the use of disposable items; expand the use of reusable materials and returnable containers; promote the use of minimum packaging; and recycle to the maximum extent practicable. Items that reduce or eliminate pollution will be used or introduced into the system whenever economically possible.

f. Commanders must implement the hazard communication program per *29 CFR 1910.1200* and DoD Instruction (*DoDI) 6050.5*. The HCA will provide and document appropriate training to persons who manage, use, store, transport, and/or ultimately handle or come into contact with hazardous materiel or waste.

g. The management of hazardous material and waste and RMW will include the following:

(1) Separation of hazardous waste and RMW from the general waste stream at the point of generation. RMW mixed with general wastes must be disposed of as RMW.

(2) Recommendation and development of local segregation policies by the infection control committee to the commander per *AR 40-5* and Federal, state, and local regulations. Generally, RMW can include:

(a) Cultures and stocks of infectious agents
(b) Associated biological, pathological waste
(c) Blood wastes
(d) All used and unused sharps
(e) Animal waste
(f) Infectious waste

(3) Training of all employees on segregating hazardous waste and RMW.

(4) Maintaining adequate control of all hazardous waste and RMW to prevent unauthorized access.

(5) Collecting, storing, transporting, and disposing of hazardous waste and RMW (See *AR 40-5*).

(6) Tracking all hazardous waste and RMW from collection to final destination.

3-45. ACCOUNTING FOR IMPLANTABLE MEDICAL DEVICES

a. Implantable medical devices, such as pacemakers, drug infusion pumps, insulin delivery systems, and similar items, will be requisitioned by the using clinical department from the IMSA/MEDLOG Bn/USAMMCE (United States Army Medical Materiel Center Europe).

b. DHP funds will be charged for these items regardless of cost. The items will not be accounted for on the activity property book.

c. A record of the requisition, receipt, and implant of the devices will be maintained by the clinical department requesting the item. This record should be in sufficient detail to meet audit requirements and notification of the patient in case of medical device alert or recall by the manufacturer. The patient's medical record must also be annotated with the appropriate data. Essential elements of information include the patient's name; Social Security Number; manufacturer, make, model, and serial number of the device; requisition number; and date implanted.

d. The reporting and tracking requirements of *21 CFR* applies.

3-46. SHIPMENT DISCREPANCIES

a. When shipments received by the IMSA/MEDLOG Bn/USAMMCE are deficient in quantity or condition, the Accountable Officer (or alternate) will inspect the shipment. See these publications:

AR 55-38
NAVSUPINST 4610.33
AFR 75-18
MCO P4610.19
Defense Logistics Agency Regulation (DLAR) 4500.15
AR 710-2 and *AR 735-11-2*
DLAR 4140.55
Secretary of the Navy Instruction (SECNAVINST) 4355.18
AFR 40-54

b. The manufacturers are only obligated to provide MSDS with the initial shipment of hazardous materials and with the first shipment after an MSDS has been updated. If the MSDS does not accompany a shipment of hazardous materials, the activity must obtain an MSDS from the manufacturer as soon as possible.

c. The PV deficiencies in quantity or condition will be handled per procedures established in the PV statement of work.

d. The IMSA/MEDLOG Bn/USAMMCE will adjust and report any discrepancies. The discrepancy reports most commonly used for medical materiel are:

(1) Standard Form (SF) 361 (Transportation Discrepancy Report; Use this report to report damage or loss attributable to a carrier or improper carrier facilities,

and is to be prepared in coordination with the installation transportation office. See these publications:

AR 55-38
NAVSUPINST 4610.33
AFR 75-18
MCO P4610.19
DLAR 4500.15

(2) The SF 364 [Report of Discrepancy (ROD)]: Use this form to report supply and packaging discrepancies that are obviously the responsibility of the supplier or supporting supply activity (see these publications):

AR 735-11-2
DLAR 4140.55
SECNAVINST 4355.18
AFR 40-54 and AR 12-12
DLAR 4140.60
SECNAVINST 4355.17A
AFR 67-7

(3) Serious Incident Report: This is used to report theft or suspected theft on high-dollar-value items or controlled substances (see these publications:

AR 735-11-2
DLAR 4140.55
SECNAVINST 4355.18
AFR 40-54
AR 190-40

e. Distribute copies per the governing regulation.

f. The IMSA/MEDLOG Bn/USAMMCE may request assistance when discrepancies cannot be satisfactorily resolved from:

(1) DSCP,
(2) DLA customer assistance teams, or
(3) The USAMMA.

g. The MTOE medical supply operations will report supply discrepancies to the supporting IMSA/MEDLOG Bn/USAMMCE per local procedures.

3-47. UNSATISFACTORY LOCAL PURCHASE SUPPORT

Reports of local purchase support that adversely affect the health care mission and cannot be resolved within channels should be forwarded through USAMEDCOM to OTSG. The reports should contain:

a. A point of contact (POC)
b. A statement of the problem
c. Actions taken to resolve the problem
d. Applicable documentation.

3-48. EXCESS EQUIPMENT MANAGEMENT PROGRAM

a. The USAMMA manages the Excess Equipment Management Program (EEMP) for the USAMEDCOM. The goals of the EEMP are to:

(1) Ensure timely and cost effective identification of excess equipment.

(2) Eliminate excess medical materiel: Any materiel on-hand and no longer required to satisfy any mission requirement should be considered as excess. Excess materiel must be:

(a) Consumables in condition code "A"

(b) Equipment that is serviceable or economically repairable

(3) Manage excess materiel as a displaced resource that consumes resources and detracts from primary mission accomplishment.

(4) Aggressively report and advertise excess materiel to:

(a) Enhance asset redistribution and use

(b) Reduce disposal requirements

b. The EEMP applies to ARNG, USAR, and all AMEDD activities.

3-49. REPORTABLE AND NONREPORTABLE EXCESS MATERIEL

a. The IMSA/MEDLOG Bn/USAMMCE will report excess materiel through the source of supply. To determine what is excess, the reporting activity must compare current, on-hand materiel with active acquisitions and requirements. The TAMMIS/DMLSS is an automated tool for assisting in this process and recommends materiel to be considered as excess. TDA activities will utilize DMLSS for excess accountability and reporting.

(1) The USAMMA must approve all lateral transfers of equipment greater than the MEDCASE high dollar threshold.

(2) Equipment less than the MEDCASE high-dollar threshold can be laterally transferred without the USAMMA's approval.

b. Reportable non-expendable or expendable excess materiel can fall into one of the following categories:

(1) Non-expendable:

(a) Medical equipment with a line item value that is consistent with current MEDCASE high dollar value threshold.

(b) Serviceable nonstandard medical equipment with a line item dollar value of $2,500 or above.

(c) Regulated medical items identified with AAC "A" in the AMDF or FEDLOG. This includes MESs listed in the SB 8-75 series or critical aeromedical evacuation equipment, such as patient monitors, defibrillators, pulse oximeters, and suction pressure apparatuses.

(d) Medical materiel with recoverability codes "D", "K", or "L" regardless of the condition code.

(e) Equipment possessing electrical characteristics unique to a command (220 volts, 50 hertz (HZ)).

(f) Equipment (audiovisual, radioactive, or telecommunications) requiring special disposal procedures.

(g) Automated Data Processing Equipment.

(2) Expendable and durable excess medical materiel:

(a) Standard or nonstandard with a line item value of $500 or more.

(b) Repair parts with a purchase cost of $100 or more.

(c) Compressed gas cylinders (see *AR 700-68/DLAR 4145.25/ NAVSUPINST 4440.128C/MCO 10330.2C/AFR 67-12*).

(d) Aeromedical Evacuation materiel: This materiel could include litters and mattresses, pillows, blankets, litter straps, and patient restraints.

c. The IMSA/MEDLOG Bn/USAMMCE must dispose of or destroy excess materiel not meeting the criteria above. Destruction or disposal can be completed through the use of:

(1) Government awarded pharmaceutical return contracts.
(2) Contracts with other DoD medical facilities.
(3) Contracts with DVA.
(4) Other Government Agencies (National Institute of Health and Public Health Services).
(5) Government awarded disposal contracts.
(6) Supporting Defense Reutilization and Marketing Office (DRMO).

d. The IMSA/MEDLOG Bn/USAMMCE will transfer the excess materiel at no cost to the receiving activity. The shipping cost will be borne by the losing activity.

e. Non-reportable excess materiel follows:

(1) Non-expendable:

(a) Uneconomically repairable equipment with no recoverability code
(b) Equipment where the manufacturer no longer exists
(c) Equipment that lacks a model or part number
(d) Equipment that is no longer made or has exceeded its life expectancy (*TB MED 7* or manufacturer literature)
(e) Equipment with a condition code “F”

(2) Expendable and durable:

(a) Materiel with an expiration date of 3 months or less
(b) Refrigerated and freezer items
(c) Veterinary items.

(3) Miscellaneous materiel:

(a) Medical books and scientific journals (see *AR 40-2*): In OCONUS, MTOE units should turn in obsolete, unserviceable excess medical books to the supporting medical facilities with the appropriate MACOM/Command Surgeon approval. Volumes containing official AMEDD history will be sent to:

Director, Center of Military History
ATTN: DAHM-HM
Washington DC 20314-0200

(b) Radioactive materiel (see *AR 385-11*)
(c) Flags and Guidons (see *AR 840-10*).

3-50. REPORTING EXCESS

a. The IMSA/MEDLOG Bn/USAMMCE must report any reportable excess materiel monthly in the form of a manual or automated report. The *AR 725-50* prescribes the codes for the automated report.

b. The RMC/MSCs will establish manual reporting procedures for non-expendable and expendable excess materiel within their command. The USAMMA will establish manual reporting procedures for the USARC, ARNG, CONUS, and OCONUS activities not supported by an RMC.

(1) Examples of manual reporting procedures for non-expendable materiel follow:

(a) For regulated medical items to include MES, include the set control code, estimated dollar value or shortages, and a statement of the set's condition. Aeromedical evacuation materiel and equipment is reported per procedures in *AR 40-538*/ Department of the *Navy Bureau of Medicine and Surgery Instruction (BUMEDINST) 6700.2B/AFR 167-5*.

(b) For equipment requiring special disposal procedures, report through the commodities NICP or the responsible governing agency.

(2) The RMC/MSCs will establish manual reporting procedures for expendable materiel. One category of expendable materiel requiring specific reporting is compressed gas cylinders. These cylinders should be reported for turn-in by using the NSN of an unserviceable (empty) cylinder.

c. The AMEDD TDA activities will use DMLSS ETM to report non-expendable equipment. Activities using DMLSS ETM will report equipment excess in accordance with the procedures outlined in Chapter 5, Para 5-9b. The MTOE units will follow guidance from either their MACOM or the USAMMA when using the Standard Property Book System - Redesign. The MTOE can only generate excess non-expendable equipment through a change of the MTOE authorization document, fielding plans, and/or deployment/contingency.

(1) The Property Book Officer (PBO), when using DMLSS ETM, will establish excess property records for reportable excess equipment. The USAMMA coordinates the report of excess equipment worldwide for redistribution.

(2) Automation equipment requires specific automated reporting procedures (see *AR 25-1*). The AMEDD activities will establish an Automation Resources Management Systems account with the Defense Automation Resources Management Program to report excess automation equipment per *DoD 7950.1M*.

d. The RMC/MSC will require the following information on manual or automated excess reports:

(1) Nomenclature, make, and model number
(2) NSN, if assigned
(3) Date placed in service
(4) Quantity
(5) Line item dollar value
(6) Condition code
(7) Local point of contact

3-51. QUARTERLY EXCESS REPORT TO THE USAMMA

The RMC/MSCs will report the excess equipment/materiel redistributed through the EEMP to the USAMMA on a quarterly basis. This consolidated excess report is due no later than the 20th of January, April, July, and October of each year. Figure 3-1 shows the proper format for the RMC/MSC consolidated excess report.

QUARTERLY REDISTRIBUTED EXCESS EQUIPMENT/MATERIEL REPORT	
Date Prepared _____	
Value of reported excess equipment	$_____
Value of redistributed excess equipment	$_____
Distribution of excess equipment/materiel:	$_____
Within the RMC/MSC	$_____
Outside the RMC/MSC	$_____
Through DRMO to Other Activities	$_____
To Department of Labor, state, or local facilities	$_____
To USAR or ARNG	$_____
Value of redistributed excess equipment equal to or greater than current MEDCASE high dollar value	$_____
Value of redistributed excess equipment not advertised	$_____
Value of excess equipment turned in to DRMO not listed on excess report	$_____
Value of excess equipment turned in to DRMO and listed on excess report	$_____
Total dollar amount of excess equipment turned in to DRMO	$_____

Figure 3-1. Format of the Quarterly Distributed Excess Equipment/Materiel Report

3-52. ADVERTISING EXCESS

a. The RMC/MSC will establish advertising procedures within their health care boundaries for excess equipment and materiel. The RMC/MSC will consolidate and screen all excess reports from their supporting activities. The RMC/MSC will satisfy any requirement within the command during the screening process.

b. The RMC/MSCs will advertise excess materiel distributed throughout the command for no longer than 15 calendar days. If an organization outside of the RMC/MSC command boundaries requests an item on the advertised excess list, the RMC/MSC must request an exception to the redistribution priority scheme from the USAMMA. Lateral transfer procedures will apply (see *AR 710-2*). After the 15-day period, RMC/MSC will submit the consolidated excess materiel report to the USAMMA.

c. The USAMMA will consolidate the excess reports from the RMC/MSCs. The consolidated excess report will be distributed worldwide for advertisement purposes via message format and the USAMMA home page. After the 30-day advertisement period, the IMSA/MEDLOG Bn/USAMMCE can process the unclaimed, unwanted equipment or materiel through the DRMO.

3-53. REDISTRIBUTING EXCESS

a. The USAMMA manages excess equipment/materiel redistribution Army wide. The USAMMA will follow the sequence below to redistribute assets:

- USAMEDCOM
- Other MACOMs
- DoD activities
- Other Federal agencies
- Local redevelopment authority
- DRMO

b. The **losing** activity will:

(1) Notify the gaining activity of the transfer arrangements.

(2) Complete all necessary documentation per *AR 710-2* to facilitate the transfer.

(3) Ensure that appropriate maintenance personnel technically inspect the equipment to be transferred. A DA Form 2407 will be completed and sent with the equipment.

(4) Ensure equipment is properly packed, crated and shipped per *AR 746-1*. The following must accompany the shipped equipment:

(a) Supporting supplies (expendables) and accessories
(b) Repair parts and listing
(c) Operator and technical manuals and manufacturer literature
(d) The maintenance history/records, to include the DA Form 2407.

(5) Receive a signed copy of the completed lateral transfer document.

(6) Notify the Resource Management Office to have the LIN deleted from the TDA, if applicable.

(7) Delete the property record.

(8) Maintain the lateral transfer documentation for two years.

c. The **gaining** activity will:

(1) Notify the USAMMA of the requirement for excess equipment/materiel.

(2) Arrange the transfer with losing activity's point of contact.

(3) Upon receipt of the excess equipment:

(a) Inspect transferred equipment for damage and resolve discrepancies with the losing activity. If improper packaging is suspected, notify the USAMMA.

(b) Sign and return a copy of the lateral transfer document to the losing activity within 3 days.

(4) Establish a property book record within 3 days of receipt.

(5) Submit DA Form 2028 (Recommended Changes to Publications and Blank Forms) to their Resource Management Office to add the LIN to the TDA, if applicable.

(6) Maintain accountability for the transferred equipment throughout its life cycle.

3-54. DISPOSAL THROUGH DRMO

a. The IMSA/MEDLOG Bn/USAMMCE will manage medical materiel turn in from installation and area activities to the DRMO. Other medical supply operations will turn-in materiel through the IMSA/MEDLOG Bn/USAMMCE to the DRMO. The IMSA/MEDLOG Bns/USAMMCE will establish local procedures to minimize redundant storage and

handling of turn-in materiel. When conditions permit, PBOs may establish equipment turn-in procedures directly to the DRMO, without physically moving the items through the IMSA/MEDLOG Bn/USAMMCE storage facility. The IMSA/MEDLOG Bn/USAMMCE must approve these procedures. The IMSA/MEDLOG Bn/USAMMCE should process and approve documentation for materiel turn in with condition codes that indicate a continued value to the government. This materiel will move directly from the unit to the DRMO. The PBO may turn in medical equipment with condition codes "H" and "S" directly to the DRMO. The IMSA/MEDLOG Bn/USAMMCE will:

(1) Report the materiel turn-in to the DRMO

(2) Provide technical assistance to the DRMO as required

b. The DRMO will process materiel requiring special handling as follows:

(1) Medical materiel that is unserviceable, uneconomically repairable, or otherwise unsuitable for use will be marked

"**CONDEMNED - NOT FOR PATIENT CARE**"

Medical materiel determined to be hazardous, where the hazardous condition cannot be repaired, will be clearly marked and tagged to state the nature of the hazard. This marking will render the materiel unusable for its intended purpose before turn-in.

(2) Serviceable stock/materiel with lot or batch numbers and an acquisition cost of $500 or more per lot or batch number will be processed according to *DoD 4160.21-M*. Examples are as follows:

(a) The FSC 6505 - Drugs, Biologicals and Reagents (excluding filled gas cylinders) will **not** be disposed through the DRMO. The IMSA/MEDLOG Bn/USAMMCE may request DRMO assistance in reutilization or donation of non-controlled, non-hazardous drugs following the procedures outlined in *DoD 4160.21-M*.

(b) The FSC 6510 - Surgical Dressing Materiel

(c) The FSC 6515 - Sutures Only.

(3) Compressed gas cylinders will be prepared for turn-in as prescribed in *AR 700-68/DLAR 4145.25/NAVSUPINST 4440.128C/MCO 10330.2C/ AFR 67-12*, prior to transfer to the DRMO. As an alternative, IMSA/MEDLOG Bn/USAMMCE may contract for gas cylinder disposal with vendors who are licensed in accordance with Federal, State, and local laws.

(4) The IMSA/MEDLOG Bn/USAMMCE will retain physical custody of standard and nonstandard pilferable items listed below until disposition instructions are provided by the DRMO.

- Medical items containing recoverable amounts of precious metals. The IMSA/MEDLOG Bn/USAMMCE should precisely mark the items so that disposal personnel may take special handling precautions (see *DoD 4160.21-M*). Standard pilferable items are identified as Note "M" in the FSC and as Recoverability Code "A" in the AMDF or FEDLOG.
- Standard precious metals. These are identified as Note "R" in the Federal Supply Catalog.
- Tax-free alcohol and serviceable hypodermic needles and syringes: Clearly identify before transferring to the DRMO to ensure special processing (see *DoD 4160.21-M).*

(5) Unexposed medical and dental film, which is not expired, will be disposed through the precious metals recovery program.

c. The MACOM/Command Surgeons will establish property disposal policies and procedures based on local command and DRMO procedures and the above guidelines.

d. Medical materiel eligible for disposal may be designated for training with the HCA commander's approval. Items approved for training use will be clearly identified with a "FOR TRAINING ONLY" label to prevent accidental use on actual patients. Medical personnel must ensure that approved training materiel has been properly disposed after the training mission. Expired drugs, biologicals, intravenous solutions, and reagents may be used for training purposes.

e. To prevent needed medical materiel from being transferred or disposed prematurely, obtain professional guidance from outside Logistics Division, e.g., pharmacy, pathology/laboratory, radiology departments, as to the materiel's further or potential use.

3-55. DISPOSITION AND REPLACEMENT CREDITS FOR EXPIRED DRUGS, BIOLOGICALS, AND REAGENTS

a. The IMSA/MEDLOG Bn/USAMMCE can use pharmaceutical returns contracts for expired drugs and biologicals. These contracts are with companies who remove expired drugs and biologicals from an activity and obtain credits from pharmaceutical manufacturers for these unserviceable products. The companies then return the credits to the PV which the activity can use for the procurement of new pharmaceuticals. For pharmaceuticals where no credits can be obtained, the company must destroy the unserviceable materiel per Federal, state, and local laws.

b. The IMSA/MEDLOG Bn/USAMMCE will use existing AMEDD-wide pharmaceutical returns contracts. No facility will enter into a local contract for pharmaceutical returns (even if it is more advantageous) without prior coordination with the USAMEDCOM, MCLO-O. The supporting contracting office will award local contracts per procedures in the FAR.

c. The pharmacy service of an HCA can dispose of expired drugs, biologicals, and reagents in one of two ways.

(1) Turn-in expired stocks to the supporting IMSA/MEDLOG Bn/USAMMCE.

(2) Use a pharmaceutical returns contract.

d. Some pharmaceuticals contain constituents that result in products being classified as hazardous waste upon expiration. All activities will determine the appropriate disposal code for the expired products and will dispose of products identified as hazardous through the installation approved hazardous waste disposal procedures.

3-56. CUSTOM ARMY REPORTING SYSTEM (CARS)

a. The AMEDD is required by DoD to significantly reduce non-productive expenses (interest penalties) for cost savings across the AMEDD. The U.S. Army MEDCOM Chief of Staff will monitor interest payments for reductions by RMC/MSC during quarterly Command Management Reviews.

b. Delinquent receiving reports over 30 days are incurring costly interest penalties to MEDCOM. The Assistant Chief of Staff for Logistics (ACSLOG) goal is to ensure those Personnel who are responsible for completing receiving reports provide them to

Vendor Pay Offices within five working days of delivery or completion of services in accordance with DFAS-IN 37-090102F. Meeting this goal can be best accomplished through electronic submission of invoices and receiving reports in WAWF–Receipt and Acceptance (WAWF-RA).

c. Assistant Chief of Staff for Resource Management (ACSRM), Finance and Accounting Office (F&AO) developed a web-based program that allows activities to monitor contract payments. The CARS program tracks financial transactions within the DFAS. The program extracts data almost daily from the DFAS-SA Commercial Accounting and Payment System Worldwide (CAPS-W), which provides payment status on contracts.

d. Logistics Divisions will monitor their contracts using the CARS tool as often as required or at least monthly to prevent aged invoices from accumulating interest penalties. All Invoices 15 days and older are of particular concerned; these require immediate attention and must be worked. Contract payment information can be reviewed by installation name, DODAAC and Allotment Serial Number (ASN).

e. The CARS report is located on the MEDCOM ACSRM website at http://www.medcomrm.amedd.army.mil. The instructions below will assist in assessing the report.

(1) At the website, select "Finance & Accounting" tab from the menu on the left and select Home Page.

(2) From the menu select Vendor Pay/WAWF (Wide Area Work Flow).

(3) Click on "CARS Report" from the drop-down menu, select "Save", and save the file under your "Desktop". When prompted close the dialog box and exit out of the website.

(4) on your "Desktop" click on the cars.exe icon and select Run in the dialog box. Click unzip to save database files to default location C:\CARS, select "OK" and close to exit zip program.

(5) Data can be retrieved in several ways. The recommended procedures for data retrieval is to access "My Computer", go to the "C" drive and open the CARS folder and double-click the **CarsNG.MDE** file. The file may also be retrieved by opening the Microsoft ACCESS CARS Program, double-click on "more files" and select the C drive in the "look-in" window. Double-click the CARS folder then open the **CarsNG.MDE** file to execute the program.

(6) The "main menu" screen will open to view "Invoices without Rec. Reports". Six icons are available; choose the first icon (Invoice Details). Go to the "Filter By" dialog box and click on "DODAAC" to find a specific activity. Choose the DODAAC from the drop down menu and select "Run that Puppy" to run the query. Review the report for the Element of Resources (EOR) 26 and 31 (supplies and equipment) to determine current billing status at DFAS-SA for any pending receiving reports or outstanding invoices.

f. Logistics Division reviewing/submitting receiving reports must pay close attention to the received date, projected interest amount, and the EOR column. The received date column is the date DFAS received the vendor's invoice and alerts the activity to submit their receiving report to DFAS. The projected interest amount column represents the projected interest amount payable on the **Amount Clin** column. Interest penalties begin to accrue when invoices are overdue 30-days.

3-57. WIDE AREA WORKFLOW – RECEIPTS AND ACCEPTANCE

a. All MEDCOM activities are required to utilize the DoD e-commerce initiative, WAWF-RA, for contractual goods and services not purchased by credit card or convenience check. This initiative, which uses existing systems compliant with the Prompt Payment Act, will decrease interest penalties. The DoD paperless contracting initiative was created in response to the DoD Comptroller Management Reform Memorandum #2, 21 May 1997, "Moving to a Paper-free Contracting Process by January 1, 2000".

b. The WAWF-RA enables vendors and government officials to electronically access and process the documentation to generate payment for goods and services. This is done by utilizing contracts, invoices and receiving reports within a web-based system.

c. The WAWF-RA offers important benefits to the Logistics, Resource Management and Finance communities.

(1) Users have global access to basic and supporting documents to reduce the need for re-keying, improve accuracy, and provide real-time processing with access to documents status. Users will no longer handwrite information, manually fax, or mail forms to DFAS.

(2) Users have instant visibility of contracts, thus eliminating the 5-day waiting period required by Contracting to forward paper documents and complete receiving reports. The DFAS will have all documentation required to pay vendors, which minimizes late interest penalties.

d. The Chief of Logistics' key role in WAWF-RA implementation is to ensure receiving reports are promptly signed and submitted electronically IAW DFARS, Appendix F-401 standards. The following guidelines are provided:

(1) Activities will operate only at the assigned basic DODAAC address level. Activities utilizing extensions, Accounting Processing Code (APC), dummy DODAAC, or equivalent will be dropped from WAWF.

(2) Activities receiving goods and services must record the receipts upon delivery or completion of services. Medical Maintenance and Property Management will ensure they receive and process receipts prior to completing technical inspections, calibration, or equipment system tests.

(3) Commercial items and services are not subject to extended acceptance periods. The inspection and acceptance process must be completed within five working days unless contract specifications state otherwise.

(4) Activities will forward receiving reports to the designated DFAS by the fifth working day after acceptance, or as otherwise specified in the contract.

e. Designated Logistics personnel will have their computers configured with WAWF-RA and will then complete the DD Form 2875, System Authorization Access Request Form, available at https://wawf.eb.mil. Submit the DISA form and then self-register at the site. Users are highly encouraged to register with the Electronic Document Access located at http://eda.ogden.disa.mil. This site has valuable information on validating receiving report data, vendor invoice data, contract numbers, and other important data field information.

f. Additional information on WAWF-RA e-commerce is available at https://wawf.eb.mil. The website contains information such as Web-based T raining, Active DODAACs and Roles, Frequently Asked Questions, DD Form 2875, and Policies and Procedures for Submitting Receiving Reports. Utilization of WAWF-RA is a

Command Logistics Review Program item, and activities will be inspected for compliance.

3-58. FUNDING LOCAL PURCHASES

a. DHP funds to finance local purchase of nonstocked medical supplies and equipment items.

b. For equipment funded through MEDCASE, follow procurement procedures in *SB 8-75-MEDCASE*.

3-59. DEFENSE ATTACHÉ MEDICAL SUPPLY SUPPORT

Medical funds available to the command will finance medical supplies issued pursuant to this section unless different billing arrangements have been made.

a. Army personnel serving, as Defense Attachés will use local supply sources or HCA located within a reasonable distance.

b. Major OCONUS Commanders will provide medical supply support upon request if:

(1) The personnel are stationed within the command's area of support.

(2) Communications and transportation permit: Examples of communication and transportation that may be available are State Department pouch, U.S. Military Post Office, or Embassy Post Office.

c. Commander, Walter Reed Army Medical Center (WRAMC):

(1) Provides medical supply support where other sources are not available or where difficulties exist in communications.

(2) Designates the U.S Army Health Clinic, Pentagon, as a supply source. Forward requests for medical supplies through the Army's Assistant Chief of Staff for Intelligence to the U.S. Army Health Clinic, Pentagon. Normally, this supply action is limited to delivery by State Department pouch.

d. Prescription-type items will be dispensed from a pharmacy when a doctor's prescription is presented, per *AR 40-2*.

e. Requests for exception to this procedure will be forwarded to USAMEDCOM, ATTN: MCLO-O, Fort Sam Houston, TX 78234.

3-60. RENOVATION OF HEALTH CARE FACILITIES

a. Obtain equipment and furnishings needed to support Medical Military Construction (MILCON) projects by using MEDCASE procedures (see the 2004 edition of the *SB 8-75-MEDCASE*).

b. Use GSA or commercial interior design services to determine entire furnishing requirements and design decor when renovating entire offices or areas. Fund design services from local operating funds.

3-61. REVIEW PROGRAM FOR DURABLE MEDICAL MATERIEL

a. The HCA Commanders/Command Surgeons establish a formal program for reviewing the consumption of durable medical materiel. This program is designed to:

(1) Improve supply discipline
(2) Emphasize economy
(3) Monitor usage
(4) Focus attention on the prudent use of durable medical materiel.

b. To manage the program, commanders must conduct semi-annual consumption reviews. The review should include the 20 durable medical materiel items where the activity experienced the greatest expenditure during the last year. During the semi-annual review, Commanders should focus attention on increased usage and potential savings for the activity. MTF reviews are to focus on internal hospital consumption of durable items as demands for external customers are beyond their control. Reviews may also be conducted on the remaining durable medical materiel items for which the activity desires control visibility, such as items experiencing a high loss rate. From this review, items will be selected for intensive management and will be managed as stated below (see para c and d). The ARNG activities will conduct annual reviews.

c. Durable medical materiel selected for intensive management may be managed as turn-in and direct exchange items. If an unserviceable item is not available for exchange, the IMSA/MEDLOG Bn/USAMMCE justifying the items can require a letter or form.

d. Usage levels can be established for the organization and for individual customers. Actual usage should be reviewed against established usage levels. Activities will document the review to include corrective action taken or the cause(s) for usage in excess of the established rate. These reviews will be maintained according to *AR 25-400-2*.

e. The MTOE units normally will not establish usage levels unless actively engaged in patient care.

f. Activities will dispose of uneconomically repairable durable medical materiel items through their IMSA/MEDLOG Bn/USAMMCE to the DRMO.

3-62. MEASURING MEDICAL SUPPLY PERFORMANCE

Paragraphs 3-63 through 3-66 provide formulas for computing medical supply performance standards (in addition to those outlined in *AR 710-2*).

3-63. MEASURING CUSTOMER SUPPORT

a. Demand satisfaction: Demand satisfaction represents the percentage of demands for stocked lines satisfied by 100 percent of the total quantity demanded. Used the formula shown below to compute this figure:

(1) Formula:

$$\frac{\text{Valid Demands for Stocked Items 100\% Filled}}{\text{Total Valid Demands for Stocked Items Received}} \times 100 = \text{Demand Satisfaction Stocked Items Satisfied by 100\%}$$

(2) Example: 6,378 of 6,700 total demands for stocked items were 100 percent filled.

$$\frac{6{,}378}{6{,}700} \times 100 = 95\%$$

b. Performance measures are as follows:
(1) Management objective: 95 percent
(2) Management level 90 to 98 percent

c. Indicate the adequacy of RO levels; that is, whether stockage quantities are sufficient considering OST and fluctuating demands.

d. May indicate, if extremely high, that stock levels are too high. If demand satisfaction is low, examine the following items:
(1) Zero-balance rate.
(2) Receipt processing time.
(3) Validity of OST quantities based on recent experience.

3-64. MEASURING INVENTORY MANAGEMENT

a. Zero balance rate (percentage out of stock).

(1) The zero balance rate indicates the percentage of stocked lines that are at zero balance.

- It is an indicator of inventory management effectiveness and is usually related to demand satisfaction.
- It's a measurement that detects inventory management problems earlier than other indicators.
- It gives a rapid general picture of inventory status for RO/level (demand supported) stocked lines at a given point in time.

Potential problems highlighted by this indicator may not have been discovered with other indicators, because the system deficiency may have occurred only recently. For example, if a series of requisitions to a supply source had been lost or if transportation breakdowns had frustrated one or more shipments, this measure would quickly reflect either problem. Only later would these same problems also affect the demand satisfaction. A very low zero balance rate may reflect significant improvements in the resupply system, improvements in transportation support to the IMSA, or a significant downturn in customer demands.

(2) Formula:

$$\frac{\text{Number of Stocked Lines at Zero Balance with an Established Due-Out}}{\text{Number of Stocked Lines}} \times 100 = \text{Zero Balance Rate}$$

(3) Example: If there are 70 stocked lines at zero balance out of a total of 1,578 stocked lines, then:

$$\frac{70}{1,578} \times 100 = 4\%$$

(4) Performance measures are as follows:

(a) Management objective: less than 5 percent.

(b) Management level: 2 to 8 percent.

b. Issue Priority Designator (IPD) high priority request/requisition rates.

(1) This rate indicates the percentage of all requisitions placed upon a supply source (either local procurement or the DLA supply system) that have an IPD of 01-08 (exclude life or death IPD 03 requisitions from all calculations).

(2) Use the formula below for computing these rates.

(a) Formula:

$$\frac{\text{IPD 01 to 08 Requests/Requisitions}}{\text{Total Requests or Requisitions}} \times 100 = \text{IPD Request/Requisition Rate}$$

(b) Example: If there are 17 IPD 01 through 08 requests/requisitions out of 189 total requests or requisitions submitted,

$$\frac{17}{189} \times 100 = 9\%$$

(3) Performance measures are as follows:

(a) Management objective: Less than 20 percent.

(b) Management level: None.

(4) Excessive use of high IPDs is symptomatic of a variety of potential problems but may, infrequently, be totally reasonable and necessary. Routine use of IPDs 01 through 08 indicates the following:

(a) Basic data believed reliable in establishing OST values may not be valid.

(b) Proper materiel is not stocked.

(c) Customers require assistance in identifying new requirements for IMSA/MEDLOG Bn/USAMMCE stockage or need assistance in establishing a local resupply mechanism.

(d) The pipeline for heavily demanded materiel has been interrupted.

(e) A new, high priority mission is demanding expedited support.

c. Inventory accuracy rate

(1) The inventory accuracy rate provides information regarding the accuracy of on-hand balances recorded on accountable records.

(a) Formula:

$$\frac{\text{Total Number of Lines Requiring Adjustment}}{\text{Total Number of Lines Inventoried}} \times 100 = \text{Percentage}$$

Then,

Percentage - 100% = Inventory Accuracy Rate

(b) Example: If 100 lines required adjustment at the conclusion of the inventory and 1,000 lines were counted,

$$\frac{100}{1{,}000} \times 100 = 10\%$$

(c) Then, 100% - 10% = 90%
The inventory accuracy rate is 90 percent.

(2) Performance measures are as follows:
(a) Management objective: 95 percent.
(b) Management level: 90 percent or above.
(3) Values less than 90 percent indicate a problem as to the reliability of on-hand balances. Problems affecting accuracy may be failure to post receipts in a timely manner or issuing items by the wrong unit of issue.

d. Percent of excess to total inventory.
(1) Excess inventory is that materiel measures both the stocked and non-stocked inventory that is not supported by demands.

(a) Formula:

$$\frac{\text{Dollar Value of Excess Inventory}}{\text{Dollar Value of On-Hand Inventory}} \times 100 = \text{Percent of Excess to Total Inventory}$$

(b) Example: The account has $25,000 of excess (stocked and non-stocked combined) as shown in the Stock Status Report (or DMLSS Excess Report). Total dollar value of on-hand inventory is $1,000,000. The percent of excess to total inventory would be:

$$\frac{\$25{,}000}{\$1{,}000{,}000} = 0.025 \times 100 = 2.5\%$$

(2) Performance measures are as follows:
(a) Management objective: 10 percent or less.
(b) Management level: less than 15 percent.

(3) A rate greater than 15 percent indicates that the account is not taking timely action to remove non-demand supported items from the inventory.

e. Maximum percent of IMSA/MEDLOG Bn pharmaceutical stockage levels CONUS activities only).
(1) This measures the percent of pharmaceutical stocks to the value of annual pharmaceutical orders. The intent is to maximize utilization of government contracted

commercial distributors (PV/ECAT). Utilizing these contracts results in inventory reduction through engaging "Just in Time" supply support.

(a) Formula:

$$\frac{\text{Dollar Value of Pharmaceutical Stockage Level}}{\text{Annual Total Dollar Value of Pharmaceuticals Ordered}} \times 100 \text{ Max \% of Pharmaceutical Stockage Levels}$$

(b) Example: The IMSA/MEDLOG Bn has a stockage level for pharmaceuticals valued at $50,000. During the year, the pharmacy service ordered $5,000,000 of pharmaceuticals directly from a government contracted commercial distributor. The percent of IMSA/MEDLOG Bn pharmaceutical stockage level would be:

$$\frac{\$50{,}000}{\$5{,}000{,}000} = 0.01 \times 100 = 1\%$$

(2) Performance measures are as follows:
(a) Management objective: Less than 4 percent
(b) Management level: None

(3) A rate of 4 percent or greater may indicate that the IMSA/MEDLOG Bn is investing too many dollars in pharmaceutical inventory. In this case the IMSA/MEDLOG Bn is not taking advantage of PV/ECAT contracts as a means of reducing inventory.

3-65. MEASURING PROCESSING TIME

a. Request processing time:

(1) For stocked lines, it is the number of days from the date a customer request is received at the IMSA/USAMMCE/MEDLOG Bn to the date the materiel is delivered to the customer or the customer is notified that the materiel is ready for pickup.

(2) For nonstocked lines, it is the number of days from the date a customer request is received at the IMSA/USAMMCE/MEDLOG Bn to the date the request is passed to the supply source or to the supporting contracting activity.

(a) To compute the request processing time at the IMSA/USAMMCE/MEDLOG Bn, survey past customer requests. The date received is not counted; however, the date passed to the supply source or supporting contracting activity is counted, as is the date of delivery or date of notification to the customer. The computation is the Processing Time = Date Passed minus (–) the Date Received plus (+) 1, as such when the requisition is passed on the same day it was received the Processing time is one (1) day.

(b) This measure indicates the efficiency of the IMSA/USAMMCE/MEDLOG Bn in processing requests for both stocked and nonstocked lines. Longer processing times may indicate:

System deficiencies
- Inadequate staffing
- Training shortfalls
- A combination of these factors

(3) Performance measures are as follows:
(a) Management objective: One (1) day
(b) Management level: One to two (1 to 2) days.

b. Receipt processing time:
(1) This measure represents the lapsed time from the receipt of materiel at the IMSA until the receipt is posted to accountable records.
(2) Use the receipt documentation and accounting records to obtain needed information. The date received is not counted; however, the date posted is counted. The computation is similar to above, Receipt Processing time = Date Posted – Date Received + 1.
(3) Performance measures are as follows:
(a) Management objective: 1 day
(b) Management level: 1 to 2 days

(4) Longer processing times may indicate:
(a) Inadequate receiving or posting procedures
(b) Training needs
(c) Staffing level problems

3-66. MEASURES OF STORAGE MANAGEMENT

a. Materiel release denial rate (warehouse denials).
(1) This is the percentage of Materiel Release Orders (MRO)/pick list denied by storage. It indicates the number of MROs/pick list lines generated where stock is not on-hand in the warehouse, though records indicate that on-hand balances exist.

(a) Formula:

$$\frac{\text{Number of MRO Denials}}{\text{Total MROs}} \times 100 = \text{Materiel Release Denial Rate}$$

(b) Example: If there are 28 MRO/pick list denials out of 3,253 total MROs/pick list lines, then:

$$\frac{28}{3{,}253} \times 100 = 0.9\%$$

(2) Performance measures are as follows:
(a) Management objective: 1 percent
(b) Management level: 0-2 percent

(3) This measure can indicate a variety of potential problems, such as:
(a) Erroneous inventories
(b) Locator inaccuracies
(c) Stocks released to customers without the transaction being posted to accountable records
(d) Inaccurate selection of materiel for shipment or delivery

(e) Erroneous quantities verified on receipt documents
(f) Erroneous posting of receipt documents or misappropriation.

b. Location accuracy (see *AR 710-2*).

(1) This measure is a comparison of locator records with actual physical location of assets expressed as a percentage of accuracy. It is produced from a random sample of storage locations from either the locator records or from the physical location.

(2) There are two types of location survey errors:

(a) Location records showing a recorded location without corresponding stock at that warehouse location, provided that a permanent location is not being reserved for the item.

(b) Physical assets in warehouse locations without a supporting location record.

(3) Formula

$$\frac{\text{Total Correct Inventory Locations}}{\text{Total Inventory Locations Surveyed}} \times 100 = \text{Location Accuracy}$$

(4) Example: If out of 150 locations surveyed, 146 were correct, then:

$$\frac{146}{150} \times 100 = 97\%$$

(5) Performance measures are as follows:

(a) Management objective: 98 percent
(b) Management level: Greater than 95 percent

(6) Location accuracy shows the effectiveness of the storage activity at placing materiel in its designated location and posting appropriate data to locator records, to include deleting invalid location assignments resulting from re-warehousing (reorganizing and restocking the current warehouse) and stock depletion.

3-67. MEDICAL MATERIEL STORAGE

a. Storage conditions: Specialized procedures and equipment are required to prevent the deterioration of medical materiel in storage. Medical materiel is frequently sensitive to sunlight, heat, and moisture. Therefore:

(1) Proper temperature monitoring is paramount to cold chain management. The majority of commonly stored vaccines and other Temperature Sensitive Medical Products (TSMP) require thermostatically controlled storage temperatures of 2°C to 8°C (36°F to 46°F) while others must remain frozen at -20˚C to -10°C (-4ºF to 14°F). Additionally, some vaccines are sensitive to sunlight, moisture, and excessive heat and require special equipment to protect them from deterioration during storage and distribution. Vaccines must be carefully transported and stored within the storage range approved by the manufacturer to ensure their potency, purity, and chemical composition.

(2) Each MTF will develop and maintain a Standing Operating Procedure (SOP) for monitoring refrigerators/freezers storing vaccine and other TSMP. The information below is provided as a guideline.

(a) A temperature alarm system will be installed on bulk storage refrigerators/freezers in Logistics, Laboratory and Pharmacy areas storing medical supplies. The alarms will be monitored electronically and physically on a 24-hour basis. The optimal choice is a system that will both monitor and record temperatures for easy retrieval on a frequent basis and possess the capability to alert individuals (telephonically, pager etc.) who will take appropriate action to safeguard the vaccine should storage conditions become compromised.

(b) The entire alarm system from the refrigerator/freezer unit to the remote monitoring station will be tested monthly at a minimum. (Areas that are continually occupied on a 24 hour basis such a Blood Banks or Laboratories can test quarterly). Documentation of the test will be kept on file at the Logistics Division and available for inspection. The alarm system on all units will be hardwired to sound at the Administrative Office of the Day (AOD), installation Fire Station, Provost Marshal Office, or other location that is monitored 24-hours/seven days a week. Storage areas with restricted access will have a device installed (light indicator/audible alarm) indicating when the storage unit temperature is out of range and can be checked without physically entering the restricted area.

(c) Local policy will include the requirement for the AOD and/or other designated individual to physically check all refrigerator/freezer units storing bulk TSMP on a routine basis (at least two times per shift).

(d) Activities will identify an alternate storage facility (Clinic, Laboratory, Pharmacy, external storage facility, etc.) with back-up power (generator) and storage capacity where vaccines can be temporarily relocated and monitored if necessary. Additionally, identify proper handling procedures and the means of transport to the secure storage location.

(e) The SOP as a minimum must include emergency contact/notification information for the following:

(1) Logistics, Pharmacy, Provost Marshal, and Medical Maintenance personnel
(2) Refrigeration repair technician
(3) Temperature alarm repair technician
(4) Back-up storage areas
(5) Dry ice vendors
(6) Emergency repair companies
(7) Vaccine manufacturers (e.g. Merck Sharpe & Dohme: 800-672-6372; Aventis Pasteur: 800-VACCINE (800-822-2463); GlaxoSmith Kline: 888-825-5249; Wyeth Lederle Labs: 800-666-7248) (These companies may change over time and must be kept current)

(f) The SOP must include methods to determine if the vaccine is still viable.

(g) Activities maintaining vaccines outside of bulk storage areas such as a Soldier Readiness Processing (SRP) site or clinics should maintain minimal on-hand stock to minimize potential losses. These sites will post temperature logs in their refrigerator/freezer unit that must be filled in at least twice daily. If this is not feasible, alternative monitoring procedures are required and must be included in the SOP.

(h) Any loss of significant amounts vaccines due to out-of-range temperatures will be documented with the precise date and time sequence. The Logistics Chief will prepare a Commander's Critical Information Requirement (CCIR) to document the loss and forward to the proper notification authority immediately.

(1) An Emergency or battery-powered temperature alarm system will be used on refrigerator/freezer storage units at the IMSA/MEDLOG Bn/USAMMCE.

(2) Alarms will be monitored electronically and physically on a 24-hour basis. Optimally the alarm system will monitor and record temperatures for later retrieval and alerts individuals (telephonically, pager, etc.).

(3) Items requiring refrigeration will be stored and shipped at temperatures between 35° and 46°Fahrenheit (F) [2° and 8°Celsius (C)] and frozen items at temperatures below 32° F.

b. The IMSA/MEDLOG Bn/USAMMCE and other medical supply operations will comply with all special instructions on the item, shipping label, manufacturer's literature, UDR or in the FSC.

c. X-ray film will be stored per manufacturer's recommended storage methods, usually on edge in a vertical position. Film may fog if stored horizontally.

d. Dry-cell batteries will be removed from instruments prior to storage.

e. Rubber goods will be stored in rolls or laid flat. Talc will be used to separate surfaces.

3-68. STORAGE METHODS FOR IMSAS, MEDLOG BNS, USAMMCE, AND OTHER MEDICAL SUPPLY OPERATIONS

a. Store medical materiel in unit of issue and/or unit of measure. Establish stock control records for both unit of issue and unit of measure items. Determine the unit of measure price by dividing the unit price by the number of units of measure in the unit of issue.

$$\frac{\text{Unit Price}}{\text{\# of Units of Measure in the Unit of Issue}} = \text{Unit of Measure Price}$$

b. Store controlled items that require special storage and handling procedures to protect against theft per *AR 190-51*.

c. Store hazardous materiel, including acids, flammables, corrosives, gasses, and poisons per:

(1) Technical manual (*TM) 743-200-1*.

(2) *TM 38-410/Defense Logistics Agency Manual (DLAM) 4145.11/Navy Supply Publication 573/AFR 69-9/MCO 4450.12*.

(3) *AR 200-1*.

(4) Applicable Federal, state and local laws.

d. When storing hazardous materiel, at a minimum, the activities must:

(1) Consider the:

(a) Compatibility of chemicals

(b) Ventilation

(c) Fire protection

(d) Spill prevention and response

(e) Containment

(f) Protection from the weather

(2) Locate an inventory list and all applicable MSDS near the storage area within the HCA.

e. Provide heat, refrigeration, and humidity control where necessary to protect stock (see *TM 743-200-1*). Physically separate suspended materiel from other stocks and mark with the authority for suspension.

f. Establish stock locator systems, automated or manual, at each storage site to control the use of storage space. Survey all storage locations at least annually, and reconcile survey results with the locator file.

g. Medical supply operations must establish stock locator systems per:
(1) MACOM or Command Surgeon guidance
(2) *AR 710-2*
(3) *DoD 4145.19-R-1*

3-69. MEDICAL INSTRUMENT RECYCLING PROGRAM

a. Program definition

(1) The Medical Instrument Recycling Program (MIREP) provides for the repair, refinishing, and reconditioning of economically repairable instruments. It applies to medical and dental instruments and involves returning the instruments to a serviceable condition.

(2) Recycling includes:
(a) Replacing missing parts for example, screws and carbide inserts.
(b) Adjusting for proper tension.
(c) Redefining ratchets.
(d) Sharpening cutting edges.
(e) Cleaning, re-polishing, and re-plating surfaces.
(f) Realigning tips and edges.

b. Implementation

The MTF commander will establish a MIREP if economically feasible based upon a cost benefit study. Costs inherent to administering the MIREP contract must be judiciously considered. A copy of the cost benefit study will be retained on file for review by the USAMEDCOM command logistics review program team. If determined not economically feasible, an update review of the cost benefit study will be conducted annually.

c. Recycling guidance

(1)Instruments that are damaged or unsuitable for use will be turned in to a designated collection point by the functional area within the MTF. String or other appropriate binding may be used to group like items for ease of management and turn in. Groups should be tagged. The tags should indicate the NSN/MCN (Management Control Number), nomenclature, total number in group, and generating functional area.

(2)The designated collection point program manager will determine the procedures for turn-ins and account for all receipts, repairs, and disposals. If a PR is initiated for each turn-in to the contractor, a suspense copy should be retained on file.

(3)Recycling costs will be borne by the functional area.

(4)The MIREP assets will remain functional area-owned from the time of turn in until the item is subsequently reissued.

(5)All instruments must meet the following recycling criteria:

(a) The instrument should be unserviceable or otherwise unsuitable for use.
(b)A replacement item is required to accomplish the mission.
(c) The replacement unit cost exceeds $8.

(6) The estimated recycling cost is less than 60 percent of estimated replacement cost.

(7) The Accounting Requirements Code (ARC) is D (that is, a durable item) in the AMDF or FEDLOG or a similar nonstandard item.

f. The MTF commanders may exempt any specific instrument from MIREP for a valid reason. A record of exempt items and the reason for exemption will be maintained on file.

X-X3 Medical instrument recycling equipment program contracts
Recycling services will be obtained through local purchase procedures. Contracts will provide for:
a. An itemized receipt for instruments turned over to a contractor for recycling.
b. An itemized statement of recycling cost.

3-70. CUSTOMER SUPPORT

The IMSA will have a “Customer Support Pamphlet” for the customers that details how customers receive support from the IMSA. Support for external customers can either be an “Appendix A” to the Pamphlet or a stand alone document.

As a minimum that Pamphlet will cover:

a. Logistics’ Organizational structure with POCs and phone numbers.
b. Detailed specific procedures for all functions of Logistics. (Excess turn in, requisitioning, maintenance, obtaining status, etc.
c. Sample documents that customers need to complete prior to visiting Logistics.

CHAPTER 4. QUALITY CONTROL INFORMATION

This Chapter provides sequentially, those procedures to be used by all Activities that store medical materiel.

4-1. QUALITY CONTROL

Medical logistics activities (IMSA/MSA/MEDLOG Bn/USAMMCE/Army Pre-Positioned Stock (APS)) are the focal point for all Quality Control Information, which includes-

a. Dissemination and collection Medical Material Quality Control (MMQC) information.
b. Establish and operate medical materiel surveillance programs. To include registering and maintaining materiel in the DoD/FDA SLEP Program.
c. Act on all Quality Control (QC) information by ensuring that all sequentially numbered USAMMA Quad-Service DoD-MMQC; vendor generated messages; SB 8-75 series and recall notices from the supporting commercial distributors' PV are received, registered, validated, observed and disseminated to all customers.
d. Act on all sequentially numbered DoD/FDA SLEP Messages.
e. Provide QC information to medical receiving, storage, shipping, and maintenance elements and to supported activities that consume medical materiel.
f. Provides QC information (such as reports of materiel defects) to the wholesale system based on surveillance findings and reports from customers.
g. Prepares reports or takes other actions as required by regulation, *SB-8-75-S7*, *SB-8-75-S10* (ARNG only) and this SB.
h. Ensures that materiel is stored in such a manner as to prevent deterioration and in accordance with manufacturer's guidance.
i. Act as a source of QC information by conducting a constant surveillance program of medical materiel in storage or use.
j. Dispose of unserviceable materiel through the use of national, regional, or local disposal contracts.
k. Provides logistics assistance to supported units for QC matter.

4-2. SOURCES OF QUALITY CONTROL INFORMATION

a. The Quality Control Information is disseminated in the following ways:

(1) Department of Defense MMQC (DoD-MMQC) messages
(2) Army Medical Materiel Information (MMI) messages
(3) DoD/FDA Shelf Life Extension Program Messages (SLEP)

b. Procedures**:** Supply accounts at the IMSA/MSA/MEDLOG Bn/USAMMCE/APS level will maintain a record, either automated or manual, of these messages in numerical sequence. As a minimum, the data will reflect the date received, message number, NSN (or other identifying number), nomenclature, action required, and remarks. If a message is missing, initiate tracer action through message-routing channels or obtain a copy from either:

(1) World Wide Web Address: **http://www.usamma.army.mil**

(2) Commander, USAMMA
ATTN: MRMC-MMO-SO
1423 Sultan Dr., Suite 100 Fort
Detrick MD 21702-5001

(3) The DoD/FDA SLEP System:
https://slep.dmsbfda.army.mil

(4) Activities with an automated QC module in their inventory management system, i.e., TAMMIS/DMLSS, are not required to maintain a manual register, except for the DoD/FDA SLEP messages. The MMQC messages and the DoD/FDA SLEP messages will be retained on file for at least the current calendar year and the prior calendar year per *AR 25-400-2.*

c. Transmission:

(1) The DoD-MMQC messages are published on the USAMMA website **(http://www.usamma.army.mil).** Units and activities of the Active Army, USAR, and ARNG, as well as the other services are required to register on the USAMMA website to receive Department of Defense Medical Materiel Quality Control (DoD-MMQC) messages via email. These messages are also disseminated via FTP to USAMMCE (Germany) and 16th MEDLOG (Korea). They are also provided to the JMAR and Defense Medical Logistics Supply System (DMLSS) for dissemination.

(2) The USAMMA MMI messages are also published on the USAMMA website **(http://www.usamma.army.mil).** Only registered US Army Activities, (Active Army, USAR, and ARNG) will receive the MMI messages via email as well.

d. The DoD SLEP Messages are the responsibility of the DMSB. Their website is:
https://slep.dmsbfda.army.mil

(1) Effective 13 June 2005 the DMSB established the DoD/FDA SLEP Web Based System. This system creates is a one-stop shopping for SLEP management and allows each activity to:

Enter their own inventory
View results of FDA testing
View SLEP messages
Be tasked to provide Samples to the FDA for testing
Management of Labels for extensions

(2) Access is limited by password and user permissions. This includes access to the SLEP messages. All testing and extension data provided to the SLEP by the Food and Drug Administration is considered For Official Use Only and cannot be shared with anyone outside the user's organization. Sharing this information with local, civilian counterparts is a violation of the terms agreed to by the FDA but also a violation of the Memorandum of Agreement each participant organization signs prior to entering the SLEP program. Non-SLEP organizations that use SLEP information are in violation of Federal law (Code of Federal Regulation 21) that governs "misbranded" pharmaceuticals.

(3) Activities may register for access to the SLEP system. To access the SLEP web application:

- Open your Internet Explorer
- Click on File
- Click on Open
- Type in the following URL https://slep.dmsbfda.army.mil
- Click Okay
- Save this page as one of your favorites

- You should now be at the SLEP Main Page

- Click on USER REGISTRATION on the top Left on the page

  - Read the General Counsel Directive
  - Click Continue

- Scroll down the page and make sure that you have a SUBMIT APPLICATION button at the bottom of the page. If you do not see it, close your Internet Browser and begin again, your browser did not completely load

- If SUBMIT APPLICATION button is at the bottom of the form, complete the form, please make sure you tell why you need access to the SLEP System, but you are limited to 4 lines. Make sure you use your Activity's FedEx Address (Street, Building and Room Number). This address is where your labels will be sent.

- Once you have access to the system, go to INVENTORY, down load and print the INVENTORY HELP. This is part of the Users Manual, and will be you help until version 2, is completed fall 2006.

Your Password and User ID will be sent to you in 1-2 working days after your Security Officer has responded back to the email requesting verification that you have a positive National Agency Check (NAC).

See the SLEP FAQ on the LEFT side of the MAIN Menu before email questions to:
DMSBDOD-FDASLEP@AMEDD.ARMY.MIL

(4) Activities must be registered to receive SLEP messages. Only SLEP Messages for FY04 and before are available on the USAMMA Web site. All SLEP Messages from 2005 forward are on the DoD/FDA SLEP Web Site.

e. The IMSA/MSA/MEDLOG Bn/USAMMCE/APS are responsible for making distribution of messages to support customers, minus the DoD/FDA SLEP Messages; they are for internal use only.

f. Army National Guard actions: Upon receipt, Chief, National Guard Bureau (NGB) will distribute copies of all MMQC messages to DMSO and ARNG training sites operating troop medical clinics. Additionally, the Chief, NGB, will immediately distribute all MMQC messages concerning Type I medical materiel complaints and the FDA Class I recalls to the State Safety Office and all medical elements in the State, including separate medical detachments and medical sections of maneuver battalions. ARNG units who store stockpiles of medical materiel, e.g. the Weapons of Mass Destruction Civil Support Teams (WMD-CST) will register and maintain their inventory in the DoD/FDA SLEP System as directed by the National Guard Bureau and SB-8-75-S10.

g. The USAR action: The MEDLOG Bns and USARC medical units designated as a SSA within a command or area of operations are responsible for the distribution of all applicable DoD-MMQC messages to supported customers, minus the DoD/FDA SLEP Messages; they are for internal use only. USAR medical units, e.g. MEDLOG Bns, ASMB and hospitals will register for the DoD/FDA SLEP program upon mobilization.

h. On-line query search: The USAMMA has an on-line query capability for all QC messages, SLEP messages before FY05, and information bulletins. Search by Message MMQC/MMI Number, NSN, National Drug Code (NDC), Subject, or Lot Number by accessing the USAMMA homepage at http://www.usamma.army.mil

i. The *SB 8-75 series:* The SBs are distributed through normal Army distribution channels and provide other essential medical logistical information.

j. The *AR 702-18, DLAR 4155.37,* and *AFR 67-43:* These publications contain storage QC procedures and serviceability standards applicable at all levels of materiel management. Questions related to information contained in the publications may be directed to:

Commander, USAMMA
ATTN: MCMR-MMO-PM
1423 Sultan Dr., Suite 100
Fort Detrick MD 21702-5001

The MEDSILS, FLIS, AMDF, FEDLOG, and, UDR: The MEDSILS, AMDF, or FEDLOG, UDR, and FLIS are the official sources of supply management data, i.e., Shelf Life Codes (SLCs), and AAC. They have precedence over conflicting data published in other Army publications as well as *AR 702-18, DLAR 4155.37,* and *AFR 67-43,* unless otherwise stated in DoD-MMQC messages. Issues with Shelf Life codes may be sent to DSCP through https://dmmonline.dscp.dla.mil, NSN Action Feedback Form or to the DoD/FDA SLEP Program, DMSBDOD-FDASLEP@AMEDD.ARMY.MIL

4-3. STORAGE PROCEDURES AND SHELF LIFE OF MEDICAL MATERIEL

a. All activities that store medical materiel are responsible for the--

(1) Care, preservation, and surveillance of all medical materiel under their control.

(2) Establishment of storage policies for the materiel they store.

b. Store medical materiel in unit of issue and/or unit of measure. Establish stock control records for both unit of issue and unit of measure items. Determine the unit of measure price by dividing the unit price by the number of units of measure in the unit of issue.

$$\frac{\text{Unit Price}}{\text{\# of Units of Measure in the Unit of Issue}} = \text{Unit of Measure Price}$$

c. Storage conditions. Specialized procedures and equipment are required to prevent the deterioration of medical materiel in storage. Medical materiel is frequently sensitive to sunlight, heat, and moisture. Therefore,--

(1) Emergency or battery-powered temperature alarm systems will be used on refrigerator storage units at the IMSA/MSA/MEDLOG Bn/USAMMCE/APS. Alarms will be electrically monitored on a 24-hour basis. This can be done manually or through technical design. Items requiring refrigeration will be stored and shipped at temperatures between 35

and 46º Fahrenheit (2º and 8º Celsius (C)) and frozen items at temperatures below 32º Fahrenheit (0º C).

(2) Heat, refrigeration and humidity control will be provided when necessary to protect medical materiel in accordance with all special instructions on the item, shipping label, manufacturer/product's literature, *UDR*, *TM 743-200-1* or in the FSC. IMSA/MSA/MEDLOG Bn/USAMMCE/APS sites that are storing stockpile of materiel will maintain an automated or manual log of the daily temperature and humidity in the storage facility. This information will be reported in the DoD/FDA SLEP System on a monthly basis. Normal temperature for pharmaceutics as defined by the US Pharmacopeia as Controlled Room Temperature is 68-77 degrees Fahrenheit at 60 relative humidity and allows for a variation of between 59-86 degrees Fahrenheit which may be experienced in pharmacies, hospitals and warehouse.

(3) X-ray film will be stored per manufacturer's recommended storage methods, usually on edge in a vertical position. Film may fog if stored horizontally.

(4) Dry-cell batteries will be removed from instruments prior to storage.

(5) Rubber goods will be stored in rolls or laid flat. Talc will be used to separate surfaces.

(6) Controlled items that require special storage and handling procedures to protect against theft, will be stored per *AR 190-51, AR 40-2* and chapter 3 of this *SB*.

(7) Hazardous materiel, including acids, flammables, corrosives, gasses, and poisons will be stored per:

(a) *TM 743-200-1*.

(b) *TM 38-410/DLAM 4145.11/Navy Supply Publication (NAVSUP PUB) 573/AFR 69-9/MCO 4450.12*.

(c) *AR 200-1*.

(d) Applicable Federal, state and local laws

(8) When placing medical materiel in storage, at a minimum, consider the following;

(a) Temperature

(b) Compatibility of chemicals.

(c) Ventilation.

(d) Fire protection.

(e) Spill prevention and response.

(f) Containment.

(g) Protection from the weather.

(9) Post an inventory list and all applicable MSDSs near the storage area within the activity.

(10) Suspended materiel will be physically separated from other stock and marked with the authority for suspension, e.g. DoD/FDA SLEP Message Number xx, MMQC Message yy

d. Storage QC records. The IMSA/MSA/MEDLOG Bns/USAMMCE will maintain supplemental records for all expiration-dated materiel that is stockpiled. This record will be maintained in the DoD/FDA SLEP System. Other medical supply operations will maintain QC records in accordance with command or command surgeon guidance. As a minimum, QC records will reflect the manufacturer, lot number, and current expiration date. The DA Form 4996-R (Quality Control Card) will only be used for activities without automated records, i.e., TAMMIS/DMLSS QC module, will be used and for non-stockpiled medical materiel. The DA Form 4996-R can be reproduced locally on 8-by 5-inch card stock. A copy for reproduction is located in the back of this regulation. Table 4-1 provides the preparation steps for DA Form 4996-R. Use QC records to--

(1) Ensure rotation of stocks.

(2) Prepare reports of items that cannot be used prior to expiration for extension, disposal, or destruction.

(3) Budget for replacement of expired stocks.

e. Marking potency extensions. Medical items in storage whose potency expiration date is being extended will be re-marked with the new expiration date. The DoD/FDA SLEP will send you labels for each item extended in the SLEP program. The label must be placed on each item, covering the current expiration date, before it may be issued. The large labels are to be used on the carton/box/pallet. The smaller labels are to be used for the individual item. The quantities and lots of labels that are sent are based on the current on-hand inventory your activity has in the SLEP system. You may not line out expiration dates. Additional direction on placement and use of the labels will be on the back of each label or as directed by USAMMA.

Table 4-1. Steps to Preparing DA Form 4996-R

Step	Description
1	NSN: NSN/MCN/universal product number/NDC (pen entry)
2	Description: Name of item (pen entry)
3	Inspection frequency: How often does this item need to be inspected? (See *AR 702-18/DLAR 4155.37/AFR 67-43, UDR,* or *Defense Logistics Information System (DLIS)*
4	Date last inspected: (pencil entry)
5	Date next inspection: (pencil entry)
6	Manufacturer: Name of manufacturer. There may be more than one.
7	Lot number: Lot number from package.
8	Expiration date: Expiration date on package, if applicable.
9	Date manufactured: Date manufactured on package, if applicable.
10	Shelf life: Type I (excluding pharmaceuticals/drugs), Type II, and Estimated Storage Life (ESL) from FEDLOG or UDR
11	Date received: (pencil entry)

4-4. DETERMINING SHELF LIFE FOR MEDICAL MATERIEL

a. The Shelf Life of an item begins when it is manufactured. The 21 CFR requires all Pharmaceutical items to have an expiration date (potency and dated) (P&D) on them. The US Pharmacopeia (USP) founded in 1820, is a nongovernmental, nonprofit organization whose mission is to promote public health and is recognized by Federal law as the official body that sets standards for prescription drugs. The USP defines the expiration date as "the time during which the article may be expected to meet the requirements of the pharmacopeia monograph provided it is kept under the prescribed conditions." The expiration date, which limits the time during which the article may be dispensed or used, is based on scientifically sound stability studies carried out by the manufacturer and is usually expressed in terms of the month and year, as stated on the manufacturer's container. This means that the product may be used until the last day of the stated month and year, unless it has been extended by the FDA through empirical testing at its labs through the DoD/FDA SLEP program. Medical materiel storage periods are categorized as follows:

(1) Type I shelf life items. Type I items are those items of supply having a definite storage period terminated by an expiration date that was established by empirical and technical test data. Routinely, these supply items are considered non-extendable except when large quantities are being stored for contingency purposes. In these cases, the supply item may qualify (based on technical and economic considerations) as a candidate for the DoD/FDA SLEP. This program requires testing by the FDA. Type I shelf life items are identified by "01" in the fourth and fifth positions of the MCSC and by an alpha character in the SLC.

(2) Type II shelf life items. 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) Shelf life condition codes. Shelf life medical materiel is condition coded per *AR 702-18/DLAR 4155.37/AFR 67-43* as follows:

(a) Condition code A - 6 months remain on the shelf life.
(b) Condition code B - 3 to 6 months remain on the shelf life.
(c) Condition code C - less than 3 months remain on the shelf life.

(4) 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 unexpired dating period. This is automatically done to the items in the DoD/FDA SLEP system. The CONUS and OCONUS activities may receive condition code A stocks for shelf life materiel issued from DSCP. Condition code B stocks are issued only to CONUS activities unless the OCONUS activities, with prior approval, have agreed to accept Condition Code B stocks. Activities will report, using the shipping discrepancy report, chapter 3 of this SB to report any potency dated materiel, which OCONUS activities receive with a shelf life condition coded B or C or CONUS activities receive with a shelf life condition coded C.

b. The FDA, under the DoD/FDA SLEP is the approving authority for medical extensions on Type I shelf life items.

c. The Shelf Life of a medical item is only for the period of time it is in storage. Once it is removed from storage, its Service life begins. The Service life for a medical item is the period of time it may be used after it is removed from storage and or issued. It is determined by:

(1) How was it stored?
(2) Its current expiration date
(3) The number of hours, days, months it may be used after it is mixed or removed from refrigeration or the freezer, e.g. Pyridostigmine Bromide Tables may only be out of the refrigerator for a total of 90 days to be eligible to be issued to an individual.
(4) A maximum of one (1) year from the day issued, per the US Pharmacopeia <1136>

4-5. MANAGEMENT OF SHELF LIFE ITEMS

a. Medical logistics activities to include Army Pre-positioned Stocks, MCDM, Unit Deployment Packages (UDP), Installation CBRN, and any other stockpile of Army medical materiel:

(1) Register and participate in the DoD/FDA SLEP Program.
(2) Issue the earliest dated materiel first.
(3) Enter on-hand, stockpiled inventory in the SLEP system as soon as the items are received and update the inventory on a quarterly basis.

(4) Store all materiel in a controlled environment under conditions recommended by the manufacturer. Those stocks that were stocked outside of the manufacturer's recommended storage parameters will be reported to USAMMA, ATTN: MCMR-MMO-PM.

(5) Maintain an automated or manual log of the daily temperature and humidity in the storage facility. This information will be reported in the DoD/FDA SLEP System on a monthly basis. Normal temperature for pharmaceutics as defined by the US Pharmacopeia as Controlled Room Temperature is 68-77 degrees Fahrenheit at 60 relative humidity and allows for a variation of between 59-86 degrees Fahrenheit which may be experienced in pharmacies, hospitals and warehouse

(6) Send all samples requested by the FDA for testing with-in 14 days of the request. Instructions on how to ship and where to ship to is on the DoD/FDA SLEP site, SLEP message 2005-57.

(7) Comply with all directions that are in the DoD/FDA SLEP message, e.g. suspend, destroy, re-label.

(8) Re-Label all products in accordance with the SLEP message. As a minimum, you must re-label the exterior package/pallet/box. The individual items do not need to be labeled until you go to issue it.

(9) See SB-8-75-S7 for additional directions on management of MCDM, APS, UDP and the DoD/FDA SLEP Program.

b. Biologicals. The FDA will not accept shelf life extension requests for FSC 6505 items classified as "biologicals", e.g. vaccines or lab reagents. The USAMMA will provide guidance through MMQC messages on reporting and disposal of biologicals.

4-6. SURVEILLANCE OF MATERIEL

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

The basic publications and systems used for surveillance programs are:

(1) MEDSILS, FLIS, AMDF, FEDLOG and UDR
(2) *AR 702-18/DLAR 4155.37/AFR 60-10*, Appendix M
(3) *DA SB 8-75* series
(4) Military Item Disposition Instructions (MIDI)
(5) Universal Data Repository (UDR)
(6) Defense Logistics Information System (DLIS)
(7) Military Environmental Information Source (MEIS)
(8) DoD-MMQC messages
(9) DoD/FDA SLEP messages

b. *AR 702-18/DLAR 4155.37/AFR 60-10, and DLAM 4155.5*, 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. The Appendix M is available for viewing on the USAMMA web site at http://www.usamma.army.mil/

4-7. INSPECTION OF LOCALLY PURCHASED MATERIEL

a. Personnel assigned to the receiving section of the IMSA/MSA/MEDLOG Bn/USAMMCE/APS will inspect all materiel before acceptance. When materiel is delivered direct to the activity/requester, individuals receiving materiel are required to conduct an inspection prior to acceptance. The SLEP messages should be used for this surveillance. Furthermore, IMSA/MSA/MEDLOG Bn/USAMMCE/APS should report any problems discovered relative to usage as medical materiel complaints. This requires a visual inspection of materiel to ensure that the product appears in good condition. For specialized materiel requiring inspection expertise beyond the capabilities of the IMSA/MSA/MEDLOG Bn/USAMMCE/APS, the requester or other appropriate specialist should assist in the inspection. The supporting medical maintenance activity will perform technical inspections of all medical equipment as appropriate. Receiving reports will be processed in a timely manner. Report problems with materiel identified after the receiving report has been processed to the supporting contracting officer for appropriate resolution. The USAMMA can provide assistance in specialized or technical inspections.

b. The IMSA/MSA/MEDLOG Bn/USAMMCE/APS or credit card holder will respond within the scope of their authority using local credit card procedures to resolve the issues. Contact the issuing contracting office for further resolution as required.

c. The receiving activity/requester must forward a copy of the MSDS when direct delivery occurs to the IMSA/MSA/MEDLOG Bn/USAMMCE/APS and comply with the activity's hazard communication program.

4-8. 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. Activities having quantities of these items on-hand will suspend the materiel from issue and use.

c. The CONUS activities will contact the respective manufacturer or distributor for disposition instructions.

d. The OCONUS activities will comply with DoD-MMQC messages. If further disposition instructions are required, report NSN and quantities suspended to:

Commander, USAMMA ATTN: MCMR-MMO-SO
1423 Sultan Dr., Suite 100
Fort Detrick, MD 21702-5001

except as indicated in para 4-6.f. Reports must include the following items:

MMQC message reference
Nomenclature
Lot or batch number
Quantity
Requisition number under which the materiel was obtained
Purchase order or contract number
Location of the materiel.

e. The USAMMA will coordinate with DSCP or the manufacturer for disposition instructions and will advise the reporting activities.

f. The OCONUS activities may contact the responsible manufacturer or distributor for items procured directly from an overseas acquisition source other than DSCP.

4-9. DISPOSAL AND DESTRUCTION

The preferred method of destruction is using contracted services for disposal of unserviceable medical materiel. In the event that the item(s) cannot be disposed of using contracted services, then local destruction of unserviceable medical materiel is authorized. Local destruction is restricted to those items approved by the Environmental Science Officer (ESO) of the Preventive Medicine (PMed) Service consultants or ESO from the RMC/MSC.

a. The IMSA/MSA/MEDLOG Bn/USAMMCE/APS will accept items for destruction from any activity that is not capable of accomplishing destruction actions. This acceptance constitutes informal accountability and storage by the IMSA/MSA/ MEDLOG Bn/USAMMCE pending review by the ESO destruction officer. The IMSA/MSA/MEDLOG Bn/USAMMCE/APS will sign the DA Form 3161 (Request for Issue or Turn-In) from the activity to show acceptance and storage of the items pending environmental review and destruction.

b. Medical materiel accepted by the IMSA/MSA/MEDLOG Bn/USAMMCE/APS will be recorded on a DA Form 3161, prepared by the activity desiring destruction per this regulation and clearly marked “FOR DESTRUCTION PURPOSE ONLY” (see Table 4-1). Document numbers for the DA Form 3161 will be assigned by the activity preparing the document. The IMSA/MSA/MEDLOG Bn/USAMMCE/APS will also assign a voucher number to the document (considered a debit/credit voucher and not posted to the accountable records) for internal control and filing.

c. Medical materiel authorized for destruction will be processed as follows:

(1) The fixed facility HCA or deployable unit commander will appoint a disinterested officer (E7/GS 07 or above) to be responsible for all destruction at the IMSA/MSA/MEDLOG Bn/USAMMCE/APS or deployable unit and for controlled substances at the user level.

(2) The ESO/destruction officer will certify as to the accuracy of all facts entered on destruction documents. Units not authorized TAMMIS-Medical Supply (TAMMIS-MEDSUP/DMLSS) may use DA Form 3161 as their destruction document (see table 4-1). Activities using TAMMIS-MEDSUP/DMLSS will use the system generated destruction document. The statement shown in Figure 4-1, signed by two witnesses, will be placed on the destruction document below the signed certificate of the ESO/destruction officer.

d. The Military Item Disposal Instructions/Military Environmental Information Source provides guidance for the destruction of materiel. If a method of destruction code is required but not assigned, contact:

Commander, U.S. Army Center for
Health Promotion and Preventive Medicine
ATTN: MCHB-TS-EHM
5158 Blackhawk Rd.
Aberdeen Proving Ground MD 21010-5403

Items included are as follows:

(1) Unidentifiable items or items which, when intended to be disposed of, are hazardous wastes according to criteria developed under the authority of Public Law 94-580 and its implementing Federal and state regulations, such as Parts 260-270, Title 40 *(40 CFR 260-270).*

(2) Partially used items that are excess. These items tend to deteriorate faster after the opening of a container. The packing list or attached covering label may not actually describe the contents of the container.

(3) Items cited for destruction by the MMQC or MMI messages

(4) Items cited for destruction by the DoD/FDA SLEP messages and the SB 8-75 series.

(a) When a contractor disposes of hazardous waste, contracts will contain a statement requiring the contractor to furnish a certificate of destruction with the invoices for payment. Follow-up will be made on the status of destruction when invoices are received without a certificate of destruction.

(b) A witnessing statement on the DA Form 3161 is not required when a contractor accomplishes destruction of hazardous waste.

(c) Local controls will be established to ensure that the contractor is given an itemized listing indicating the product identification number, nomenclature, unit of issue, quantity, and shipping weight of all items to be picked up for destruction. This listing will be filed with the required DA Form 3161.

(5) The completed DA Form 3161 will be used as a voucher for dropping the materiel from accountability. It will cite the reason for destruction, method of destruction (disposal code) (MIDI), and the location of destruction.

(6) When instructed by the USAMMA or DSCP, the medical activity will submit certificates of destruction. Where credits are involved, the local finance and accounting division must also submit MILSTRIP DIC FAE (request for billing adjustment) transaction. This transaction generates interfund credits from the DSCP while the certificate is used by the DSCP to support claims for reimbursement against contractors. (See *AR 725-50*.)

(7) The Chief of Preventive Medicine Service (or designated representative(s)) will review destruction documents from HCA customers and certify that the destruction codes assigned to the items are correct. The installation environmental coordinator will review destruction documents from deployable units that have the capability of performing their own destruction actions. The destruction codes will be checked using the publications stated above. The following statement will be cited on all destruction documents and will be signed by the ESO or installation environmental coordinator:

"I certify that the destruction codes assigned to the above items are acceptable, environmentally sound, destruction/disposal methods for this materiel, and comply with Federal, state, and local laws."

(8) Materiel in less-than-unit-of-issue quantity will be informally accounted for pending destruction. Keep a copy of the turn-in document with the materiel until destruction. Upon destruction, file the copy with the destruction certificate.

(9) Note R and Q drugs less-than-unit-of-issue quantities will not be turned in to IMSA/MSA/MEDLOG Bn/USAMMCE/APS. They will be returned to the supporting pharmacy for destruction.

Table 4-2. Steps to Preparing DA Form 3161 as a Destruction Document

Step	Description
1	**Sheet Number:** Self-explanatory.
2	**Number of Sheets:** Self-explanatory.
3	**Voucher Number:** Self-explanatory.
4	**Send to:** Destruction.
5	**Request from:** Activity/unit desiring destruction.
6	**Item Number:** Self-explanatory.
7	**Stock Number:** Enter NSN, MIIN (Medical Item Identification Number), NDC, UPN, or MCN.
8	**Item Description:** Brief nomenclature, manufacturer, lot number, expiration date/manufacture date, and reason for destruction, e.g., expired, MMQC message, manufacturer's recall, broken, non-returnable excess.
9	**Unit of Issue:** Self-explanatory.
10	**Quantity:** Enter quantity to be destroyed.
11	**Code:** Destruction Code from the MIDI, U.S. Army Center for Health Promotion and Preventive Medicine, or activity ES/PMed officer. If the code is obtained from other than the MIDI, state from whom and when.
12	**Supply Action:** The quantity actually destroyed. Entered by Destruction Officer.
13	**Unit Price:** Self-explanatory.
14	**Total Cost:** Self-explanatory.
15	**Sheet Total:** The sum of all lines on the sheet.
16	**Grand Total:** The sum of all sheet totals for the same voucher number.
17	The document will be closed with either "LAST ITEM" or "NOTHING FOLLOWS."
18	The certificate of the destruction officer will begin on the next available line or on a continuation sheet. The certificate will be signed and dated. The typed name and grade of the destruction officer will be entered. The certification statement should state specifically how each line was destroyed following the codes assigned and definitions provided in the SB 8-75 series. **NOTE:** If the items are turned over to a contractor for destruction, the name of the contractor will be shown, the destruction certificate will be changed to reflect this action, and the representative will sign for receiving the items in the presence of the two witnesses.
19	If the materiel is buried in an on-post landfill, the grid coordinates of the site will be shown. If using an off-post landfill, include specific address (street, city, state) and grid coordinates. If the materiel is incinerated, include the on-post building number or specific off-post address
20	The witnesses' statement (see the sample in figure 4 below), will start on the next available line. The statement will be signed and dated by both witnesses. Be sure typed names and grades are shown.
21	The certification of the ESO/destruction officer will begin on the next available line. When an ESO is not assigned, the appointed Destruction Officer will sign the certification. This certification is required for Federal, state, and local environmental standards.
22	Add a statement on the destruction document that credit was sought but not granted if the destruction includes nonstandard drugs or biologicals with a line acquisition value of $100 or more and replacement or credit was not obtained

Figure 4-1, below, is an **example** of how the Destruction Statement Format should be written.

I have witnessed the destruction of the materiel described and it was destroyed on the date and in the manner stated.
(Signature) Witness 1) (Typed name, Witness 1))
(Signature) Witness 2) (Typed name, Witness 2))

Figure 4-1. Destruction Statement Format

4-10. QUALITY ASSURANCE FOR MEDICAL GASES

a. Bulk (liquid) gases may be oxygen or ethylene oxide. The Quality Assurance (QA) procedures for bulk (liquid) gases are:

(1) The HCA Commander will designate in writing, those individuals who must have received training in the use of the gas analyzer as being responsible for monitoring bulk gas deliveries. These individuals will:

(a) Document name of individual responsible for receipt of bulk gas and date and time of delivery.

(b) Document the results of gas analysis before acceptance.

(c) Document amount received.

(d) Document corrective actions if gas fails to meet standards (less than 95 percent by volume for oxygen).

(e) Maintain accuracy of gas analyzing equipment.

(2) The HCA Commander will ensure that the bulk gas storage container has an outlet that allows for gas analysis. Specific storage procedures for bulk gases are found in *AR 700-68* and NFPA codes.

(3) Records of receipt and gas analysis must be maintained for two years per *AR 25-400-2.*

(4) The HCA Commander will establish a written plan to handle bulk gas emergencies (medical gas alarms or equipment failures). This plan must identify clinical areas requiring alternate gas supply until the central supply is functioning properly.

(5) Equipment using bulk gases must be tested for proper functioning before patient's use. Follow manufacturer guidelines to complete this testing.

(6) The HCA Commander must ensure that all personnel handling bulk gases are properly trained. Training must be documented.

b. Medical gases maintained in cylinders require QA procedures.

(1) Upon receipt, the cylinders containing oxygen must have DD Form 1191 (Warning Tag for Medical Oxygen Equipment) attached (*TB MED 245*).

(2) Cylinders containing any gas must have the cylinder valve cap in place when so designed.

(3) Cylinders must be inspected upon receipt for proper color-coding, bulges, or damage (*MIL-STD-101*).

(4) Cylinders must be stored per NFPA codes and *AR 700-68*.

(5) Cylinders cannot be refilled and shipped if past retest date(s). It is permitted to continue to use gas from a cylinder that is past due for retest. No time limit is imposed.

(6) Safe handling practices of cylinders *(TB MED 245)* must be followed.

(7) Disposal and turn-in procedures are contained in *AR 700-68,* Sections 7 and 8.

4-11. SUBMITTING MEDICAL MATERIEL COMPLAINTS

a. All medical materiel complaints, regardless of procurement source, will be submitted on a Complaint Form to DSCP via online at https://dmmonline.dscp.dla.mil/forms/mpqdr_entry_new.asp

b. Complaint Forms completed on nonstandard items procured through DSCP must cite the purchase order number and document number.

c. Report the circumstances of Type I complaints immediately to DSCP, through the quickest means, that is, by telephone or immediate message.

(1) During normal duty hours (0700 - 1700 hours Eastern Time), call the DSCP ESOC at DSN 444-2111/2112, or commercial 215 737-2112. A fax may also be sent to: Commercial 215 737-2081/7109 or DSN 444-2081/7109.

(2) After duty hours, the numbers called above will automatically transfer to the Staff Duty Officer. If the transfer does not occur or the call is not answered, call the following numbers: DSN 444-2341 or commercial 215 737-2341.

d. The HCA submitting Type I complaints will document the call immediately and send written confirmation within 12 hours via facsimile or submit a Complaint Form online. For Type I complaints only, the identity and contact information for the authorizing Medical Officer is required. When a Type II or III complaint is determined appropriate, the medical unit will submit the Complaint Form within 48 hours either by mail to the DSCP address shown below, facsimile to DSN 444-3120/Commerical 215-737-3120, telephonically to DSN 444-2891/Commerical 215-737-2891 or online.

Director, DSCP
ATTN: DSCP-MRCM
700 Robbins Ave
Philadelphia PA 19111-5092

e. Follow-up by mail or electronically with photographs and drawings of equipment with Type III complaints to help describe or substantiate the complaint.

f. Include a specific statement on the storage conditions of the materiel on the Type II complain. An example of the statement would be: “Controlled temperature warehouse or unheated warehouse.”

g. Forward copies of the Complaint Form as directed below:

(1) If not submitted online, forward one copy of complaints regardless of procurement source to:

Director, DSCP
ATTN: DSCP-MRCM
700 Robbins Avenue
Philadelphia PA 19111-5092

(2) One copy of complaints on standard and nonstandard materiel purchased locally to the appropriate local contracting activity.

(3) One copy of complaints for GSA catalog materiel to the GSA regional office.

(4) Information copies of all complaints will be sent to the following addressees

(a) Defense Medical Standardization Board
ATTN: Staff Director
1423 Sultan Drive
Fort Detrick MD 21702-5013

(b) Commander, USAMMA
ATTN: MCMR-MMO-SO
1423 Sultan Drive, Suite 100
Fort Detrick MD 21702-5001

h. The preferred method for the submission of a complaint is electronic filing of a Complaint Form. This method provides simultaneous copies going to DSCP, the DMSB, and the USAMMA, through the INTERNET at https://dmmonline.dscp.dla.mil/forms/mpqdr_entry_new.asp . Upon submission of the complaint, DSCP acknowledges receipt of the complaint via email or other method.

i. Medical materiel complaints submitted on a Complaint Form are exempted from information requirements control under *AR 335-15*.

j. The 21 CFR prescribes reporting certain materiel/equipment conditions to the FDA under the Safe Medical Devices Act (SMDA). Logistics personnel will coordinate and provide a copy of the Complaint Form to the Risk Manager as part of the Risk Management Program. The Risk Manager is required under Joint Commission on Accreditation of Healthcare Organization (JCAHO) to review the SMDA information on the Complaint Form and assess the potential risk.

Additional reports may be required under *AR 385-40*

CHAPTER 5. MEDICAL EQUIPMENT MANAGEMENT

5-1. PROPERTY ACCOUNTABILITY AND MANAGEMENT

a. USAMEDCOM activities will maintain formal property book accounting records only for equipment costing $5,000 or more with the exception of equipment that falls into one of the below criteria. This equipment requires formal property book accountability regardless of cost.

(1) Property that is rented, leased, or loaned.

(2) Equipment that is maintenance significant to include Test, Measurement and Diagnostic Equipment (TMDE).

(3) Army-Managed items with Reportable Item Control Codes of 2, A, B, C, D, E, F, G, H, and J.

(4) Army-managed items with CIIC 1-9, $, N, Q, R, and Y (night-vision goggles). These items are categorized as sensitive and inventoried quarterly.

(5) Property determined to be highly pilferable to include property that may be converted to private use, or has a high potential for theft. Regardless of cost, this property is recorded and controlled as accountable property. Included in this category, but not limited to, are the following items:

Photocopy Machines, Video Cameras, Video Cassette Recorders, Televisions, Automatic Data Processing Equipment (Personal Computer Systems, Laptop Computers, External Modems and disk drives, personal data assistants (PDAs), Printers and Plotters), Facsimile Machines, Portable and Cellular Telephones and All Firearms.

(6) Property authorized by TDA

(7) Property authorized by *CTA 50-900*

(8) Property authorized by *CTA 50-909*

(9) Research, development, test and evaluation property authorized by *AR 70-6*

(10) On-hand commercial items similar to items coded non-expendable in FEDLOG.

(11) Homeland Defense and Special Medical Augmentation Response Team equipment. For purposes of accountability, Homeland Defense equipment is defined as all Hazardous Materiel (HAZMAT) and specialized equipment designed to support MCDM, incidence response. This includes personal protective equipment, decontamination equipment and any other locally procured defensive or response equipment.

b. Rented, Leased, and Loaned Equipment: The PBO will establish property accountability for this equipment within three working days after receipt, regardless of the length of the lease, rental, or loan agreement. Identify this equipment with the appropriate ownership code in accordance with system procedures.

(1) The PBO will maintain a leased equipment file for each contract IAW *AR 710-2*. The PBO will establish similar folders for rented and loaned equipment. For medical equipment, include a copy of the maintenance acceptance inspection work order in addition to the documents required by *AR 710-2* and *AR 71-32*.

(2) A lease/purchase analysis is required for each lease/rental over 60 days in accordance with the Defense Federal Acquisition Regulations Supplement (*DFARS)*, sub-part 207.4, paragraph 207.401. A copy of the lease/purchase analysis will be kept in the leased-equipment file.

c. AUTHORIZATION OF PROPERTY - Property authorizations serve as the authority (but not funding source) to requisition and retain equipment to perform directed missions. Commanders will ensure all property acquired from whatever source, to include excess, will have the proper authorization and justification documents developed and in place prior to obtaining the property.

d. AUTHORIZATION DOCUMENTS - The authorization document is the basis and authority for submitting requisitions for authorized equipment listed in the document. The property book will reflect this authorization. Non-expendable personal property acquired for use within USAMEDCOM will use the following authorization documents:

(1) A TDA is a document that prescribes the organizational structure, personnel, equipment authorizations and requirements of a command. *AR 71-32* governs TDAs. A TDA consists of the following three sections:

Section I: General, describes summary of manpower/equipment, the mission, organization, capabilities, and other general information pertinent to the unit.

Section II: Personnel Allowances, reflects the types and quantities of civilian and military expertise at paragraph and line level of detail. It includes position titles, MOS, grade/rank, identity code, branch code requirements authorizations, and remarks codes.

Section II: Equipment Allowances documents at the LIN level detail, the controlled and non-controlled Army adopted items of equipment having a standard LIN in *SB 700-20*, except for CTA items listed in Chapter 8. LIN, generic nomenclature, and the required and authorized quantities identify equipment allowances.

(2) The Common Table of Allowances (CTA) is an authorization document for items of materiel costing less than $100,000 required for Army-wide use. The purpose of the CTA is to authorize widely used items of relatively low dollar value in one document rather than documenting the items separately in each TDA. Items authorized by a CTA will not be further documented in the TDA. A CTA item can be authorized for various purposes. CTA items are addressed in:

CTA 8-100, Army Medical Department Expendable/Durable Items
CTA 50-900, Clothing and Individual Equipment
CTA 50-909, Field and Garrison Furnishing and Equipment
CTA 50-970, Expendable/Durable Items (except Medical, Class V, Repair Parts and Heraldic Items)

(3) Non-expendable property authorized in *CTAs 50-900* and *50-909* will be accounted for on-property books as prescribed in *AR 710-2,* paragraph 2-5,. Include the appropriate LIN from the cited CTA in the authorization information.

(4) Printed or hard copies of these CTAs are no longer available through publications channels. Electronic versions of these publications are located on the U.S. Army Force Management Support Agency (USAFMSA) web site at: **http://www.usafmsa.army.mil/usafmsa/**.

(5) As a general rule ARs are not permitted to be equipment authorization documents; however, the regulations listed below are exceptions. Listed with each

regulation and directive is a brief description of the equipment the regulation authorizes. The regulations and directives listed below can be used as authorization on the property book:

(a) *AR 1-100*, *Gifts and Donations*, 15 Nov 83. Donated, conditional or unconditional gifts of tangible personal property.

(b) *AR 25-1*, *Army Information Management*, 31 May 02. Non-investment systems or equipment for authorized visual information activities.

(c) *AR 40-61*, *Medical Logistics, Policies and Procedures*, 28 Jan 2005. Medical equipment and supplies not listed in Chapters 2, 4, or 6 of *SB 700-20*. Medical equipment assigned a LIN and listed in the above document must have TDA authorization.

(d) *AR 70-6*, *Development, Test, and Evaluation Army Appropriation,* 16 Jun 86. Research, Development, Test, and Evaluation (RDTE) property.

(e) *AR 600-8-22*, *Military Awards*, 25 Feb 95. Trophies and similar devices. (See Chapter 10).

(f) *AR 608-4*, *Control and Registration of War Trophies and War Trophy Firearms,* 28 Aug 69. War trophies and war trophy firearms.

(g) *AR 725-1*, *Special Authorization and Procedures for Issues, Sales and Loan*s, 17 Oct 03. General officer pistol and flag.

(h) *AR 840-10*, *Flags, Guidons, Streamers, Tabards and Automotive and Aircraft Plates*, 1 Nov 98. Flags, guidons, plates, and tabards.

(i) *AR 870-20*, *Museums, Historical Artifacts, and Art*, 1 Nov 99. Historically significant items such as weapons, military equipment, flags, or articles of uniform or personal equipment.

(j) Local Commander Authorized Approval. This is an authorization for personal property item that is not covered under above sources, not qualified for inclusion on the TDA, and is required by the command. It will be identified on the property book using equipment authorization "*AR 71-32*".

5-2. EQUIPMENT RECEIPT PROCESSING

a. All accountable property items will be processed through the organization's PBO so that the control and accountability for the property can be established and maintained.

b. When accountable property is received, the PBO will:

(1) Update the property records. File the receipt document in the supporting document file to support the increase to the property accounting records. Submit a work order to the medical maintenance branch for a Technical Inspection (TI) of all medical equipment. Medical maintenance personnel will perform a TI of the equipment to ensure the delivered equipment is in compliance with the specifications of the contract, and is operational and safe for patient use. Attention to detail should be given to this process as some equipment may require vendor installation and any package opened may void the contract. A complete TI, if possible, will be performed within four (4) workdays of receipt of the work order by medical maintenance. Upon release of the equipment by medical maintenance personnel, arrange for delivery to the using activity and obtain the hand receipt holder/custodian's signature on the hand receipt transaction register/custodial actions list or DA Form 3161 if equipment is issued before the hand receipt transaction register/custodial actions list is produced. Equipment requiring an extended storage period before installation or acceptance will remain the custodial responsibility of the PBO until installation and acceptance are completed.

(2) File the signed copy of the hand receipt transaction register/ custodial actions list or DA Form 3161 in the applicable hand receipt/property custodian file. Destroy this copy when the item appears correctly on the hand receipt/custodian receipt/locator list and the hand receipt-holder/custodian has signed it.

c. No equipment will be delivered directly to the end user. However, should delivery occur, the end user/hand receipt holder/custodian is required to notify the PBO immediately. Local instructions will be published to inform customers of this requirement. The PBO will coordinate the proper receipt and inspection with the appropriate supply support activity and medical maintenance, if applicable.

d. Receipts for the accountable property must be posted to the property records within three working days of receipt of the item. The three working days begin when Property Management personnel physically receive the item as signified by the date the receiving document is signed. No delay in the receiving process is authorized for technical inspection of the equipment either by the vendor or Medical Maintenance Branch.

e. Concern for voiding a manufacturer's warranty as a result of opening packages to obtain receipt data is not reason for delay in posting items to the property book. While it is important not to unpack equipment prior to the arrival of a vendor who is contractually bound to assemble or install the equipment, this does not prevent recording the receipt of the equipment. Information from the receipt document or packing list accompanying the equipment should be used to process an initial receipt. When the vendor installs the equipment, the initial receipt can then be adjusted with the actual data required to properly account for the item on the property book. In this way, both accountability and responsibility for the equipment are established without invalidating the warranty. The longer equipment remains unaccounted for at an activity, the higher the probability for theft, diversion, or misappropriation.

5-3. DEFENSE MEDICAL LOGISTICS STANDARD SUPPORT (DMLSS) PROPERTY RECORD ADMINISTRATIVE ADJUSTMENT REPORTS

a. Property Record Administrative Adjustment (PRA) reports are automatically generated by Defense Medical Logistics Standard Support (DMLSS) when transactions are processed to change the serial or stock number of an item. The report documents minor changes used to adjust or correct property record deficiencies. The PRA report will not be used as a substitute for financial liability investigations of property loss or other adjustment documents when the possibility of physical substitution or actual loss of property exists.

b. The PRA reports produced by DMLSS will contain a document number with a Julian date equal to the current date and DMLSS assigned serial number. The DMLSS assigned document number will be used to record and file the automated PRA report.

c. The PBO and the Chief of Logistics will sign the last page of the PRA report indicating a review and concurrence of actions taken. The report contains only minor property adjustments; therefore there is no need for command review or approval. Once signed, the PRA report is filed in the supporting document files.

Supporting document files contain all documents supporting entries to the accounting data record in the property book and must be maintained for 6 years in accordance with *AR 710-2*, paragraph 2-5o and 2-5r.

5-4. HAND-RECEIPT HOLDER/CUSTODIAN PROCEDURES

a. Acceptance of and relief from custodial responsibility for accountable property will be accomplished as follows:

(1) When hand receipt/custodial responsibility is to be assumed, the PBO will provide the hand receipt holder/custodian with a Hand Receipt/Custodian Receipt/Locator Listing showing all property charged and due in to the hand-receipt/custodian account. Upon signing and dating the listing, the hand-receipt holder/ custodian assumes responsibility for all in-use items in the quantities indicated and verifies the requirement for all due-ins on the listing. The hand receipt-holder/ custodian will return the original signed listing to the PBO and retain a signed copy as a record of equipment authorized and on hand or due in. As items are issued to or turned-in from the account, the hand-receipt holder/custodian will keep a signed hand receipt transaction register/custodian action list or DA Form 3161 showing the action taken, until the item is correctly listed on the applicable hand receipt/ custodian receipt/locator list at which time it may be destroyed.

(2) The hand-receipt holder/custodian will ensure, by spot check and periodic inventory, that all property in the account is properly charged to the account, is physically on hand, or that appropriate action has been taken to effect settlement for missing or damaged items.

(3) Before a hand-receipt holder/custodian is relieved from duty, transferred, separated from service, or absent from the account for a period longer than 30 days, the PBO will transfer the property to an authorized successor. The hand-receipt holder/custodian will not be relieved of property accountability responsibility until officially cleared by the PBO.

b. Contractors or contractor's personnel shall not be hand-receipt holders/custodians for equipment listed on a USAMEDCOM activity's property books. A contractor can only have responsibility for specifically identified Government Furnished Property (GFP) provided to the contractor under the terms of the contract.

c. Annual Property Inventory.

(1) All property will be inventoried annually by the hand receipt holder/custodian in coordination with the PBO. The PBO will establish a schedule with which to complete the inventory, conduct training, ensure bar code scanners are used, and accomplish the automated reconciliation process available in DMLSS to determine discrepancies between the physical inventory and the property book.

(2) Hand receipt holders/custodians will use bar code scanners to scan all property, conduct a thorough physical area search for any non-expendable personal property not bar coded. Record the results of the inventory on a memorandum. Report all property overages and shortages on the memorandum. The hand-receipt holder/custodian will sign the memorandum. The original copy of the memorandum is filed in the hand receipt/custodian receipt/location list file maintained by the PBO. The hand receipt holder/custodian retains the duplicate copy.

(3) The PBO will review all inventory memorandums submitted by hand receipt holders/custodians for completeness and conduct causative research of any discrepancies. Causative research includes but is not limited to, comparing all postings to the applicable property book records against documents that support those postings, verifying all hand receipt/custodian receipt/location listing change documents, and searching storage areas controlled by the PBO. A Financial Liability Investigation of Property Loss will be initiated and properly adjudicated for any property losses that cannot be reconciled. Establish property-book accountability for un-reconciled overages using "found on installation" procedures.

5-5. MONTHLY WEAPONS AND AMMUNITION INVENTORY

a. *AR 710-2*, Table 2-1j, prescribes monthly physical inventories of weapons and ammunition. Standard procedures for performing the inventory are in *DA Pamphlet 710-2-1*, paragraph 9-10. Specific procedures for USAMEDCOM activities are outlined in the paragraphs below.

b. The PBO will monitor and receive inventory results. As a minimum, the PBO will:

(1) Establish stringent controls on conducting inventories at least monthly (every 30 days). Provide the inventory officer with a serial number listing, either automated or a preprinted memorandum.

(2) Ensure all weapons and ammunitions inventoried are on the property book.

(3) Ensure completion of inventories for all weapons and ammunition on the property book.

(4) Reconcile ammunition expenditures with recorded property book balance.

(5) Confirm someone other than the responsible hand receipt holder/custodian conducts the monthly inventory, and ensure the same individual does not conduct consecutive inventories.

(6) Take immediate corrective action to resolve all discrepancies.

(7) Retain copies of the monthly inventory reports on file IAW *DA Pamphlet 710-2-1*, paragraph 9-10b (4) (two years if no discrepancy noted; four years if a discrepancy was noted).

c. The individual(s) appointed to conduct the weapons/ammunition inventory will:

(1) Record the serial number of weapons inventoried and weapons properly checked out. Clearly distinguish between the two groupings. Notify responsible individual and PBO of any listed weapons you cannot locate, or which are not properly checked out. Weapons checked out should have a DA Form 3749, Equipment Receipt, in the arms rack. Installations/activities will maintain a current listing of all weapons not on hand because of repair.

(2) Record the ammunition inventoried by quantity, lot number, and NSN. Clearly highlight discrepancies noted during the inventory of both weapons and ammunition with information recorded on the memorandum or automated listing provided by the property book officer.

(3) Sign and date the inventory reports and forward the original copy to the PBO.

5-6. MANAGEMENT OF CAPITAL EQUIPMENT

a. Equipment that is defined as investment or capital equipment must be accounted for and reported for capitalization and depreciation in accordance with the Chief Financial Officer (CFO) Act of 1990 and the Federal Financial Management Improvement Act of 1996. USAMEDCOM is responsible for reporting medical investment equipment accounting information to DFAS annually for all USAMEDCOM activities.

b. Automated property accounting system user will adhere to their automated system's procedures when entering investment/capital equipment into the system.

(1) Depreciation of investment equipment is calculated in DMLSS, based on a straight-line depreciation method over a five-year life. Fully depreciated equipment will have zero depreciation at the end of the five years and will no longer be reported. The useful life of five years does not change the life expectancy for the equipment listed in *TB MED 7*.

(2) Original acquisition cost includes all costs incurred to bring capital equipment into service for its intended use. These costs include amounts paid to vendors, transportation to point of initial use, handling and storage costs, interest costs paid, direct and indirect production costs, installation costs, value of equipment traded-in, and training costs.

(3) Investment equipment acquisition date (in-service date) is the date when the title for the equipment passes to the Army or when the item is delivered to the Army or to an agent of the Army. Investment equipment acquired under a capital lease should be recorded as an asset at lease inception. For constructed assets, the "acquisition date" should be the date the asset is placed in service.

(4) Only add the value of upgrades/improvement costs if equal to or greater than $100,000.

(5) Transportation costs for lateral transfers must be added to the equipment CFO Record for a single piece of equipment or to the system line ("AA") if it is a system. Do not add it to the component lines. The losing PBO must request a copy of the Government Bill of Lading showing the transportation cost, shipping and handling from the Installation Transportation Office (ITO). For shipments containing multiple items, ask the ITO to list the costs of the individual items of equipment, if possible. If the ITO cannot provide the separate lines, then pro-rate the cost to each item by dividing the total cost equally among the items and input to the CFO Record. If the transportation cost is not available at the time of shipment, the losing PBO will, upon receipt of the transportation costs, adjust the equipment record. Print and fax a copy of the adjusted CFO Record to the gaining activity with the added transportation cost. The transportation costs are depicted on both property books, as a loss to the loosing activity and a gain to the receiving activity.

c. The Property Book Officer (PBO) is responsible for ensuring required source documentation is maintained for all capital equipment on hand. Capital equipment (including central purchases) will be supported by the contract (DD Form 1155), receiving report (DD Form 250), vendor invoice, and other sources that capture and document ancillary costs. Transferred capital equipment will be supported by the DD Form 1149/DA Form 3161, contract, receiving report, vendor invoice, and other appropriate documents. Figure 5- 1 outlines procedures the PBO must follow to locate the source documentation if not on file.

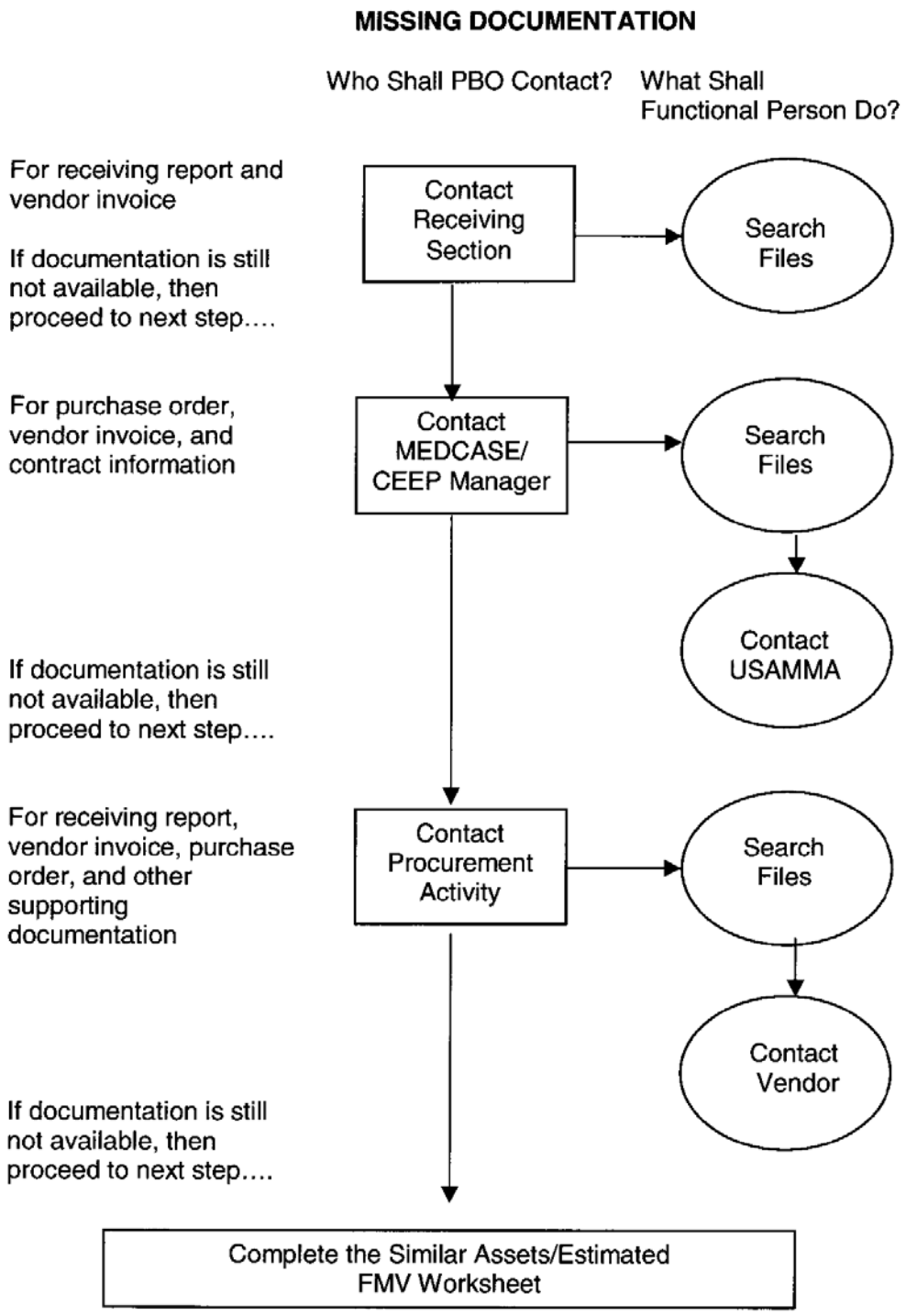
MISSING DOCUMENTATION
Who Shall PBO Contact?
What Shall Functional Person Do?
For receiving report and vendor invoice
If documentation is still not available, then proceed to next step....
Contact Receiving Section
Search Files
For purchase order, vendor invoice, and contract information
Contact MEDCASE/ CEEP Manager
Search Files
Contact USAMMA
If documentation is still not available, then proceed to next step....
For receiving report, vendor invoice, purchase order, and other supporting documentation
Contact Procurement Activity
Search Files
Contact Vendor
If documentation is still not available, then proceed to next step....
Complete the Similar Assets/Estimated FMV Worksheet

Figure 5-1

If the source documents cannot be obtained, the PBO will prepare a Similar Assets/Estimated Fair Market Value (FMV) Worksheet. A copy of the instructions and worksheet are Appendix A.

(1). Donated or found capital equipment will be supported by the Similar Assets/Estimated FMV Worksheet.

(2). Searching for source documentation or preparing the Similar Asset/Estimated FMV Worksheet is not required for fully depreciated equipment as of 1 October 2003.

(3). Acquisition cost estimates will be used only when the acquisition cost is unknown, source documentation is unavailable, and a similar asset exists. If a cost estimate is required for capital equipment item, the PBO will proceed as follows:

(a). Locate a similar asset using the property book database.

(b). Determine if the assets have similar model years.

(c) If the previous two criteria are met:

(1) Obtain a copy of the supporting documentation and document on a Similar Assets/Estimated FMV Worksheet why the assets are comparable.

(2) Review the documentation for cost information, specifications, and other pertinent information (method of acquisition, nomenclature, and description of function) to assign an acquisition cost. The estimated acquisition cost may be based on the following information:

a) The cost of similar assets at the time of acquisition, or

b) The acquisition costs of similar assets, taking into consideration changes in the Consumer Price Index between the date the item was acquired and the date the similar asset was acquired.

(d). If a similar asset cannot be located, determine the capital equipment's FMV from the vendor quote, the catalog price, or the GSA schedule. Document the information on the Similar Assets/Estimated FMV Worksheet.

(e). In the event the documents described above are not available, document the justification for the estimated FMV on the Similar Assets/Estimated FMV Worksheet.

d. When transferring capital equipment between property books, data required by the CFO Act must be entered on the applicable lateral transfer document (DD Form 1149 or DA Form 3161). Data elements required in addition to identification data elements are:

(1) Acquisition Cost – required.
(2) Residual Value – optional
(only required if assigned by losing activity).
(3) Transportation Cost – optional
(only required if assigned by the losing activity).

(4) Improvement Cost – optional
(only required if assigned by the losing activity).
(5) Accumulated Depreciation – mandatory.
(6) Accumulated Improvement Depreciation – optional
(This is only required if assigned by losing activity. If there is an improvement cost there must be accumulated improvement depreciation.).

e. All documentation must accompany equipment when it is transferred. This includes the documents from the supporting document file, MEDCASE file and a copy of the CFO Record. Copies of supporting documentation shall be retained by the transferring activity; the originals are forwarded to the gaining activity. The gaining PBO must contact the losing PBO if this documentation isn't received with the equipment.

f. The lateral transfer loss is not removed from the loosing activity accountable records until a copy of the signed DD Form 1149 or DA Form 3161 is received from the gaining PBO.

g. Capital equipment leases are leases that transfer substantially all benefits and risks of ownership to the lessee. If, at its inception, a lease meets one or more of the following four criteria, the lessee should classify the lease as a capital lease.

(1) The lease transfers ownership of the property to the lessee by the end of the lease term.

(2) The lease contains an option to purchase the leased property at a bargain price.

(3) The lease term is equal to or greater than 75 percent of the estimated economic life of the leased property.

(4) The present value of rental and other minimum lease payments, excluding that portion of the payments representing executor cost, equals or exceeds 90 percent of the fair value of the leased property.

h. If the leased equipment meets any one of the four criteria for capital lease, identify it on the automated property records as such in accordance with the system procedures. The acquisition cost will be the actual cost of a like item or the fair market value if no like item is available. An acquisition cost is required regardless of the type of lease. Leases not meeting the above criteria are classified as an operating lease. Operating leases are leases in which the activity does not assume the risks of ownership of the equipment. Multi-year service contracts and multi-year purchase contracts for expendable commodities are not capital leases.

i. Reporting and turn in of investment equipment is processed IAW *AR 710-2* and *AR 40-61*. All documentation will be transferred with the equipment when turned-in to the supply support activity or DRMO. The PBO will retain a copy of this documentation on file along with the turn-in documentation.

5-7. MANAGEMENT OF SYSTEMS AND COMPONENTS

a. Accountable property should be recorded on an item-level basis (i.e., each individual item in a separate record). However, when considered advantageous to

do so or required to comply with capital equipment reporting requirements, records will be maintained on a system basis.

(1) The system method may be used when:

(a) Two or more individual items (equipment components) are part of a system; and

(b) The system is considered to be incomplete or inoperable in the absence of any one of its component equipment items.

b. DMLSS users will adhere to the following procedures to establish a system on the property book:

(1) Establish a "due-in" for the item in accordance with DMLSS procedures.

(2) Receive the system in accordance with DMLSS and local procedures. Identify this with an Equipment Type of "System". This is an actual item and should be the major component of the system. Record the total cost of the system on this Equipment Control Number (ECN).

(3) Gain the other components of the system using the DMLSS ETM Gain module with the reason "Component Gain". Ensure the components are associated with the same ECN used for the system.

(4) Return to the system record and select the Acquisition Cost icon and adjust the purchase price to reflect the actual acquisition cost, installation cost, trade-in value, etc. The total cost of the system is recorded on the system line.

(5) Identify components requiring medical maintenance services. Update the catalog record to signify which components require maintenance services.

c. USAMEDCOM activities with Digital Imaging Network – Picture Archiving Communications Systems (DIN-PACS) will ensure the system and all components are properly accounted for in DMLSS. Device tracking is a requirement of JCAHO. Appendix B contains detailed procedures.

5-8. MILITARY MEDICAL BENEFITS PROPERTY (MMBP) LOAN PROCEDURES

a. Activities maintaining equipment accounting record using the DMLSS system will manage the Military Medical Benefit Property (MMBP) loans in accordance with the applicable system's operating procedures.

b. Activities using manual equipment accounting records or an automated system without a specific MMBP loan process will account for and record MMBP property loans as follows:

(1) MMBP property will be listed on a separate hand receipt.

(2) MMBP property lent to a patient will be listed on DA Form 3161.

(a) Block 2 of DA Form 3161 will reflect the complete name, address, category, telephone number, and social security number of the borrower.

(b) DA Form 3161 will have, in addition to a listing of the equipment lent, the following statement:

I hereby acknowledge acceptance of the above-listed Government–owned equipment received in good working order and repair, for temporary use. During the period (___enter date ___) to (___ enter date ___). I understand that I am responsible for proper care and safekeeping of the equipment and will promptly return it/them in the same condition as received, fair wear and tear expected, upon termination of the loan period specified unless an approved extension is obtained, or at such earlier date as I may elect. In the event of loss, damage or destruction of the equipment through fault or neglect, I agree to reimburse the Government the cost of repair or fair market value of the equipment as appropriate.

I have been informed that periodic maintenance services are to be performed (insert frequency). Service is required (_____ enter dates _____). When feasible, it is my responsibility to transport the equipment to (_____insert HCA_____) to obtain the required services. Prior arrangements by telephoning (___number___) for services should be made. If I relocate to another area and will receive medical care from another Federal health care facility must notify (___ insert property manager _____) so that equipment transfer can be accomplished and designation of a new supporting maintenance activity can be established.

It is further understood that the equipment on loan is not to be permanently removed from the address indicated in block 2 of the hand receipt without prior authorization of the commander (name of the HCA).

(Signature of patient or sponsor)

(c) DA Form 3161 will be prepared in duplicate and signed by the patient or sponsor accepting the loan. The MMBP manager will keep the original copy with the written prescription or letter. The second copy will be given to the borrower.

(d) MMBP Reconciliation: The physical inventory of MMBP equipment on loan is not required. However, equipment on loan will be reconciled each year to verify the accuracy of property book and hand receipt balances. Reconciliation may be accomplished telephonically or by certified mail. If all efforts to reconcile lent MMBP property fail, obtain relief from property accountability through procedures in *AR 735-5*.

5-9. OXYGEN FOR HOME USE

Oxygen and oxygen-related supplies that are provided to outpatients for home use may be provided pursuant to the availability of funds by one of the following methods:

a. The HCA may contract with a local oxygen supplier to provide complete home service. This service should include safety and operating instructions, gas cylinders, tubing, regulators, maintenance, and all other related supplies.

b. When a HCA does not contract for home oxygen service, government-owned cylinders and equipment may be provided for outpatient use. If this method is used, follow these guidelines:

(1) Establish local procedures to provide safety, operating, and refill procedures as well as tubing, regulators, and other necessary supplies.

(2) Establish procedures for medical maintenance to inspect regulators and other oxygen related equipment prior to issue or loan to the patient, during home use, and upon return of the equipment to the HCA.

5-10. ORGANIZATIONAL CLOTHING AND INDIVIDUAL EQUIPMENT (OCIE) WAIVER PROCEDURES

a. All USAMEDCOM activities/units located on an installation with a Central Issue Facility (CIF) must seek and obtain OCIE support from the supporting CIF. Coordination should be made with the supporting CIF to transfer on-hand property book OCIE items and determine specific method of support; support levels and means or reimbursement must be documented on an Installation Support Agreement. When the activity/unit is not located on an installation, or located on an installation without a CIF, and the distance is such as to cause significant inconvenience/hardship, the activity/unit must request authorization to maintain OCIE as an exception to policy.

b. The request must explain why installation support is not used. Along with the request for an exception to policy, the activity/unit must submit its written operating procedures for the unit OCIE Issue Point in accordance with *AR 710-2*, *DA Pamphlet 710-2-1*, and *AR 735-5*. The exception to policy must be submitted through formal channels beginning with the applicable RMC or MSC through USAMEDCOM to the DA. The USAMEDCOM will review and submit to DA (for approval/disapproval) only those exceptions to policy, which meet the criteria identified above.

c. Commanders authorized to maintain OCIE on their property books will follow procedures described in *DA Pamphlet 710-2-1*, Chapters 4 and 10, to account for and assign responsibility of OCIE, respectively.

5-11 LATERAL TRANSFER PROCEDURES

a. Activities may laterally transfer excess equipment with a unit price less than $350,000 without reporting it as excess if they have identified a gaining activity. Activities will report excess equipment command wide if they cannot find a gaining activity.

b. The losing activity commander signs the lateral transfer document as the approving authority. The RMC can withdraw or modify lateral transfer authority from its activity commanders. The RMC commander can supplement these lateral transfer procedures as they see appropriate.

c. The losing activity should ship equipment to the gaining activity within three weeks of disposition instruction receipt. The gaining activity is responsible for all shipping costs. Equipment will be shipped in accordance with *AR 746-1*. Ensure equipment is properly packed, crated, and shipped. Activities receiving damaged equipment will attempt to resolve the situation at their level.

d. Laterally-transferred equipment will include:
(1) Supporting supplies (expendables) and accessories on hand.
(2) Supporting repair parts and listing(s) on hand.

(3) Operator's manuals, manufacturer's literature, and technical manuals.

(4) The maintenance history/records to include the work order requesting the excess technical inspection for condition code. Activities using DMLSS to account for their property will send the Historical Maintenance Report and the Equipment Detail Report. Both reports are printed from the Equipment Management equipment detail window.

(5) CFO files when applicable.

e. The gaining activity establishes property accountability upon receipt and will return the signed lateral transfer document within three (3) days of receipt. They acknowledge receipt by returning the original signed copy of the lateral transfer document to the losing activity. The losing activity will place the signed copy of the documentation for the lateral transfer in the supporting document files.

5-12. EXCESS PROPERTY PROCEDURES

a. Efficient and prudent logistics management is more than getting the right equipment to the right place at the right time; it also includes eliminating redundant or excess equipment. Annually, the Army spends an enormous amount of time, labor, and money maintaining and storing excess equipment. These expenses are avoidable. Effective and efficient utilization and disposal of excess equipment is one of the most important phases in life-cycle management. Every facility benefits from timely and proper disposal of excess property because:

- timely disposal makes property available to the entire DoD.
- you may be able to reduce costs by using other facility's excess equipment.
- disposal of excess equipment reduces the time needed to locate unused equipment during required inventories and for maintenance services.
- you are properly prepared for any audit.

(1) The objective for each property book is to have no more than 3% (equipment items and/or property book value) as excess.

(2) Each activity will establish controls to ensure that all hand receipt holders/custodians continually evaluate the need for assigned equipment. Hand receipt holders/custodians will retain only that equipment necessary to perform the assigned functions. When excess equipment is identified, it will be turned-in for reassignment or disposal as excess.

(3) Equipment determined to be excess to an activity is transferred to the designated excess hand receipt/custodian location list in accordance with automated property book system procedures. A technical inspection/classification will be initiated by the property book officer within 15 days of the date the equipment is turned-in as excess. It is essential that an accurate condition code be assigned to all equipment prior to it being reported as excess. This equipment is redistributed directly from one activity to another based on the reported condition code. The credibility of this program is a direct result of the reporting activity's ability to correctly identify the condition of each piece of equipment.

(4) Equipment turned-in that is neither serviceable nor economically repairable due to normal usage will be disposed of in accordance with DoD Regulation 4160.21-M within 30 days of turn-in.

(5) Serviceable/economically repairable equipment will be advertised to internal customers. The property book officer will broadcast the availability of excess equipment to internal sections and staff using standard departmental e-mail, posted lists and/or routed notices. Excess equipment not re-distributed internally will be reported as excess within 30 days of excess determination in accordance with automated property book procedures. The 30-day time limit starts on the date of transfer to the excess hand receipt/custodian location list.

b. DMLSS Reporting And Requesting Materiel Through The Tri-Service Medical Excess Distribution System (TRIMEDS)

(1) All excess reported by DMLSS sites is posted daily on the TRIMEDS website: https://afml.ft-detrick.af.mil/afmlo/TRIMEDS/main.cfm. Users can browse the website at their convenience. Air Force as well as Army excess is advertised on this site and is available to all three services. The reporting criterion for excess equipment is as follows:

- Total minimum line item value is $250.
- Condition Codes A, B and C are the only acceptable codes.

(2) Excess will be advertised for 45 days through the TRIMED website. Army excess will be available to Army activities only for the first 20 days and all other eligible requesters for the remaining 25 days. The gaining activity is responsible for coordinating the acquisition of excess equipment. The gaining activity is responsible for all shipping costs.

(3) Activities should screen the TRIMED website excess list closely for items that can be used in their activities. Pay particular attention to condition codes and dates. When requesting equipment items, the BMET at the requesting activity should contact the BMET at the reporting facility to determine if the equipment can meet the requesting activity's needs.

(4) Gaining activities that receive discrepant shipments or do not receive a shipment within normal pipeline time for the mode of transportation used will notify the reporting activity in writing requesting an explanation for the delay or explaining the discrepancy. File a copy of the written notice with the receipt document.

(5) Reporting activities not receiving redistribution instructions by the end of the 45-day advertisement period will initiate a turn-in to the DRMO in accordance with DoD 4160.21M. Turn-in will be accomplished within 30 days of the end of the advertising period.

CAUTION. Excess property may not be provided to governmental agencies outside DoD such as the DVA, Public Health Service (PHS), Indian Health Service (HIS), or to state and local governments, or civilian concerns without prior screening by USAMEDCOM activities, other Army activities, and DoD, and without going through the local DRMO. DRMO is the official conduit for transferring DoD excess property to any agency outside DoD. Assistance may be obtained from the local DRMO.

c. Turn-in Procedures

Equipment reported and not being transferred to another activity or is unserviceable, and cannot be economically repaired, may be turned-in directly to the DRMO. Turn-in procedures are as follows:

(1) The PBO shall prepare a DD Form 1348-1A (Issue Release/Receipt Document) in accordance with DoD 4160.21-M.

(2) The property and a properly prepared DD Form 1348-1A will be taken to DRMO where the document is stamped/signed to verify receipt. An unsigned/unstamped (by DRMO) DD Form 1348-1A is not acceptable as a supporting document for the loss.

(3) The equipment will be removed from the property book following the automated procedures for the applicable system.

(4) Periodically, the PBO shall obtain a listing of all equipment received by DRMO from his/her activity and compare that listing to activity records to ensure that all items sent to DRMO were properly documented and processed in the property system. The PBO should resolve any errors within 5 business days. The reconciliation records should be maintained in the property records until the next reconciliation.

5-13. PROPERTY BOOK CLOSEOUT PROCEDURES

The U.S. Army Medical Command (USAMEDCOM) MSCs are responsible for verifying the final closeout of property book(s) belonging to their subordinate units, installations and activities. The purpose of verifying closure of the property book is to validate the accuracy and completeness of the property book and supporting documents, to ensure that all property-book- recorded assets have been properly disposed of, and that all open requisitions have been cancelled or a new ship to address is reflected in the logistics records. The verification process will be performed by an individual (verifying officer) from an organization other than whose property book is closing out. When a property book is to be closed, the following guidelines are given:

a. The MSC Commander will advise the unit/installation/activity commander, in writing, of the effective date and the reason for the closeout. One copy of this notification or other pertinent orders will be filed with the property records.

b. The PBO will conduct a complete physical inventory of property recorded on the property book and either laterally transfer those assets to another property book or turn in those assets to the supporting stock record account or Defense Reutilization and Marketing Office (DRMO). The property book will reflect these transactions. The intent is to bring each record on the property book to zero balance prior to the close out effective date.

c. The unit/installation/activity inactivating will submit requests for cancellation of those requisitions for all supply classes not expected to be consumed prior to the inactivation effective date. The common sense rule applies. The document register should reflect these actions. When verification of the cancellation request is not received the request for cancellation will serve as the supporting document to close the property book.

d. Request cancellation of the property book DODAAC once all property book records are reduced to zero.

e. The verifying officer will:

(1) Initiate the verification process within 10 workdays after all property book on hand balances are reduced to zero.

(2) Include as part of the verification process that;

(a) The recorded balance on each property record was properly brought to zero balance through turn-in or lateral transfer procedures.

(b) Documents listed on the document register have a corresponding hard copy supporting document on file.

(c) All open supply requests are canceled.

(d) The non-expendable document register is closed.

(e) The assigned property book DODAAC was cancelled.

f. Since it is not likely that all line items on the unit's property book can be verified, the verifying officer must take a sample. The size of the sample should not necessarily be a set percentage (10 percent, 15 percent, etc.) of the property book line items. The extent of this verification should depend on the results of recent inspections of the activities' property book. In other words, if significant discrepancies were disclosed, then a more extensive examination should be done. The line items selected for sampling should be selected on the basis of cost, sensitivity, desirability, or any other factor which may warrant inclusion. Since the examination will include only a portion of the total property book line items, it is critical that items selected for the sample have significance.

g. Upon completion of the property book closeout verification the verifying officer will report in writing to the commander that appointed the PBO that he/she has verified the property book has been closed out. When the accuracy and completeness of the property book cannot be verified, the verifying officer will recommend action under the provisions of *AR 15-6* or *735-5* to his/her appointing authority.

h. The commander that appointed the PBO will:

(1) If the property book close out cannot be verified, the commander will direct actions to correct any discrepancies. The notice of corrective action undertaken and estimated completion date will be sent to notify the MSC commander and this office,

CDR, USAMEDCOM
ATTN: MCLO (Property Management)
2050 Worth Rd. Ste 8
FT Sam Houston, TX 78234-6008

The PBO will not be relieved from accountability until all property has been accounted for.

(2) When satisfied that all required actions are completed and no formal audit, i.e., Criminal Investigation Division or *AR 15-6* investigation, is necessary, the commander will prepare a statement certifying all actions in paragraph (1) above are completed. Provide a copy to the MSC commander and this office,

CDR, USAMEDCOM
ATTN: MCLO (Property Management)
2050 Worth Rd. Ste 8
FT Sam Houston, TX 78234-6008

(3) Rescind the PBO's appointment.

Final disposition of documents supporting entries to the property book will be in accordance with *AR 25-400-2*.

CHAPTER 6. MEDICAL EQUIPMENT MAINTENANCE

6-1. Medical equipment maintenance procedures for MEDCOM TDA Activities are contained in TB MED 750-1 dated April 1998. *TB MED 750-1* procedures are further supplemented by Operation Management Bulletins.

6-2. The medical equipment maintenance procedures for TO&E units in draft form are included in Appendix C. The draft publication has been provided to the Office of the Surgeon General and is in the process of being formally staffed.

CHAPTER 7. ENVIRONMENTAL SERVICES MANAGEMENT IN HEALTHCARE ORGANIZATIONS

7-1. ENVIRONMENTAL SERVICES MANAGEMENT - SCOPE

a. The scope of Environmental Services (ES) management in the HCA encompasses, at minimum, these core functions:

- Textile care services (laundry and linen distribution),
- Housekeeping services, and
- Regulated medical waste disposition.

(1) The Director/Chief of Logistics will have management responsibility over HCA Environmental Services.

(2) The Chief of Environmental Services (C, ES,) will have functional responsibility and must be a qualified Healthcare Environmental Services Manager (i.e., GS-673 occupational series) assigned to the HCA staff to manage the ES integrated functions.

(3) The C, ES, will be responsible and accountable for the submission of data to the USAMEDCOM Environmental Service Management Information System (ESMIS) using the **http://www.medlogspt.army.mil** website. Reporting instructions are provided at the ES website.

(4) The Army Civilian Training, Education, and Development System (ACTEDS) plan for the GS-673 Occupational Series provides the careerist and management with a guide to assist in career enhancement and progression. Training and development planning is essential in developing and enhancing the C, ES's knowledge, skills, and abilities. The ACTEDS, if followed, will provide all ES personnel the avenue to become more proficient in the field.

b. Further guidance, if needed, may be obtained upon request from the USAMEDCOM ES Program Management Office.

7-2. MANAGEMENT OF HEALTHCARE TEXTILE CARE SERVICES

Policy and Procedural Guidance

a. The current editions of following publications will be readily accessible: *AR 40-61*; *AR 210-130*; *29 CFR*; and the *JCAHO Accreditation Manual for Healthcare Organizations*.

b. The HCA commander will establish a Linen Management Committee (LMC).

c. The C, ES oversees the day-to-day functions involved with management of textile care Services to include textile accounting, identifying requirements, stockage levels, storage, handling, distribution and contract administration.

d. The C, ES will ensure that:

<u>Textile Services Operations Program:</u>

(1) Complies with the HCA infection control procedures.

(2) Provides for textile repair and special fabrications.

(3) Provides a documented continuing education program for textile services personnel.

Textile Accounting:

(1) HCA-owned-and-provided textiles are accounted for on DA Form 1296 or automated equivalent.

(2) DA Form 2064 or automated equivalent and voucher files are used to support all entries.

(3) Records are held for two years after the last posting date and then destroyed.

Textile Inventories:

(1) Linen inventories are conducted at least annually for HCA-owned and provided textiles, and the results are used to evaluate the effectiveness of the Textile Services Program.

(2) DA Form 444 or automated equivalent is prepared for HCA-owned-and-provided textiles to document inventory gains and losses and to adjust informal accounting records.

(3) Inventory results for HCA-owned-and-provided textiles are reported through the Linen Management Committee to the Commander for appropriate action and approval.

Textile Stockage Levels:

(1) Economic stock levels are established at the customers' locations.

(2) Customer linen usage is periodically reviewed, and patterns of inappropriate use are corrected.

Textile Handling, Storage and Distribution:

(1) Clean linen is delivered to the user in a manner that minimizes microbial contamination from surface contact or airborne deposition.

(2) Collection and processing of soiled linen is performed in accordance with the OSHA Blood-borne Pathogens standards.

(3) Soiled Linen is transported in closed containers.

Textile Disposal:

(1) Salvageable HCA-owned-and-provided textiles are turned in to the supporting DRMO or converted to rags.

(2) A disinterested officer is appointed on orders to certify that salvageable HCA-owned textiles are converted to rags.

Linen Control:

(1) Policy is established, and enforced by the LMC, to prevent the theft, abuse, and misuse of linen.

(2) HCA-owned linen is marked with HCA logo or by other means to identify it as government property.

(3) Contractor-owned-and-provided textiles are marked as prescribed in the contract.

(4) The HCA has a policy established and approved the commander, for the use of scrubs.

Contract Laundry Services:

(1) The ES Linen Management Officer, is designated as the COR if the linen/laundry service is contracted by the HCA.

(2) A quality assurance surveillance program is implemented to evaluate quality, quantity, and timeliness of performance in accordance with contract specifications.

(3) The recommended practices provided in American National Standard Institute (ANSI) (www.ansi.org) and the Healthcare Laundry Accreditation Council (HLAC) (www.hlacnet.org) are included in contract specifications.

Exposure Control Plan:

(1) The HCA or contractor, as applicable, has an Exposure Control Plan (ECP), in accordance with *29 CFR 1910.1030* and JCAHO requirements.

(2) The ECP identifies tasks and procedures where textile-care- services employees may be at risk of encountering occupational exposure to blood- borne pathogens.

(3) The ECP is reviewed and updated annually, and is available to all HCA textile-care-services employees.

Linen Management Committee:

(1) The HCA has an established LMC to recommend linen management policy and review program performance.

(2) The LMC consists of the following appointed members: Deputy Commander for Administration; Deputy Commander for Clinical Services; Chief, Logistics/Director of Logistics; C, Environmental Services; Chief Nurse; Infection Control Officer, Chief Dept of Emergency Medicine; Others, as required.

(3) LMCs if integrated with another HCA (parent) committee must be sanctioned by the commander and fully performs its responsibilities.

7-3. MANAGEMENT OF HEALTHCARE HOUSEKEEPING SERVICES

Policy and Procedural Guidance

a. The current editions of following publications will be readily accessible: *AR 40-61, AR 210-130; 29 CFR*; and the JCAHO Accreditation Manual for Healthcare Organizations.

b. The C, ES / ES Housekeeping Officer oversees the day-to-day functions involved with management of HCA Housekeeping Services.

c. The ES Housekeeping Officer, will ensure that:

Housekeeping Services Operations:

(1) A written cleaning schedule and cleaning procedures are established.

(2) A training program is in place for housekeeping employees, and documentation is maintained on personnel trained, and the training topic

Chemicals:

(1) The HCA's Infection Control Committee provides written approval, in its meeting minutes, of all chemical products used by the housekeeping organization. Chemical cleaning products must be approved annually or more often as necessary.

(2) The housekeeping organization follows prescribed manufacturer-recommended dilution rates when mixing the disinfectant detergents for prevention of nosocomial infection in patient care areas.

(3) The housekeeping organization follows prescribed contact times when applying the disinfectant detergents.

(4) The Materiel Data Safety Sheets (MSDS) for cleaning supplies are readily accessible. Note: As a minimum, a current and readable MSDS for each product in use should be located in a binder in each housekeeping closet.

(5) The housekeeping organization properly labels all secondary containers whenever cleaning supplies are transferred from the manufacturer's original container.

Infection Control:

(1) The HCA housekeeping services program integrates with the facility's infection control program.

(2) Approval is obtained from the local Infection Control Committee for cleaning procedures and cleaning supplies.

Contracting Housekeeping Services:

The C, ES / ES Housekeeping Officer is designated, in writing, as the COR. he Contracting Officer is responsible for quality assurance surveillance of the contractor's performance.

Quality Assurance Surveillance:

(1) Establish and maintain a quality assurance surveillance plan to assess and measure housekeeping service performance.

(2) The HCA housekeeping officer establishes and properly implements a random sampling inspection system, in accordance with USAMEDCOM guidelines, to evaluate the quality of contract performance.

Exposure Control Plan:

(1) The HCA has a current Blood-borne Pathogens Exposure Control Plan that identifies by position, task, and procedures where housekeeping services employees are at risk of occupational exposure to blood borne pathogens.

(2) The current Blood-borne Pathogens Exposure Control Plan is readily available for review by all housekeeping services employees.

7-4. MANAGEMENT OF REGULATED MEDICAL WASTE (RMW)

Policy and Procedural Guidance

a. In addition to hospital and installation regulations, current editions of the following publications will be readily accessible: *AR 40-61; AR 200-1; AR 200-1Spill/Emergency Plans/Waste Management Plan*; Applicable State and Local regulations; *USAMEDCOM Regulation 40-35; 29 CFR*; and the *JCAHO Accreditation Manual for Healthcare Organizations*.

b. The C, ES, will have functional responsibility for the collection, storage, and disposal of RMW.

c. The HCA Preventive Medicine Service will assist the C, ES in the management of RMW.

d. RMW Definition: Waste generated in the diagnosis, treatment, or immunization of human beings or animals which is capable of causing disease or which, if not handled properly, poses a risk to individual or a community. These wastes are also called "**Infectious** Waste," Biohazardous Waste," "Clinical Waste," Biomedical Waste," or simply Medical Waste."

e. The C, ES, will ensure that:

Management of RMW Program:

(1) Government personnel and contractor employees are trained in proper collection and handling of RMW.

(2) A written HCA contingency plan exists for RMW disposal.

Collection & Handling

(1) Sharps are placed into puncture resistant container designated for sharps use.

(2) RMW is placed in containers only designated for RMW.

(3) RMW is deposited in leak proof, puncture resistant, plastic bag lined receptacles.

(4) Plastic bags are sturdy, tear resistant, 3 mil thick bags of instillation-specific color (generally red).

(5) State requirements regarding the thickness or strength of the RMW bag for waste collection are to be met. Meeting the state requirement takes precedence over the thickness and strength requirements of MEDCOM Reg 40-35 and SB 8-75-11.

(6) Medical waste bags are securely tied and sealed before being removed from the points of generation.

(7) Medical waste bags are not shaken or squeezed in an attempt to reduce volume and never compact or crush the waste to make room for more.

(8) Sealed medical waste bags are carried by their necks to the transport cart and not lifted or held by the bottom or sides.

(9) Sealed medical waste bags are carried away form the body.

(10) Gloves are worn when handling bagged RMW.

(11) Sharps containers are removed from service when approximately three-fourths full.

Storage:

(1) RMW waste is stored in a secure, properly identified area that is kept clean and free of pests.

(2) Main storage area is identified by affixing a sign bearing an OSHA biohazard symbol and words identifying the item being stored (RMW) to the outside of the storage facility.

(3) Pathological wastes are refrigerated or frozen while awaiting pick up for disposal.

(4) Pathological wastes are removed from the refrigerators/freezer and disposed of within 30 days.

Transport:

Within the Activity:

(1) Housekeeping, or other designated personnel, collect and transport RMW to a facility RMW holding area.

(2) Carts used to transport RMW are constructed of readily cleanable material, plastic, or stainless steel.

(3) Carts used to transport RMW within the MTF are cleaned with an Environmental Protection Agency (EPA) registered hospital detergent-disinfectant, either weekly or at a frequency specified by the MTF.

(4) Bags of RMW are placed in leak proof, rigid containers and marked with the universal biohazard symbol. Red bags do no need to be marked with the universal biohazard symbol unless required by state of local regulations.

On the Installation:

(1) RMW destined for disposal is transported in a government owned or contractor-owned vehicle. The use of privately owned vehicles is prohibited.

(2) A spill containment and clean-up kit is maintained in each vehicle transporting RMW.

Outside the Installation Boundaries:

(1) Commercial activities contracted to transport are registered, licensed, and permitted RMW Transporters in accordance with all federal, state, and local laws and regulations.

(2) Government organizations that transport RMW follow the guidance provided in MEDCOM Reg 40-35.

(3) Only a DoD certifying official sign shipping papers. A DoD certifying official is a person who has successfully completed an approved DoD hazardous materials certification course and is appointed in writing by activity/unit commander.

Treatment/Disposal:

(1) Commercial activities contracted to treat and dispose of RMW are licensed to accept and process RMW in accordance with federal, state, and local requirements.

(2) On Installation treatment of RMW follow procedures and guidance provided in MEDCOM Reg 40-35.

Documentation:

(1) RMW generation-weights are tracked by the activity.

(2) RMW weight reports are maintained on file for two (2) years.

(3) Tracking documents (manifests) are maintained for the number of years required by the state.

Contingency Planning:

(1) The activity maintains a detailed contingency plan for RMW disposal as a means of managing medical waste when primary means of disposal are limited or prohibited.

(2) Contingency plans are reviewed and updated annually.

(3) Contingency plans meet all local, state, and federal regulations.

f. The Preventive Medicine Service will:

(1) Assist in developing local RMW management policies and guidance.

(2) Monitor the management of RMW, including collection, storage, treatment and disposal.

(3) Provide technical advice in identifying and characterizing RMW.

(4) Participate in the planning and providing of training.

CHAPTER 8. FACILITY LIFE-CYCLE MANAGEMENT

8-1. PURPOSE

This chapter of the 2005 SB 8-75-11 prescribes OTSG/USAMEDCOM requirements for managing facilities at the medical treatment center or activity level.

8-2. SCOPE

This chapter describes the roles and responsibilities of the facility manager at the installation level. It describes the functions associated with operating, maintaining, repairing, and constructing USAMEDCOM facilities. It is developed as a life cycle (cradle-to-grave) standard for facility management.

a. Facility Life Cycle Management (FLCM). FLCM is the process of economically managing facility operations, maintenance, repair, and alterations from the time a facility is constructed until it is demolished, in order to maximize productive use of the facility and realize a positive economic return on investment. The execution of FLCM requires that all statutory and headquarters-based financial thresholds be adhered to. Thresholds annotated in this document can change so it is incumbent upon the facility manager to verify the threshold before proceeding with any repair or construction activity.

b. Investment Strategy. A sound investment and management strategy is essential in the effective allocation of limited financial and personnel resources, and the successful implementation of a facility management program. In order to gage the success of the program and ultimately the mission of USAMEDCOM as a world-class health care organization, components of the program must be evaluated against performance indicators that reflect the best in private and governmental health care facility management. This document is the basis for a facility management performance plan.

8-3. APPLICABILITY

This document applies to all MEDCENS, MEDDACs, Health Clinics, and all facility management activities within USAMEDCOM MSCs. These include RMCs, AMEDD Center and School, U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM), U.S. Army Dental Command (DENCOM), U.S. Army Medical Research and Material Command (MRMC), the U.S. Army Veterinary Command (VETCOM), and the Armed Forces Institute of Pathology. It is not limited to only those facilities managed through the Office of the Assistant Secretary of Defense for Health Affairs (ASD/HA) Defense Health Program.

8-4. FACILITIES STRATEGY, VISION, MISSION, OBJECTIVES

a. Facilities Strategy. USAMEDCOM facilities strategy is to:

(1) Acquire, locate, size and configure facilities to meet the USAMEDCOM mission and patient demands (the right facilities).

(2) Acquire and maintain facilities that provide a quality environment of care (the right quality). The facilities strategy focuses on sustainment and modernization of facilities, available funding on the right projects, integration and prioritization of maintenance and repair, military construction resources, and establishment of a clear and stable facility

investment environment. Key elements of the Facility Strategy include the assessment of existing facilities, the projection of mission and workload demands, and the needs of local commanders. The assessment of USAMEDCOM facilities is based on a consistent application of the Facility Condition Index (FCI). The projection of mission and workload demands is based upon workload analysis and/or the health care requirements analysis of patient demand.

b. Vision. The vision of the USAMEDCOM facilities is one of having safe and reliable facilities available when and where needed with capabilities necessary to effectively support OTSG/USAMEDCOM missions.

c. Mission. The mission of the USAMEDCOM facilities is to provide, operate and maintain in a cost effective manner the facilities necessary to support OTSG/USAMEDCOM – in both war and peace.

d. Supporting Objectives

(1) Required Capabilities. Facilities are structured to provide the right capabilities. Capabilities address such issues as seeking to provide facilities that are correctly sized to meet the mission and workload demands. The overall inventory of USAMEDCOM facilities will be monitored to insure that it is composed of the correct type of facilities and in the correct numbers to meet mission demands. The facilities will be configured to support the mission (specialty vice primary care clinics, outpatient facilities vice inpatient and appropriate type of laboratory facility). The facilities will be located where they are needed and can best serve the beneficiary population.

(2) Required Conditions. Facilities are maintained and operated to provide the right conditions. Conditions address the state of the facilities that exist. Facilities will be in compliance with regulatory standards (JCAHO, American Association for Accreditation of Laboratory Animal Care (AAALAC), etc.), and be safe and reliable. Facilities will also provide quality-working conditions for USAMEDCOM personnel. Facilities management staffs will take actions to assure that the property assets are protected from deterioration, thus providing USAMEDCOM personnel with platforms for effective and efficient operations.

(3) Appropriate Level of Resources. Resources address the funding necessary to acquire, sustain, restore, and modernize both the facilities and the support elements necessary to manage and safely operate USAMEDCOM's facilities.

(4) Information Management and Information Technology Systems IM/ITS Capabilities. IM/ITS are leveraged to support facility operations. Information addresses the data necessary for management of the facilities, reporting the progress of the strategic plan, the condition of the inventory and the justification for resources.

8-5. FACILITY LIFE-CYCLE INVESTMENT PROGRAM ELEMENTS

a. General. The facility investment program is defined in accordance with current Department of Defense program elements of Sustainment, Restoration, and Modernization (SRM), and includes medical military construction.

b. **SRM**. SRM program elements must be prioritized to ensure maximum effective use of available resources. They are prioritized as follows:

(1) Sustainment. Refer to the DoD Unit Cost Factor Handbook for a complete definition of sustainment. Sustainment is the process of planning, programming, and executing those programs necessary to maintain the infrastructure of a facility from the time it is constructed until retirement. Within this context, sustainment can be viewed as a cyclic process from which financial and personnel resources are used to provide reliable

systems and an aesthetically sound, safe, and functional environment. Sustainment involves the cycle of on-going routine repair and maintenance and also encompasses scheduled major repairs of the facility.

(a) Scheduled and Unscheduled Maintenance. Scheduled maintenance (often termed preventive maintenance) is given the highest funding priority, since it significantly improves reliability of systems and components and diminishes the risk of unscheduled outages impacting patient care. Preventive maintenance is the baseline for supporting continuity of healthcare operations. Unscheduled maintenance is sometimes referred too as demand maintenance or corrective maintenance.

(b) Scheduled Major Repairs. The next priority is given to scheduled major repair. Deterioration, caused by many factors including operational usage and environmental conditions, will eventually diminish system performance below a required level. Equipment and major systems must be repaired by major overhaul or replaced.

(2) Restoration. Refer to the DoD Unit Cost factor handbook for a complete definition of restoration. Restoration includes repair and replacement work to restore damaged facilities due to accident or failure attributable to inadequate sustainment, excessive age, or other causes. This element holds a priority level below sustainment provided sustainment is being performed. Facilities that are not maintained experience accelerated deterioration, in much the same manner as an automobile whose oil has never been changed. In addition to lack of maintenance, manufacturer's flaws, poor installation, and adverse environmental conditions can cause equipment breakdown before normal life expectancy. A standardized facility assessment is required to manage restoration.

(3) Modernization. Refer to the DoD Unit Cost Factor Handbook for a complete definition of modernization. Modernization includes alteration of facilities to implement a new, higher standard (including regulatory changes), to accommodate new functions, or to replace building components that typically last more than 50 years (such as foundations and structural components). Requirements for modernization of healthcare facilities have changed significantly as population demographics have shifted and the mission of the Army Medical Department has changed. Funds for modernization can be operations and maintenance-based or military construction-based depending on the statutory requirements imposed on these programs. Under any funding scenario, modernization is a capital investment that is managed as a long-term requirement. A master plan is required to mange modernization.

c. Capital Investments

(1) Service Life. For use at the programmatic level, the life expectancy of healthcare facilities has been established at an average service life. Referencing the 2001 publication by Whitestone Research, "Building Maintenance and Repair Costs", repairs for major components are required in typical hospitals between 20 to 30 years (average 25 years). Integrating projects consisting of both major repairs and modernization during this period can be a very effective cost avoidance technique. Often, without proper planning and requirements integration, upgrades to the infrastructure do not interface with space changes required for modernization.

(2) Plant Replacement Value (PRV). The investment strategy can be easily condensed and restated in terms of PRV. PRV provides a means of recognizing widely varying facility conditions with the goal of an annually adjusted process that calculates rate of investment over a period of time. PRV can be adjusted to account for size of facility, relative location, makeup and complexity of infrastructure, contingencies for support facilities, fixed equipment, engineering and architectural cost, and economic conditions, such as inflation. It represents the sum of costs, by facility type and location, to replace the

inventory in kind. The PRV is also adjusted as facilities close or new facilities come online. The method used in the calculation of PRV is:

PRV = Facility Quantity x Cost Factor x Area Cost Factor x 1.2

Facility quantity (gross square feet for buildings) is based on building inventory recorded in IFS at the installation. Construction cost factors are listed in the latest version of the DoD Facilities Cost Factors Handbook. Area cost factors, published annually by the Tri-service Committee on Cost Engineering, are a geographic location adjustment factor for costs of labor, material, and equipment. The 1.2 multiplier accounts for supervision, inspection, overhead, and design associated with new construction.

d. Master Planning

(1) General. Ideally, master plans are performed every five years. The purpose of the Master Plan is to assess health, dental, veterinary and medical research laboratory facilities, identify current and future facility needs, and recommend strategies for facility development needed to accommodate anticipated growth and/or change in the facility and/or its mission. The Master Plan will provide a guideline to assist the facility in identifying proactive solutions to changing mission requirements. The benefit of the master planning process is that it allows senior leadership an orderly transition plan from current facilities to a future health care delivery environment based on predicted resource needs. This insures that future changes or renovation projects are not only considered individually but for how they affect the facility as a whole. This process also enables the organization to match missions with facility capabilities. In addition, a pro-active department-level facility Master Plan, which is developed in accordance with the specific medical/dental activity Business Plan, the Multi Service Market, RMC and TriCare Regional Office (TRO) Business Plans, is required to guide the Facility Manager and the Health Facility Planning Agency (HFPA) so that needed facility repairs, upgrades, modifications, restoration, modernization or replacement projects are planned and executed based upon a comprehensive Master Plan. Projects that are properly planned, phased, funded, and prioritized, in accordance with the supporting business plan, and hence the Master Plan, will provide cost effective and efficient facility solutions to the USAMEDCOM Facility Life Cycle Management program.

(2) Description. The effort contained in the scope of work will provide the subject facility and USAMEDCOM/HFPA with a Master Plan for department-level space planning correlated with health care analysis and planning. The end result will include a list of prioritized project technical solutions to identified facility and operational space deficiencies with a phased plan of correction, and other required deliverables. These solutions and corresponding quantifiable support will follow the methodology listed below to ensure compatibility with other USAMEDCOM/HFPA master planning products. The Master Planning Scope of Work will outline the process and products required for the Master Planning effort and outlines details, timelines, delivery schedule, required analysis or services and any deliverables associated with those tasks. Requirements for the Scope of Work are detailed below.

(3) Process

(a) Project Initiation. This includes a briefing to the Commander, or his representative, on project goals, assumptions, process and schedule. Coordination prior to the initial briefing may be required with the organization. The Contractor will be required to coordinate with regional and corporate management to obtain, evaluate and validate site specific data such as facility assessments, Statements of Condition, business plans, raw data (population workload, staffing) and other information deemed necessary. At the completion of the site visit, the contractor will be required to submit an in progress review or summary report. Specific site visits will be coordinated directly with HFPA and the local leadership. HFPA will normally attend all site visits and a mutually agreed upon calendar will be coordinated in advance. The contractor shall be required to complete the number of

site visits required to develop the identified site-specific deliverables. An estimate of site visit requirements will be agreed upon. The contractor will also determine what team components are required to attend particular site visits. The following will be the typical number of general tasks and site visits:
Data collection.
25%: Project Kickoff Meeting and Health Planning Review.
50%: Staffing, Program for Design (PFD), scenarios and concept design options.
90%: Final Planning review with test & fit options and draft phasing approach.

(b) Health Care/Business Analysis. Contractor will use retrospective and prospective data analysis to identify trends. Different alternatives will be developed based on alternative futures identified by the organization.

(c) Data Collection. Contractor will collect and analyze any workload, staffing, and customer base information to help validate any previous business planning efforts. This includes, but is not limited to, validation of the mission statement, business plans, beneficiary population data (MCFAS, user MCFAS and user CHCS), workload data (MEPRS/CHCS), and staffing (TDA or contracted staff).

(d) Demand Analysis. Contractor will develop a demand analysis based on population served, enrollment (into TRICARE Health, TRICARE Dental Plan, and other enrollment programs). Based on this analysis, contractor will develop utilization trends.

(e) Planning Scenarios. Contractor will develop provider and staffing requirements, volume thresholds/optimization, and functional alignment options. These options will be based on the various futures identified by the organization.

(f) Space Requirements Forecast. Based on the scenarios and requirements listed above, contractor will develop PFDs. These PFDs will demonstrate the space required to meet the planning scenarios and demand analysis.

(4) Site/Facility Analysis:

(a) Data Collection – Facilities. Contractor will collect all existing space utilization plans, architectural Computer-Aided Drafting and Design (CADD) or hard copy drawings, site drawings, list of current projects and any facility assessments or deficiency tabulations. This information will be integrated into the facility planning scenarios

(b) Facility Planning Scenarios. Based on the Health Care/Business Operations Analysis and the Site/Facility Analysis, the contractor will conduct a functional facility analysis resulting in alternative architectural solutions. Facility planning will be summarized in both narrative and graphic representations. All graphics will be submitted in CADD (single-line architectural only) and color coded, based on the following categories: inpatient, outpatient, ancillary, administrative, and support.

(c) Existing conditions. The current space utilization and departmental boundaries of the existing structures will be documented in existing condition Computer-Aided Design/Drawing (CAD).

(d) Master plan concept. Departmental function alignment options (big-block design) will be developed in narrative and CAD format and will be based on the projected PFD and future health care scenarios. These drawings will be submitted in the interim and final deliverables, but will also be used as a tool by the contractor to facilitate alternative development with the MTF leadership.

(e) Plans of correction. Final master plan concept and test-fit design will be developed as the culmination of health care analysis, site/facility assessment and facility planning. The plans of correction will be a comprehensive use/reuse plan for the organization's total infrastructure requirement (all buildings identified in the project specific requirements). The plan will account for facility opportunities and constraints and solutions will comply with all applicable standards and health care codes to include the following: life safety; ADA (Americans with Disabilities Act); JCAHO; NFPA; OSHA; AAALAC; Council of

American Pathologists (CAP); and American Institute of Architects (AIA). Test-fit design will be developed for specific projects that are identified as the organization's priority. These projects will be categorized based on the Levels of Facility Alteration outlined in MIL-HDBK-1191, Section 1, General Guidance. The purpose of the test-fit design includes the following: graphic presentation of how specific functions fit into identified space; precursor to full design or work plan development; and to provide detailed information for cost estimate development.

(f) Implementation Plan and Cost Estimates. Based on the agreed upon alternatives, the contractor will develop a sequenced phasing of projects based on funding opportunities and constraints. The implementation plan will detail how an organization can execute the moves, upgrade, renovation and/or replacement objectives outlined in the plans of correction. Phasing and order of projects will be aligned in tracks based on their interdependency. Phases are intended to reflect functional, engineering and transitional requirements. Project descriptions will contain general scope and cost estimates will be sensitive to the integrated engineering and architectural findings but will also consider different funding options (i.e. Operations & Maintenance (O&M) funds, Host Nation, MILCON and alternative timelines particular to the military.

(5) Final Reports. The contractor shall document the results of all analysis, planning, recommendations, and discussion with regard to the specified deliverables in a final report. A separate executive summary shall also be submitted. The narrative will be directly keyed to supporting graphics and photography. The contractor shall also provide supporting digital photographs and graphics including CD-ROMs with CADD drawings.

(a) General. In addition to the contracting officer's requirements, there shall be one combined final report and executive summary for each of the following. Copies of the Reports will be called out in the Project Specific Scope and provided to the following:

- Subject Facility/Organization
- RMC (if subject facility/ organization are a sub-unit of an RMC).
- U.S. Army Health Facility Planning Agency, Falls Church, VA.
- U.S. Army USAMEDCOM, Assistant Chief of Staff for Installations, Environment and Facility Management (ACSIE&FM), Fort Sam Houston, San Antonio, Texas

(b) Format. The final report as well as all other deliverables will be provided in an INTEGRATED electronic format (word processing, spreadsheets, databases and computer-aided design). Electronic format should allow users to manipulate files with existing software (Acrobat, MS Office, AutoCAD, etc.). Format should also be easily converted to html for posting to HFPA web site. Besides electronic versions, all deliverables should be printed in 8 1/2" x 11" loose leaf or A-4 notebook. Final report will include as a minimum the following sections:

(c) Executive Summary. The contractor shall prepare an Executive Summary that includes the following sections: Scope and Methodology (summary of deliverables, schedule and team composition); Site/Facility Analysis (infrastructure requirements, FCI for each building and FCI summary); Health Care Planning (summary of population, workload, health care scenarios and recommendations); Health Facility Planning (summary of projects, costs estimates and phasing). The purpose of executive summary is to summarize all major findings and recommendations concisely.

(d) Health Care Planning, Analysis and Recommendations. The methodology, health care/business planning issues, analysis, operational issues, population & enrollment, reorganization plans (product line development) and future staffing approaches will be addressed. The PFD(s) will be included as an Appendix.

(e) Facility Analysis and Problem Definition. Costs for building deficiencies corrections and improvements and their impact on future capital investment costs are

included. Architectural analysis to include existing space, existing condition drawings and narrative summaries will be included.

(f) Master Plans Concepts and Alternatives. Master Plan Concepts and Alternatives and architectural and engineering alternatives are based on the future of the organization. Various plans will be categorized under each of these alternatives. The following will be included: Existing and programmed square footage matrix; site concept; architectural concept; engineering concept; and the master plan concept (integration/ culmination).

(g) Final Facility Recommendations. The following will be summarized in narrative and graphic formats: Final Master Plan Concept (from among alternatives investigated); Project Recommendations (based on final concept design); Plans of Correction (single line test and fit project recommendations); Cost Estimates (matrix with individual project costs and total costs); Timeliness and Phasing (graphic representation of how the organization can implement the master plan concept and plans of correction).

(h) Appendix. The following will be included as Appendixes: Methodology (detailed narrative summarizing the total endeavor), PFD, Departmental Analysis (includes existing and alternatives investigated, all tools developed to obtain buy-in on the master plan concept will be included), Background (historic information related to the installation, geographic and region will be included).

8-6. ORGANIZATIONAL ALIGNMENT

a. General. The organizations primarily involved in the administration of facility life-cycle management within the U.S. Army Medical Command are:

(1) Facility management component and/or logistics division at the activity level;
(2) Facility Director and/or logistics division at the RMC/MSC;
(3) Health Facility Planning Agency (HFPA); and
(4) Office of the ACSIE&FM at USAMEDCOM Headquarters.

b. ACSIE&FM. The ACSIE&FM is the principal staff officer to the USAMEDCOM Commanding General and the Army Surgeon General. ACSIE&FM is the proponent for USAMEDCOM installation management. ACSIE&FM interfaces with Army planners, obtains and distributes resources, conveys facility program guidance, policies and priorities, assesses and evaluates facility programs, and takes action to optimize facility investments.

c. U.S. Army Health Facility Planning Agency (USAHFPA). HFPA directly supports ACSIE&FM, the activities, and RMC/MSC in planning, healthcare construction standards and technology, construction facilitation, and project integration of large capital investment projects. HFPA administers the Medical Military Construction program.

d. Regional Medical Commands/Major Subordinate Commands. RMCs/MSCs are both tactical and operational in mission. Tactical functions have a planning horizon of one to two years. RMCs/MSCs are focused on integration of health care and facility planning and compliance with USAMEDCOM policies and procedures. HFPA directly supports RMC/MSC facility sustainment programs. RMC/MSC facility directors have functions delegated to them by ACSIE&FM. RMC/MSC facility management functions cover the following areas:

(1) Facility assessment and oversight
(2) Major repair and Restoration, Modernization program
(3) Medical Military Construction Program
(4) Technical assistance
(5) Facility management program execution

e. Facility Management Staffing and Organization:

(1) General. Each MTF, MEDCEN, and research facility shall establish and staff a facility management section proportional to their respective facility. It is required that the section be either a branch established in the logistics division under the C, Logistics, or organized as a division under Deputy Chief of Administration.

(2) Facility Management Branch. The Facility Management Branch (FMB) performs functions associated with operating, maintaining, and repairing medical and research facilities. In addition to these core functions, a FMB may also perform a wide range of additional responsibilities to include administration of housekeeping, safety, physical security, transportation, medical equipment programs, etc. This document will not address the staffing or organizational requirements for these additional responsibilities. The organizational elements of a facility management branch can be divided into the following:
Management/Administrative
Engineering/Technical Support
Operations and Maintenance (O&M)
Contract Administration/Quality Assurance

(3) Management and Administrative Functions. The management/ administrative element coordinate the planning, organizing, staffing, directing, and control of all facilities support. This element consists of a Chief, Facility Management Branch, and a clerk/typist. Functions for this activity include:

(a) Coordination of planning, organizing, staffing, directing, and controlling facility activities
(b) Serving on key committees and boards
(c) Administrative approval of projects and programs
(d) Oversight of financial programs and budgets
(e) Insuring that facilities meet all applicable requirements for accreditation
(f) Establishing and maintaining liaison with the U.S. Army Installation Director of Public Works (DPW)
(g) Personnel administration and training

(4) Engineering and Technical Support. The engineering/technical support element provides design and engineering services, programming of major construction, space utilization/space management, and technical support. This element usually consists of an engineer, preferably with electrical or mechanical background, and an engineering technician. The Chief, FMB, may assume the responsibilities of this organizational element. Functions for this activity include:

(a) Manage, track, and monitor engineering work requests, execution, closeout, and warranty issues
(b) Energy management and conservation, and monitoring and control systems
(c) Implementation of Automated Data Processing support systems for maintenance, financial, and project management
(d) Consulting engineering studies and services
(e) Facility master planning
(f) Planning and estimating work
(g) Management of all major repairs: A portion of sustainment and restoration and modernization projects
(h) Space utilization/space management
(i) Project scope development and design
(j) Coordination on the design and execution of Military Construction, Army (MCA) projects
(k) Management of facility as-built plans

(5) Operations and Maintenance Function. The operations and maintenance support element manages maintenance and repair to buildings and structures, and supply and storage of tools and spare parts. This administrative portion of this element typically consists of an engineer with experience in facility maintenance, and an engineering support clerk who is responsible for maintaining job order logs, data entry into DMLSS-FM, maintenance of a facility library, and general clerk/typist. The wage grade element varies widely depending on whether maintenance is performed in-house or under contract. As a minimum, it is recommended that a small team of maintenance workers be assigned directly to the FMB to handle minor maintenance and repairs. Functions for this activity include:

(a) Operation and maintenance of utility plants and systems

(b) Storage and maintenance of spare parts, materials, and supplies

(c) Maintain an up-to-date equipment inventory

(d) Coordination of work planning and programming activities

(e) Cyclical inspections to systematically identify maintenance and repair requirements

(f) Maintain all critical system records, test reports, and emergency procedure plans

(g) Develop and maintain a maintenance program

(h) Coordinate maintenance-training activities

(i) Maintain a library of (or insure access to) all applicable regulations, codes, and standards as needed to comply with applicable sections of this document.

(6) Contract Administration Function. The contract administration/ quality assurance element manages contract activities associated with facilities maintenance and engineering, financial planning, programming, budgeting, execution, accounting, and review. This element typically consists of a contract specialist or resource management analyst, and a facility Quality Assurance Evaluator who is usually an engineering technician with experience in facility maintenance. The Chief, FMB, may assume the contractual and financial duties. Functions for this activity include:

(a) Management of applicable sections of Inter-Service Support Agreements (ISSA) and Memorandum of Agreement (MOA) with support agencies, such as DPW.

(b) Financial oversight of reimbursable accounts.

(c) Administration of contracts within delegated authorities, including conduct of quality assurance, surveillance/evaluation of contractor performance.

(d) Prepare reports required by higher headquarters.

(7) Job Qualifications and Descriptions. Facility Manager qualifications should be one of the following:

(a) Be a registered professional engineer or licensed architect with experience in facility engineering and maintenance in healthcare or research facilities, as applicable. Strong electrical or mechanical background is preferred. The FM must have an in-depth knowledge of and basic experience in facility engineering and maintenance with emphasis on the unique nature and requirements of complex healthcare and research institutions. The FM must possess strong managerial and personnel skills.

(b) Have an advanced degree in business management with experience in facility engineering and maintenance in healthcare or research facilities, as applicable. The FM must have an in-depth knowledge of and basic experience in facility engineering and maintenance with emphasis on the unique nature and requirements of complex healthcare and research institutions. The FM must possess strong managerial and personnel skills.

(c) Have equivalent experience with at least two years experience in facility engineering and maintenance in healthcare or research facilities, as applicable. The FM must possess strong managerial and personnel skills.

(8) Staffing Guidelines.

(a) Actual staffing requirements fluctuate based on the needs of the facility, and depend largely on the extent that maintenance is outsourced or contracted out. USAMEDCOM Logistics ACSLOG is implementing a template that will be used by the manpower community to identify requirements. However, the following data listed below will generate the necessary detail to further strengthen any requirements that are not identified in the template.

(b) Staffing requirements for O&M type work can be accurately based on calculations related to Preventive Maintenance (PM) effort. The number of support personnel (non-O&M) is often based on the number of O&M personnel. Staffing for trade supervisors are based on the total number of tradesman that are required. Once staffing requirements have been determined, they can be benchmarked against industry wide standards. See applicable sections of this document.

(c) To determine staffing requirements, an availability factor must be derived. The availability factor is used to determine the actual man-hours that can be applied to O&M work once training, sick leave, vacation time, holidays, and discretionary time is accounted for.

(d) Non-O&M staffing requirements can be based on roughly 15% of total PM requirements. Staffing organizational arrangements will vary widely depending on the specific needs of the activity.

8-7. FACILITY OPERATIONS AND MAINTENANCE ACTIVITIES

a. General. Operations and maintenance is the cycle of on-going, routine repair, alteration, maintenance and operation of the facility. Operating and maintaining health care and research facilities and associated common use areas is the responsibility of the facility manager.

b. Reliability Centered Maintenance. Reliability Centered Maintenance (RCM) is the integration of reactive maintenance (run-to-failure or breakdown maintenance), and proactive maintenance, such as preventive (interval based) maintenance and Predictive Testing and Inspection (PT&I), also known as predictive maintenance or condition based maintenance. RCM applies these three techniques in combination where each is most appropriate based upon the consequences of equipment failure and its impact upon organization mission, safety, environment, and Life Cycle Cost. This combination produces the required reliability at the minimum maintenance cost. RCM requires that maintenance decisions be based on maintenance requirements supported by sound technical and economic justification.

c. Preventive Maintenance (PM). PM consists of regularly scheduled inspection, adjustments, cleaning, lubrication, parts replacement, calibration, and repair of components and equipment. PM is also referred to as time-driven or interval-based maintenance. PM schedules periodic inspection and maintenance at pre-defined intervals (time, operating hours, or cycles) in an attempt to reduce equipment failures for susceptible equipment. It assumes that these variables can be determined statistically, and therefore one can replace a part due for failure before it fails. The availability of statistical failure information tends to lead to fixed schedules for the overhaul of equipment or the replacement of parts subject to wear. PM is based on the assumption that the overhaul of machinery by disassembly and replacement of worn parts restores the machine to a like-new condition with no harmful effects.

(1) A routine maintenance plan is required on all major and critical equipment, major systems, and components. The plan shall provide procedures with detailed maintenance tasks and associated frequencies. It shall also include a master schedule indicating when maintenance tasks should be performed, so that work is spread evenly throughout the year.

(2) Detailed PM procedures should include the time standard for each procedure (O&M manuals, manufacturer's data, etc.), assignment of crafts or shops to each PM procedure, assignment of tools and materials to each PM procedure, and special notes and warnings.

d. Predictive Testing and Inspection (PT&I), also known as predictive maintenance or condition monitoring, uses primarily non-intrusive testing techniques, visual inspection, and performance data to assess machinery condition. It can complement maintenance tasks with maintenance that is scheduled only when warranted by equipment condition. Continuing analysis of equipment condition-monitoring data allows planning and scheduling of maintenance or repairs in advance of catastrophic and functional failure. The PT&I data collected is used in one of following ways to determine the condition of the equipment and identify the precursors of failure. PT&I does not lend itself to all types of equipment or possible failure modes and therefore should not be the sole type of maintenance practiced. The methods of analysis include:

- Trend analysis
- Pattern recognition
- Data comparison
- Tests against limits and ranges
- Correlation of multiple technologies
- Statistical process analysis

e. Records and Documentation. The facility manager shall be responsible for maintaining the following maintenance records and documentation. This does not preclude any additional documentation required for regulatory compliance or higher headquarters requirements.

(1) Utility connection/Cutoff plans: Provide site and floor plans that indicate the main interior and exterior connection and cutoff points of all utilities. Plans shall contain enough information to enable someone unfamiliar with the facility to locate the connection/cutoff points. The plans shall indicate the room number, panel number, circuit breaker, valve number, etc., of each connection/cutoff point; as well as which system, portion of system, or area that connection/cutoff point controls. These plans are physically distinct from site and floor plans discussed above.

(2) Warranty information: List each piece of equipment furnished by the construction contract and provide a cross reference to the written warranties. The equipment list shall indicate the duration of the warranty, start and end date of warranty, and point of contact for fulfillment of the warranty. Also list all maintenance required by the government to keep the warranty valid.

(3) Equipment inventory: Provide major and critical equipment, major systems, and component inventory in hierarchical format.

(4) Training requirements: Provide a list of recommended training related to operation and maintenance of each installed system including training which is available from the manufacturer or other source.

(5) As-Built Drawing List: Provide a list of up-to-date as-built drawings. Include drawing number and title, and indicate where the drawings and specifications are physically located.

(6) System description: Provide a detailed description of system composition and operation. Descriptive matter and theory shall include technical details that are essential for understanding the system.

(7) Start-up and shutdown procedures: Provide step-by-step instructions to bring systems from static to operational status and from operating to shutdown status.

(8) Normal operating instructions: Provide discussion of the normal operation and control of the system. Include operating norms i.e., temperatures, pressures, and flow rates expected to each zone and phase of the system. The information shall be supplemented with control/wiring diagrams and data.

(9) System flow diagrams: Provide flow diagrams indicating system liquid, air or gas flow during normal operations.

(10) Emergency operating procedures: Provide emergency procedures for equipment malfunctions and shutdown instructions for fire, explosion, spills, or any other contingency.

(11) Environmental considerations: Provide a listing of systems/equipment which requires special environmental consideration, reporting, testing, analysis, or inspection to comply with Federal and related state/local environmental laws. Examples are backflow-preventer inspections, underground storage tank testing, etc.

(12) Safety instructions: Provide a list of all personnel hazards and equipment safety precautions including recommended safeguards.

(13) Provide a list of all major valves associated the system including valve type, number, function, and location.

f. IM/IT Systems

(1) Computer Aided Design (CAD). It is required that CAD systems, or other automated techniques, be employed to maintain as-built drawings, and other records and documentation.

(2) Computerized Maintenance Management Systems. It is the objective of USAMEDCOM to employ DMLSS-FM in all facilities. Typically, the Computerized Maintenance Management Systems (CMMS) provides for storage and tracking of work orders, routine maintenance, labor information, inventory, and equipment information. This section provides guidelines to assist facility managers in determining the division of work between in-house personnel and contractors. Implementation of DMLSS-FM at a medical or research facility will result in a number of benefits which include reduced equipment downtime, better organization and access of information for accreditation inspections, such as JCAHO, CAP, and AAALAC, improved inventory management, increased labor efficiency, identification of chronic equipment malfunctions, centralized maintenance data, extended equipment life, and reduced maintenance costs.

(a) Requirements of DMLSS-FM can be subdivided into those necessary to support accreditation inspections, those required specifically at Army facilities, and those related to data reliability, security, user interface, and information transferal and exchange.

(b) Proper organization of utility systems data and reporting methodology are essential in supporting documentation for accreditation. Below is a list of reports that DMLSS-FM should include to meet this need:

- Report listing all components and characteristics of utility systems.
- Report detailing all work orders performed on critical systems, such as the emergency power system.
- Work order summary report that includes description of problems, responses and associated response dates, and the name of the individual responding.
- Report demonstrating trends of equipment failures, and how these failures are addressed.
- Report summarizing the total work order history for the preventive maintenance program.

(c) Successful implementation of DMLSS-FM is to a large extent determined by the following factors:

- Accurate and up-to-date data collection on equipment, spare parts/materials, vendors, contractors, and personnel.
- On-site training of users and managers. A minimum of 24 hours of input training and 16 hours of output training should be provided.
- System commissioning under operating conditions by creating sample work orders, printing sample reports, etc. The software vendor should provide at least 40 hours of system commissioning.

(3) Nurse Call Systems. Many hospitals need to update or replace their antiquated systems. The ACSIE&FM and the Deputy Chief of Staff for Logistics have entered into a joint venture focusing on updating this critical communication system. Facility Managers and Chiefs, Property Management Branches should determine if their system needs updating or replacing. Such factors as reliability, maintainability, and technical obsolescence, should be considered. The nursing staff is a vital source of information on how the system meets their needs. Departments of Nursing may volunteer to assign a nurse project officer to evaluate the existing system and to recommend upgrades or replacements.

(a) Nurse Call System Classification. Nurse call systems are personal property (fixed). See *AR 735-5*. The nurse call system is not considered as installed building equipment (DA Pam 420-11).

(b) Funding. Nurse call systems must be purchased using Other Procurement Defense (OPD) funding under the MEDCASE program. Minor construction or repair funding cannot be used to purchase new, replace, or upgrade nurse call systems. The MEDCASE program pays for all equipment and installation costs. The ACSIE&FM site preparation program pays for site preparation and utility rough-in requirement.

g. Maintenance Contracts. Maintenance contracts are essential elements of a well-rounded facility management program. In most cases, the complexity of modern building equipment makes it unfeasible for maintenance personnel to handle all aspects of building maintenance. Many types of equipment require maintenance to be performed by specially trained personnel. Maintenance contracts can be administered as individual service contracts, comprehensive facility wide contracts, post wide contracts, and regional wide contracts. Typically, facility, post and regional wide maintenance contracts include routine and unscheduled maintenance, with provisions for repairs, and minor construction.

(1) Contract Type: It is the responsibility of the FM to support and provide input into an analysis to determine the most cost effective type of contract to be used. Ultimately, the cost of the contract must be within the funding level provided by higher headquarters.

(2) Major Repairs/Minor Construction (MR/MC): Provisions for minor construction and major repairs can be included as part of a facility maintenance contract. The level of participation by the maintenance contractor in MR/MC should be evaluated in terms of the capability of the FM to perform MR/MC through Job Order Contracting, DPW, and other locally available contract acquisition sources.

(3) Division of Work: Maintenance work is divided into levels depending on the response time and work priority. Work that is not classified as routine preventive maintenance is considered demand maintenance. Each work order is assigned a priority to distinguish the most urgent response requirements from those that require less immediate response. The work order priorities are assigned on the basis of a particular piece of equipment. Each major and critical equipment item, and major system, or major system

components will have a response priority assigned to it. The priority categories are as follows:

(a) Priority 1, EMERGENCY: This is work that is required to correct an emergency condition detrimental to the facility mission or that endangers the health and welfare of the staff and patient and reduces the operational effectiveness. Corrective action for emergency work should start immediately and continue until completed.

(b) Priority 2, URGENT: This is work to correct an unsafe condition that is not an immediate hazard to personnel, but must be initiated within the shift and completed within 5 working days.

(c) Priority 3, ROUTINE: This is work to improve the operation of the facility that can be completed within 30 working days.

(d) Priority 4, SCHEDULED: This is work that is not one of the above and can be accomplished within 120 days.

h. Utility Management

(1) Central Plant Operation. Utility management is the management of utilities (electrical, water, natural gas, etc.) necessary to maintain continuous operation of equipment and systems in a facility. It is the responsibility of the facility manager to ensure the operation, maintenance, repair, and improvement of utility plants and systems, including water supply, electrical, heating and ventilation, refrigeration, fuel dispensing, and air conditioning systems is performed in accordance with applicable regulatory and policy guidance.

(2) Operator Training. It is the responsibility of the facility manager to maintain a current list of required operator training.

(3) Permits. The facility manager shall be responsible for maintaining a consolidated list of operator permits in accordance with current statutory and regulatory requirements.

(4) Plant Management Systems. It is the responsibility of the facility manager to operate and maintain plant management systems in an efficient and cost effective manner.

i. Energy Management

(1) General. It is the responsibility of the facility manager to administer an energy management program for their respective facilities. Facility managers shall maintain an up-to-date monthly log of all utility metered readings. Reference the DoD Energy Managers Handbook. The Energy Policy Act of 1992, Executive Order 12902, and Executive Order 12123 established the DoD mandate of ultimately reducing facility energy consumption 35% by 2010, compared to 1985 baseline levels. The National Energy Conservation Policy Act of 2005 later superseded Executive Order 12123, to mandate the present goal of a 20% reduction from 2006 to 2015, compared to the 2003 baseline.
These federal mandates also authorized alternative funding methods to finance costs associated with achieving the specified reductions.

(2) Energy Conservation Investment Program (ECIP). ECIP is a DoD military construction funded program for projects over $750,000 for improving the energy efficiency of existing Army facilities or constructing new, high efficiency energy systems. ECIP projects do not compete for resources with MCA or OMA requirements. DAIM-FDF-UE conducts an annual call for ECIP project submissions in the spring of each year. DD 1391s for ECIP candidate projects should be sent to the command headquarters by 31 July of each year, so they can be forwarded for consideration for the second following fiscal year (e.g. FY09 submissions must be submitted to MEDCOM in July, 2007). Information in the DD1391 must include the cover sheet and a current well-supported economic analysis summary sheet. All appropriate savings from energy efficiency demand reduction, water conservation, reduced maintenance or manpower requirements, and utility rebates should be included.

(3) The Energy Savings Performance Contract (ESPC). The long term use of energy savings and performance contracts in USAMEDCOM is authorized, when administered in accordance with DA guidelines. The Energy Policy Act of 1992 authorized private sector funding to accomplish energy saving retrofits in Army facilities. The ESPC is a contracting methodology in which a private contractor, called an Energy Services Company performs services such as facility energy audits, installation, operation and maintenance of equipment, technical services, and similar work in "partnership" with the Army. ESPCs generally function as Indefinite Delivery/Indefinite Quantity contracts in which the contractor identifies energy improvements, performs the work at a fixed price, and secures financing to pay for the improvements. The Army then repays this loan from the realized energy savings. ESPC can be used for any work that results in a simple payback of 10 years or less. The actual loan term can extend up to 25 years.

j. Space Management and Utilization

(1) General. Space management is the process of identifying and projecting space requirements, identifying deficiencies, allocating available space to users in an equitable way, monitoring use, assisting users with space usage problems, and resolving space problems. Space management also addresses quality of space. Space management functions in USAMEDCOM facilities may or may not be a direct responsibility of the facility manager. However, the facility manager is responsible for reducing the cost of maintenance, repair, and operation of facilities through better space utilization and conservation, and avoiding unnecessary new construction projects. Space management ensures each user is assigned the appropriate space. When an activity obtains excess space, waste of scarce and expensive resources occurs due to under utilization. Conversely, over utilization occurs when an organization occupies less space than actually authorized. The costs of incorrect utilization may be additional utilities and maintenance funds and potentially degraded performance of a unit that could be occupying more productive space.

(2) Goal and Objectives. The space management goal of the AMEDD is straightforward and tasks commanders to use facilities in the most effective way for cost and mission accomplishment. Space is a resource that requires management. Failing to manage this resource can result in a loss of productivity and scarce funds. In support of the space management goal, the AMEDD has adopted the following objectives.

(a) Use existing facilities, property, and space in an efficient manner.

(b) Reduce the need to construct or otherwise acquire facilities by using existing facilities.

(c) Determine any shortfalls or excesses of assigned facilities and space consistent with activity mission.

(d) Eliminate uneconomical, high maintenance facilities.

(e) Take action to deal with shortfalls or excesses.

(f) Eliminate off-post leasing.

(g) Dispose of land, facilities, or space that is excess to our needs.

(3) Process. The process to conduct space management includes:

(a) Establishing a space utilization inventory by department or activity.

(b) Calculating space requirements by department or activity using projected workload.

(c) Identifying space allocation deficiencies and excesses by department or activity.

(d) Developing and evaluating space management options.

(e) Implementing space management decisions.

(f) Establishing a space utilization committee that is chartered to manage all space utilization issues.

k. Integrated Modular Medical Support System (IMMSS)

(1) General. The intent of IMMSS is to provide a quality interior furnishings system for USAMEDCOM facilities worldwide. IMMSS is a demountable and relocatable furniture, furnishings and equipment system composed of components, including but not limited to panels, rails and vertical and horizontal wall supports, work surfaces, storage units and electrical and plumbing hardware, that is panel/rail/wall support connected and supported to provide work stations and combined to meet various functional requirements of the facility. These products enable facilities to avoid product obsolescence due to changes of operation, equipment and personnel needs. IMMSS respects this intent and provides maximum product integration and flexibility to accommodate changing medical technology and functional requirements. The products are durable, flexible, safe, have a professional appearance and are functional within the healthcare setting. IMMSS coordinates and complements the building design and other furnishing items within a facility.

(2) Product capability. A wide selection of components is provided to meet clinical, administrative, pharmaceutical and lab system, nurse station and material handling requirements. Products are modular and capable of being relocated anywhere within the facility. Components are designed to accommodate material movement in areas of large material flow. The complete line of products benefits the entire facility from multi-occupancy admin offices to clinical need areas. IMMSS provides the ability to relocate workstation components from one location to another as functions change. There are four advantages of this contract that will complement construction and renovation projects. This contract is especially beneficial when used in conjunction with a USAMEDCOM renewal project or a restoration, modernization project. A one time Federal Prison Industries waiver/exception is required. (Note: The waiver requirement is frequently reviewed and the process can change. Contact HFPA for current guidance). Various support services include:

- Design Services
- Restorative Services
- Inventory services
- Reconfiguration services
- Panel fabric replacement services
- Clinical and functional analysis services
- Trade-in services
- Transportation Services
- Warehousing Services
- Extended Installation

(3) Property Designation. Equipment provided under IMMSS is considered “personal property” not “real property” in accordance with *AR 735-5*. This means activities are required to use their core budget CEEP funds. Some exceptions may apply, (in some cases, IMMSS product may be procured with Initial Outfitting funds or transition funds when purchased under a MILCON or Capital Investment project). Under certain circumstances, extended installation resulting in modifications to the facility (real property) may be funded by alternate sources. However, IMMSS is predominantly personal property and considered equipment and paid for by the activity. Facility Managers will not normally use their "K" dollars provided by USAMEDCOM to purchase IMMSS. There are some exceptions regarding the extended installation portion of the work if the extended installation repairs or alters real property and existing real property installed building equipment. Please contact HFPA if you have questions.

l. Building Inventory Management

(1) Conversions and Diversions. The DPW has the primary responsibility for management, acquisition, and disposal of real estate (DA Pamphlet 420-9). Conversions

and diversions are spelled out in *AR 405-70*, paragraph 3-6. A conversion is a permanent change to a facility's design Category Codes (CATCODE). A diversion is a temporary change to a facility's current use CATCODE. Real property requirements for demolition and disposal are covered in *AR 405-90*. These actions are the responsibility of the real property specialist in the DPW. Conversions and diversions of facilities are defined in *AR 405-70*. Conversion and diversion of MTF require approval of the USAMEDCOM.

(a) *AR 405-70*, paragraph 6-3.d. (10) states: "Diversion or conversion of facilities initially constructed or subsequently converted to a Medical Treatment Facility will not be converted or diverted without approval of the USAMEDCOM for United States based facilities, or the appropriate medical command if OCONUS. See *AR 40-2*, paragraph 1-10."

(b) *AR 40-2*, paragraph 1-10.b states: "Buildings initially constructed or subsequently converted to house MTF or AMEDD personnel will not be altered, modified, or diverted from their original use without prior authority of the USAMEDCOM. Authority for conversion without provision for reclaim in the event of a requirement will be granted by USAMEDCOM where no present or future medical requirement exists. Approval of the USAMEDCOM will also be obtained prior to making any major changes in the functional arrangement or layout of any part or portion of an MTF. MTF include hospitals, troop clinics, laboratories, dental and other clinics, and quarters specifically constructed for AMEDD personnel, including civilian personnel."

(c) USAMEDCOM or MSC approval of a major repair or minor construction project constitutes approval of a major change in the functional arrangement or layout of an MTF. Based on *AR 405-70*, paragraph 3-6.e, and *AR 40-2*, paragraph 1-10.b, requests for conversion require the following items:

- Facility number
- Existing design use CATCODE
- Proposed design use CATCODE
- Justification
- Date of proposed conversion
- Signature of the installation commander
- Approval from installation medical commander
- Statement that the Integrated Facilities System Mini/Micro (IFS-M) and real property records will reflect the diversion

(d) Or the following three items:

- An unexecuted, but completed, DA Form 337
- Signature of the installation commander
- Approval from installation medical commander

(2) Category Codes. CATCODE identify the facility class and the facility category group. CATCODE for various types of facilities can be referenced in *AR 40-2*.

(3) Demolition. The DPW real property specialist must get predisposal clearances for all hospital and medical facilities before they finalized the disposal and demolition of the MTF buildings. *AR 405-90*, paragraph 6-4.d. states: "The USAMEDCOM must concur in the disposal of hospitals and medical facilities under its control (See *AR 40-2*). Disposal of such facilities not under the USAMEDCOM must have prior approval of the appropriate MACOM." Based on *AR 405-90*, paragraph 6-4.d., and *AR 40-2*, paragraph 1-10.b, requests for predisposal clearance of a MTF must include the following:

- Name of installation
- Facility number and installation number
- Gross square feet and UM2 of the facility
- Facility type (permanent, semi-permanent, & temporary)
- Design use and current use CATCODE
- Original cost and year built

- Justification
- Statement of how long the facility has been vacant
- Date of proposed disposal
- Signature of the installation commander
- Approval from installation medical commander

(4) Integrated Facilities System Mini/Micro (IFS-M). All buildings, including medical, are reported in the installation's IFS-M by the DPW Real Property specialist. Information in the IFS-M database includes size, age, available utilities, building materials, user, original cost, and capitalized improvements. Every quarter, the DPW real property records are downloaded to the Center for Public Works, at Ft. Belvoir, where all of the Army's real property records are kept on a system called Headquarters Integrated Facilities System (HQIFS). The Pentagon and Department of Army staff has access to the real property records through HQIFS. The HQIFS data is used by numerous decision makers and was extensively used during BRAC. Decisions regarding mobilization expansion capability, facility investment potential, and infrastructure readiness are based in part on HQIFS data. These decisions may negatively impact on your facility if the HQIFS data is not accurate.

(5) Building Ownership. All buildings at your installation are “owned” by the installation Commander. The installation Commander has a Memorandum of Understanding (MOU) and an ISSA with the Medical Commander for the use of buildings at the installation. The DPW provides services (fire protection, security, utilities, real property IFS-M reporting, and possibly others, such as maintenance) based on the MOU and ISSA.

(6) Approval Process. The only person at the installation who can change the use of a building in the IFS-M database is the Real Property specialist. The Real property specialist has to obtain permission from their higher headquarters to change the use of buildings. Changing a building to, or from, a medical use category code needs approval from HQ USAMEDCOM, ACSIE&FM. ACSIE&FM also coordinates all VETCOM and DENCOM conversion requests for approval.

(7) Leases. Leases for additional space off post must be processed through the DPW and the local District Army Corps of Engineers. The lease process requires a minimum of 6 months lead-time. All Army leases are required, by law, to be processed through the Army Corps of Engineers.

(8) “Modular-type” facilities. “Modular-type” facilities can be identified as Medical Equipment, Real Property, or a Relocatable Building.

(9) Medical Equipment: Follows the equipment approval and acquisition procedures per *AR 40-61, SB 8-75-11* and *SB 8-75-MEDCASE*, for CEEP, Super-CEEP and MEDCASE. Examples of medical equipment are Bio-Safety Level 3 Facility (BSL3) units and MRI units. If the purchase price is less than $250,000, use Operation & Maintenance Defense (OMD) or OMA funds. If purchase price is equal to or greater than $250,000, use OPD or OPA.

Table 5-B-4
Relocatable Building Validation
Percentage (f) = (a + b + c + d) / (e) * 100

	(a) ($000)	(b) ($000)	(c) ($000)	(d)† ($000)	(e) ($000)	(f) (%)	(g)‡	(h)‡
Facility Type (e.g., barracks, admin, classroom, dayroom, arms room, maintenance, laundry, latrine, storage)	Building Disassembly (disconnect and removal from foundation)	Repackaging (including normal repair, refurbishment of components)	Non-recoverable Building Components (fasteners, seals, skirting, anchors, etc.)	Foundation	Purchase Cost of Relocatable Building (Including delivery and set up)	%	Facility is relocatable (≤20%)	Facility is Real Property (>20%)

Notes:

† "Foundation" includes blocking, footings, bearing plates, ring walls, and slabs. For the purpose of this calculation, "Foundation" does not include construction cost of real property utilities, roads, sidewalks, parking, force protection, fencing, signage, lighting, and other site preparation (clearing, grubbing, ditching, drainage, filling, compacting, grading, and landscaping).

‡ If the percentage in column (f) is less than or equal to 20%, enter "Yes" in column (g). If the percentage in column (f) is more than 20%, enter "Yes" in column (h).

All requests for relocatable buildings must be provided on the Relocatable Building Request Worksheet to the DPW for approval action.

See Table 5-A-1 for approval authorities.

Table 5-A-1
Personal Property Relocatable Building Approval Authorities [1]
(*AR 420-18*) (OMB Cir. A-11)

Relocatable Building Action	Director Installation Management Activity (IMA) and MACOM Commander (for areas outside of the geographic boundaries of HQ IMA)	DASA (I&H)	Office of the Secretary of Defense (OSD)
Lease or Contractor-Provided	**Time:** Not to exceed 1 year and **Cost:** Not to exceed $100,000.	**Time:** Greater than 1 year and less than 3 years **Cost:** Greater than $100,000 per year	**Time:** Greater than 3 years
Extension of Existing Lease	**Time:** Not to exceed 1 year and **Cost:** Not to exceed $100,000 per year (maximum of 3 years).		
Transfer to Other Locations	**Time:** Not to exceed 1 year and **Cost:** Not to exceed $100,000 per year.		
Option-to-Renew Clause	**Time:** Not to exceed 1 year and **Cost:** Not to exceed $100,000 per year.		
Purchase as Personal Property	No Authority	**Time:** Greater than 1 year and less than 3 years	**Time:** Greater than 3 years

For purchase of relocatable less than $250,000, use OMD or OMA funds. If purchase price is equal to or greater than $250,000, use OPD or OPA for lease of the relocatable building.

[1] All authorities are on a "per lease" basis.

(10) Real Property: Separate and individual building, structure, utility system or other real property improvement identifiable in the three-digit category code listed in *AR 415-28* and following the requirements in *AR 415-15*. The DPW is the installation staff officer responsible for work classification and approval at the local level or forwarding to the Regional Installation management Activity (IMA) for approval action. Classification will be identified as repair, minor construction or MILCON. Sustainment, Restoration, Modernization funds (OMD, OMA, MED MILCON, or MCA) are used only for property of this category.

(11) Relocatable Building: A personal property building designed to be readily moved, erected, disassembled, stored, and reused. The estimated costs for building disassembly, repackaging (including normal repair of components), and non-recoverable building components, including foundations, may not exceed 20% of the acquisition cost of the relocatable building. (See Table 5-B-4, Relocatable Building Validation for formula)

(a) Operating Lease: Must meet all (6) criteria:

(i) Ownership of the relocatable building remains with the lessor during term of lease and is not transferred to the Government at or after the end of lease term.

(ii) Lease does not contain a bargain- price purchase option.

(iii) Lease term does not exceed 75% of the estimated economic life of the relocatable building.

(iv) Present value of the minimum lease payments over the lease does not exceed 90% of the fair market value of the relocatable building at the beginning of lease term.

(v) Relocatable building is general-purpose, not a special purpose of the Government and is not built to the unique specification of the Government as lessee.

(vi) There is a private sector market for the relocatable building. For operating lease, use OMD or OMA funds.

(b) Capital Lease: Any lease other than a lease-purchase that does not meet criteria of an Operating Lease. NOT RECOMMENDED, capital leases require funding the entire lease up-front and withdrawing the lease payments.

(i) If less than $250,000, use OMD or OMA funds.

(ii) If equal or greater than $250,000, use OPD or OPA.

(12) Site Preparation (prep): Site prep for any of the “modular-type” facilities is considered installation real property and follows *AR 415-15* and *AR 405-45*. Site prep includes: foundations, exterior utilities, parking, lighting, and other construction costs. The DPW is the installation staff officer responsible for work classification and approval at the local level or forwarding to the Regional IMA for approval action. Classification will be identified as repair, minor construction or MILCON.

(13) The activity is not allowed to “keep” the building if purchased as personal property. Disposal or an approved reuse plan is the only options available at the end of the approved period of use. I n extremely rare instances a relocatable building may be converted from personal property to real property with approval through the funding MACOM, the Center for Public Works and the Office of the Assistant Secretary of the Army for Installations, Logistics, and the Environment.

m. Equipment Site Preparation.

(1) General. Equipment site preparation is a responsibility of the Facility Manager. Facility Managers coordinate and develop requirements for installation of Super-CEEP and MEDCASE equipment purchases.

(2) Planning and Coordination:

(a) Planning for site prep should begin during initial equipment programming. Funding to support Super-CEEP and MEDCASE site preparation is centrally managed at ACSIE&FM. Site prep should be completed prior to the equipment delivery date.

(b) Repair or minor construction projects to support failing infrastructure, aesthetics or functional requirements should be planned and programmed as SRM projects and timing should be in coordination with site prep activities. Funding to support repair or construction projects in support of these equipment purchases are addressed in Supply Bulletin 8-75-11, Chapter 8-9, paragraph d: "All projects will be submitted to the MSC for validation, approval and regional prioritization. Upon approval, the MSC will prioritize and fund the project based on funds available and if it is within specified funding range. Currently, this range is $25,000 to $300,000. Projects greater than $300,000 will be forwarded by the MSC directly to ACSIE&FM for approval. The ACSIE&FM will release funds for approved projects. Projects will be funded in accordance with the MEDCOM prioritizing scheme and the MTFs ability to execute." Items purchased for MILCON projects are exempt from the site preparation program.

(3) What is considered Site Preparation or "site prep" for installing Super-CEEP and MEDCASE purchased equipment? The following list, thought not all inclusive, provides guidance on what qualifies for site prep.

(a) Site preparation consists of providing the means to physically attach the piece of equipment to the real property MTF, which may include plumbing, cabling, or wiring necessary for the specific piece of equipment.

1) Secondary utility work necessary to connect the equipment to existing utility services within the building. This work lies between the primary entry or source within the building and the room in which the equipment is to be placed.

2) Installation of air conditioning for types of equipment where the manufacturer's written specifications states that the equipment must be operated in an air-conditioned space and provides temperature and/or humidity parameters which cannot be sustained by existing air conditioning.

3) Provision of false floors or platforms required solely for the operation of the equipment.

4) Installation of required shielding for electromagnetic radiating devices such as X-ray machines and linear accelerators. This includes wall construction with lead lined sheetrock.

5) Temporary removal and reinstallation of items such as portions of walls, roof, and utility systems to permit installation of equipment. Reinstallation may involve rerouting or relocation of some items.

(b) Most work eligible for funding as site preparation will be classified as "non-construction" (i.e., engineer's "M" cost account, municipal services) by the DPW on the work request (DA Form 4283). The DPW is responsible for properly segregating and classifying all work.

(c) Site prep that adds real property outside the footprint of the MTF, such as a foundation and utilities for a Relocatable building, will be considered construction, NOT site prep.

(d) Only that work which is specifically required to make the piece of equipment operate is eligible to be funded as site preparation. Work generated to repair failing infrastructure, or for aesthetic or functional reasons will NOT be funded with site prep funds.

(e) The repair or minor construction work associated to repair failing infrastructure, improve aesthetics or functions may be performed in conjunction with the site prep work, but funding and approval will follow the procedures of Supply Bulletin 8-75-11, Chapter 8-9, paragraph d.

(f) The transportation, assembly, installation, calibration, and testing of the equipment are NOT site prep costs.

(4) Funding policy:

(a) Site preparation funds support equipment purchased through Super-CEEP and MEDCASE Programs. Items purchased for MILCON projects are exempt from this program.

(b) Site preparation costing less than $1,000 will be financed from local resources.

(c) Activities are not authorized to reprogram site preparation funds to any other requirement unless such reprogramming is approved by the ACSIE&FM.

(d) The following documents are required to be submitted to the ACSIE&FM site prep point of contact for site prep funding release:

(1) An approved DA Form 4283 identifying work classification and approval amounts.

(2) Completed Site Prep Categories spreadsheet

(3) Scope of work and cost estimate of site preparation to be completed.

(e) Site preparation funding will be distributed via Financial Authorization Document (FAD) and will be accounted for under Army Management Structure Code (AMSCO) 847714.87

n. Support Agreements

(1) Inter-Service Support Agreements (ISSA): The FM should reference DD Form 1144 and *AR 5-8*. The ISSA designates a supplying and receiving activity, and governs services required from the providing agency to the receiving agency. As such, resource managers and Commanders or their designated representatives usually sign it. The proponent for the ISSA is Resource Management. For each support category, a basis for reimbursement and estimated reimbursement amount are provided. Support categories that are usually related to facility management functions are:

- Common Use Facility Operations, Maintenance, Repair and Construction
- Facility Maintenance and Repair of Real Property and Space Management
- Utilities

(2) MOA. The FM should include the following when developing a draft MOA:

- Detailed Standard Level of Service (Includes compliance standards, such as JCAHO, response times, quality assurance)
- Quantity
- Frequency
- Basis for Reimbursement (Includes basis of payment, method of payment transfer, rate scheme)

(3) Basis for Reimbursement. Basis for reimbursement can be complicated when installation facility support services are supplemented with contract support services. The FM is responsible for working with the RM and the supplying agency, in most cases the DPW, on development of a basis of reimbursement that offers the greatest economy, efficiency, and flexibility. Costs, such as annual fees, special service rates, and internal and external overhead, may be immediately apparent from the ISSA reimbursement schedule. A clause should be included giving the receiving agency, such as the MTF, the authority to

use an alternate supplier, such as an outside contractor, if the supplier cannot meet the conditions stipulated in the ISSA. This is commonly referred to as right of first refusal.

8-8. PROJECT MANAGEMENT

a. General: Project management consists of planning, programming, budgeting, and executing sustainment, restoration and modernization projects. This section applies to major repairs for projects over $25,000. Projects that are under $25,000 are considered minor repairs. Minor repairs are managed as part of the activity's recurring maintenance and minor repair program (i.e., R-Line distribution).

b. Minor Construction: Reference 10 U.S.C. Section 2805 (Public Law 107-107), *AR 420-10*, Management of Installation Directorates of Engineering and Housing, 2 Jul 87, and *AR 415-15*, Army Military Construction Program Development and Execution, 30 Aug 94. The threshold for minor construction projects is $750,000.

c. Life, Health, or Safety: A special threshold for minor construction projects to correct life, health, or safety deficiencies became effective with Section 2801 of Public Law 107-107. Effective with the President signing the FY02 Defense Authorization Act, Section 2805 of Public Law 107-107 provides special threshold for unspecified minor construction projects to correct life, health, or safety deficiencies. The limits are not retroactive. The limits are as follows:

(1) The minor MCA subsection of the Law adds the following: "However, if the military construction project is intended solely to correct a deficiency that is life-threatening, health-threatening, or safety-threatening, a minor military construction project may have an approved cost equal to or less than $3,000,000." Medical Unspecified Minor Construction (UMC) projects will be submitted to:

Health Facility Planning Agency (HFPA)
5109 Leesburg Pike, Suite 679
Fall Church VA 22041-3258

UMC projects must be accomplished with photos, clear description of the project requirements, and justification identifying the life-threatening, health-threatening, or safety-threatening deficiencies.

(2) The O&M section of the Law is changed to the following:

(a) $1,500,000, in case of an unspecified military construction project intended solely to correct a deficiency that is life-threatening, health-threatening, or Safety threatening; or

(b) $750,000, in the case of any other unspecified military construction project."

(3) IMA or MACOM Commanders can approve the new O&M limit or delegate it to their Delegation of approval authority is to be in writing. The new special threshold does not change any other approval limits or work classification requirements. The local DPW maintains the responsibility for work classification. However, it is the responsibility of the Facility Manager to justify deficiencies that are questioned by the DPW. ACSIE&FM will assist the MTF in stating the life-threatening, health-threatening, or safety-threatening deficiencies and endorse the need for valid projects

d. USAMEDCOM Approval Process: The local Facility Managers, with approval from their Commands, submit all projects over $25,000 to the RMC/MSC for validation, approval and regional prioritization. Upon approval, the RMC/MSC will prioritize and fund the project

based on funds available and if it is within specified funding range. Currently, this range is $25,000 to $300,000. Projects greater than $300,000 will be submitted by the RMC/MSC to ACSIE&FM as a Major Repair and Renewal (MRR) Project. The request for submission of unfunded MRR projects for the budget year plus 2 years will be requested annually via a data call in April of the current year. Facility Directors are responsible for obtaining Command approval of their program prior to submission to ACSIE&FM. Emergencies or urgent requirements that are identified in a current fiscal year and cannot wait for annual submission will be submitted through the RMC/MSC Facility Director to ACIE&FM for evaluation for insert into the current year program. Each request will include a justification of the emergent/urgent requirement and where in the regional priority list it will be inserted. During the fiscal year, when a project is 'ready', funding for a MRR project will be released via FAD to the MTF.

e. Department of the Army Approval Process. Any repair project must have an approved DA 4283 work request and/or Maintenance & Repair (M&R) DD1391 for the work being performed. It is the DPW/Garrison Commander's responsibility to classify work as maintenance, repair or new work (construction). An approved DA 4283 must be signed by authorized DPW personnel for the repair and/or construction of the project. Work classification ("K" & "L") should be identified on this document. If the repair ("K") work exceeds $3M or the work exceeds 50 percent of the replacement value of the facility greater than $500,000, then a Maintenance and Repair (M&R) DD 1391 must be developed and approved by the Department of the Army. Form DD 1391s are developed by the local DPW and forwarded up to the regional IMA. The Regional IMA will review the 1391 and forward the 1391 to Headquarters, IMA who forwards the 1391 to the Army Chief of Staff for Installation Management (ACSIM). Final approval is given by the Deputy Assistant Secretary of the Army (DASA) Installation and Housing. If the repair 1391 exceeds $7.5 Million, then Congress must be notified 21 calendar days before project approval is given by DASA (I&H). M&R DD1391s only approve repair work, if there is new work (construction) associated with the project within O&M limits, this work needs to be approved on a DA4283.

f. Medical Facility Support Program. The Medical Facility Support Program allows FMs and USAMEDCOM DPWs access to a number of innovative and cost-effective operations, maintenance, repair, minor construction contracts as well as a variety of facility-related services. The compilation of these contracts is called "toolbox". Toolbox contracts are in place at selected contracting activities called "Medical Support Teams" (MSTs) that meet the regulatory requirements under the Economy Act and Intra-DoD Offloading. The USAMEDCOM and has established MOUs with MSTs. This allows MTFs to obtain operations and maintenance and other support services on a timely and cost effective basis. The DPW must be offered reimbursable projects prior to obtaining the services from alternate sources. Toolbox allows the FM and DPW a way to accomplish mission requirements. The USAMEDCOM TOOLBOX manual provides guidance on planning, executing, and administering work within the Medical Facility Support Program.

g. Responsibilities.

(1) HFPA.

(a) Provide Medical Support Commands and Regional Support Commands with annual programming guidance and criteria for development of medical facility projects and programs.

(b) Provide Program Analysis and Evaluation for the Medical MILCON Program.

(c) Provide Master Plans and special studies for AMEDD facilities

(d) Develop planning documentation for Medical MILCON Projects.

(e) Perform user reviews of Army medical facility designs for medical functionality.

(f) Submit the proposed Army medical facility program to the ASD(HA) Portfolio Planning and Management Division

(g) Monitor and analyze medical construction program execution.

(2) ACSIE&FM. ACSIE&FM has the responsibility for management of project support services and the toolbox program. ACSIE&FM will:

(a) Identify MSTs to provide the acquisition and engineering/technical support for toolbox and negotiate MOUs.

(b) Identify and provide scopes of work to MSTs for those services that are required by FMs support operations and maintenance.

(c) Issue and maintain the toolbox manual.

(d) Provide technical assistance to the FMs using project integrators.

(e) Coordinate COR duties in support of the contracting officer.

(f) Provide technical assistance to FMs in preparation of development of work plans and cost estimates.

(g) Review request for contract services from FMs and forward to MST.

(3) Facility Managers. FMs will:

(a) Develop internal procedures for implementation of toolbox contracts.

(b) Establish working agreements with the DPW and other host installation support activities for processing work requests and obtaining approval for reimbursable projects.

(c) Identify to ACSIE&FM any additional services desired for inclusion into toolbox.

(d) Insure the complete requests for services packages are prepared for processing through the MSTs.

(e) Maintain a file of each delivery order issued by the contract POC for the activity.

(f) Provide required level contract management of each project.

(g) Provide the contract POC a receiving report or completion of services statement, as required.

(4) DPW Interface. The DPW must:

(a) Receive requirements for the FM.

(b) For approval of repair work or new work, return approval to the FM with a DPW signed work request, DA 4283, showing work classification, K, L, etc.

(c) Accomplish work by:

- In-house work forces or other pre-established contracts.
- Competitive bid.
- Accomplish work using toolbox contracts.

h. Work Plans. Work plans are an alternative means of project execution in lieu of the lengthy process of full-scale project design and execution. The contractor generates a work plan for the project based on a site visit and a written scope of work. This work plan is provided to the FM for review and comments. The FM must obtain all local reviews and coordinate the return of all comments. The work plan includes these items. Some of these can be waived on small and uncomplicated projects.

(1) Executive summary providing a brief description of the work

(2) Narrative description of work required, referencing study and design calculations

(3) Sequential listing of steps required for the project execution

(4) Work schedule

(5) Drawings, as applicable

(6) Standards and engineering specifications

(7) Engineering calculations and analysis

(8) Scope of work
(9) Material take-offs
(10) Catalog cuts and equipment specifications
(11) Manufactures and installation procedures or execution specifications
(12) Outline of training
(13) Outline of O&M documentation
(14) Video of site

i. Work Plan Coordination. Reviews and coordination of these work plans and/or design must be efficiently accomplished in order for toolbox major repair and minor construction projects to. This reduces the need for costly modifications and delays during the construction phase. All functional areas should be involved in the reviews. Reviewers will screen proposed work plan for conflicts and/or omissions within their functional area. They should provide written comments in the Corps of Engineers comment review format (Dr. Check's software program, www. Projnet.org) within the suspense time set for the review by the Facility Manager. The Facility Manager will compile and forward comments to the appropriate Corps of Engineers District. The work plans should be reviewed in the following functional areas as applicable to the size and type of project:

FUNCTIONAL AREA REVIEW AGENCY

- Facility O&M Facility Manager
- Physical Security Phys Sec Br/ PMO
- Information Systems Info Mgmt Office
- Environmental HealthOccupational Health
- Safety Safety Officer
- Fire Safety DPW
- Environmental Assessment DPW
- Historical ComplianceDPW
- Utility System Standards DPW
- Mechanical System Standards DPW
- Technical Engineering Criteria DPW
- Installation Design Guide DPW

8-9. FACILITY REPLACEMENT

a. Regulatory Basis. *AR 415-15*, Army Military Construction Program Development and Execution, establishes Army policies, responsibilities, and procedures for the development and execution of MCA and Unspecified Minor Military Construction, Army programs. Section 1-20 of *AR 415-15* specifies responsibilities of The Surgeon General in Medical Military Construction Programs. DA Pam 420-9 shows an MCA program development flow chart, illustrating the process for MCA program design through execution.

(1) Projects for construction of new or replacement facilities costing more than $750,000 must be submitted to Congress for funding if their costs exceeds specified limits. The process for preparing the documentation for Congress is known as construction programming. Typically the installation master planner who works within the Directorate of Public Works prepares this documentation. Installation master planning supports the process by coordinating and preparing the 1391.

(2) Construction programming is divided into several funding categories. The medical construction program (MED MILCON) is used to fund construction of new clinics, hospitals, medical training facilities, and medical research facilities. MCA is used to fund the

construction of barracks, administrative buildings, childcare centers, and many other types of non-medical projects.

b. Requirements Identification. Identifying requirements for the MED MILCON program is the responsibility of the entire Army Medical community. Once identified, MED MILCON projects are included in the Future Years Defense Plan. The objective of a 50-year life cycle for the medical infrastructure can only be achieved if requirements for construction projects are identified early in the planning process and supporting documentation is carefully completed.

c. MED MILCON Development. To develop the MED MILCON Program, each year the OSDHA requests a prioritized listing of all requirements for MED MILCON projects for a six year period. The Army's listing of projects is developed by the MSCs and submitted through the USAHFPA and the Army Staff to ASD/HA. Typical projects include:

(1) Complete replacement of a facility. Criteria for a justification for a replacement facility include:

- There is an additional mission.
- The current facility is substandard and cannot pass accreditation (even if the Life safety Upgrades (LSU) or Addition and/or Alteration (ADAL) is performed.
- An economic analysis identifies a new facility as more cost effective than the LSU or ADAL.

(2) Consolidation of two or more freestanding facilities. Consolidations generally occur when two or more facilities are required for one mission. Justification for consolidation depends on the condition of the facilities and the impact numerous facilities have on the mission.

(3) Addition and/or alteration (ADAL) to an existing facility. An ADAL is required when space, services, or systems are required in addition to the existing facility. This assumes that the existing facility is in adequate or repairable condition.

(4) Life safety Upgrades (LSU): LSUs are required when NFPA standards are not met, or when the facility cannot obtain JCAHO accreditation. Generally, JCAHO accreditation is not obtained due to facility deficiencies, which cannot be remediated with simple repairs or corrections.

d. Documentation. Documentation required for MED MILCON projects is:

(1) Project Planning Package/1391. DD Form 1391 is the form that officially requests project authorization and appropriation by Congress. As soon as a MED MILCON requirement is identified, a DD Form 1391 should be initiated. The MED MILCON program is a six-year program. The fiscal year of execution of a MED MILCON project can be estimated to be six years from the time of project identification. The fiscal year of execution will be adjusted annually, as the MED MILCON project develops. With few exceptions, such as a Congressional insert, DoD requires that project identification be at the 35 percent design (concept) stage before the DD Form 1391 is submitted to Congress.

(2) Project Narrative. Project Narrative summarizes the sizing decision process, siting, significant planning information and results.

(3) PFD. Program for Design, (PFD), space program, including the required number of parking spaces.

(4) Equipment Planning. Defense Medical Facilities Office (DMFO) is responsible for planning for installed (built-in) medical and dental equipment and the associated MILCON budgeting to support this requirement. DMFO shall provide the using Military Department with an initial equipment listing based on the Program For Design for their review and input prior to furnishing the document to the Design Agent. Each equipment list may be tailored or modified by the using Military Department as appropriate. Equipment in Logistical

category Codes E and F may be altered by the using Military Department if funding source requirements are not exceeded.

(5) Project Book. The Project Book summarizes existing site conditions and utilities. The following information, at minimum, is required:

(a) Area maps, location maps, site location, site description (to include grades, gates, etc), style of architecture, construction season limitations, seismic, wind and snow considerations, SOFA, host country agreements, soil and foundation conditions, utility conditions (water, sewer, power, steam, electrical capacities and location), site restrictions (airfield, AICUZ potential helipad approach/departure zone obstructions, flood land, rights-of-way, etc.), and National Capitol Planning Region considerations, etc.

(b) Utility availability, existing fuel sources, central heat or chilled water systems and capacities, power service characteristics and locations, electrical distribution, water and wastewater considerations.

(c) Environmental impact requirements, archaeological and historical considerations, explosive ordinance locations, contaminated soil (fuel, asbestos, etc.), coastal zone considerations, wetlands and watershed considerations, threatened and endangered species considerations, water quality, air quality, asbestos contamination, protection of natural resources information, and any other EPA or OSHA considerations necessary which might impact the MILCON project.

(d) Security requirements, contingency or blast considerations and Anti-Terrorism / Force Protection (AT/FP) requirements.

(e) Fire protection considerations, such as accessibility and water supply.

(f) Communications, information or data systems, telephone and signal interface requirements for fire, police, etc., telephone switch capacities and line availability for MILCON project, Energy and Utility Monitoring and Control System (EMCS, UMCS) interface, master antenna, cable TV and closed circuit availability, computer interface, and all other similar or useful information.

(g) Preliminary analysis of replacement versus addition/alteration where requested by DMFO.

(h) Completed site survey.

e. MILCON Project Space Management: The MILCON replacement of a facility always draws auditors and high-level command interest and requires special emphasis. The cost-effective reuse/demolition of the old facility is always one of the major items of interest. It is mandatory to complete the following procedures at least 12 months prior to occupancy of the new facility. Once completed, update the process periodically until final disposition of the old facility occurs.

(1) Establish a space utilization inventory for new and existing facilities by department or activity. The space inventory already exists for new facility in the form of the PFD. The PFD is the space program that the architect used to design the new facility. The PFD identifies assigned personnel (included are the contract and partners if identified during the programming stage) and the room or space required by these personnel and their activities. If the MTF does not have an existing inventory of assigned space, the MTF must develop it. If a building is excess, determine only the buildings gross area. This will identify all known excess facilities and provide a departmental inventory of assigned space for all activities not included in the new facility.

(2) Calculate space requirements by department or activity. This requirement already exists in the PFD. The HFPA prepare the PFD to meet the DoD medical space planning criteria. The only activities not covered by the PFD should be as a result of new missions or activities purposely not included in the new construction. Calculate the space requirements for these activities using the DoD Medical Space Planning Criteria (MSPC). This criterion exists in a PC-based, automated format that is available from HFPA. The DoD MSPC is contingent upon optimal conditions at a medical center. Because of this, you may

find that the criteria are above what your MTF actually requires. This will not be unusual especially at community hospitals. In those instances, use your professional and clinical common sense to establish a requirement that meets the needs of your activity. There should be few, if any, instances where the planning criterion does not provide sufficient space.

(3) Identify space allocation deficiencies and excesses by department or activity. This step is simply a comparison of the space inventory versus the space requirements. This will identify space deficiencies and excesses.

(4) Develop and evaluate space management options. There are basically three ways to satisfy space deficiencies.

(a) Consolidate into the best existing facilities. The activity must begin by evaluating existing facilities to determine if any remaining facilities can satisfy the space deficit. If renovation is necessary, compare the renovation cost to the cost of new construction and leasing. If renovation is the most cost-effective solution, the activity must consolidate into the best facilities. In no instance will a World War II wood building be acceptable as a medical facility. Vacate all World War II wood buildings as soon as possible and find other facility solutions to replace them.

(b) New construction, permanent, or temporary: If acceptable existing facilities are not available, take steps to initiate new construction projects. This can be done as a submission to our minor construction program (greater than $25K but less than $750K of new work); the Unspecified Minor Construction Program (greater than $750K but less than $1,500,000); or the construction is not possible in the required time, a temporary facility may be the interim solution. In all instances, an Economical Analysis of renovation versus new construction versus lease must be available.

(c) Lease. If leasing is a viable option, the Economical Analysis must prove that it is the most cost-effective solution.

(5) Excess space: Identify all excess buildings to the installation as excess to medical requirements. Do this only after coordination with our Director of Healthcare Operations and the Assistant Chief of Staff for Installations, Environment, and Facility Management. The DA medical requirements such as TO&E hospital movement or mobilization requirements, not yet known by the MTF or the installation, may be available at USAMEDCOM headquarters. As per *AR 40-2*, Army Medical Treatment Facilities General Administration, paragraph 1-10b, the installation must formally obtain our approval prior to diversion, conversion, or demolition. USAMEDCOM will not fund the operation and maintenance of any facility/space that is excess.

8-10. FINANCIAL MANAGEMENT

a. General. Facility managers shall adhere to financial guidance published by ACSIE&FM and ACSRM on an annual basis, and any SRM and real property services policies issued by the DCSRM. All transfers of funds into and out of SRM Accounts (Resource Summary Programs R, S, and X) require HQ USAMEDCOM, Office of the ACSIE&FM approval. Reference DFAS-IN Manual 37-100-xx (year), OMD funds are to be used for all facilities in the DHP inventory. All new work less than $25,000 will be charged to the activity mission core funds.

b. Facility Restoration and Modernization

(1) General. Restoration and Modernization provide resources for improving facilities. Restoration includes repair and replacement work to restore facilities damaged by lack of sustainment, excessive age, natural disaster, fire, accident, or other causes. Modernization includes alteration of facilities solely to implement new or higher standards

(including regulatory changes), to accommodate new functions, or to replace building components that typically last more than 50 years (such as foundations and structural members).

(2) Program X. Restoration and Modernization is distributed under the Program X of the Resource Summary through the major subordinates command or directly from HQ USAMEDCOM. Restoration and Modernization projects, termed renewal projects, which have a sustainment component, will be executed as restoration and mode

(3) Minor Construction. Minor Construction ("new work") over $25K is part of Restoration and Modernization. Statutory limitations on minor construction projects are still in place under SRM. New work that is less than $25K shall be funded with Program M and not with Program R dollars.

c. Sustainment

(1) General. Sustainment funding is programmed specifically for the routine maintenance, minor repair, and major scheduled repair of category 500 and certain non-category 500 buildings to the five-foot line. This includes regularly scheduled adjustments and inspections, preventive maintenance tasks, and emergency response and service calls for minor repairs. It also includes major repairs or replacement of facility components (usually accomplished by contract) that are expected to occur periodically throughout the life cycle of facilities. It does not include repairing or replacing equipment in place (i.e., small refrigerators or X-Ray machines) or furniture, or building components that typically last more than 50 years (such as foundation and structural members), or housekeeping contracts.

(2) Program S and R. Sustainment is distributed under the Programs R and S of the Resource Summary through the MSCs or directly from HQ USAMEDCOM. The use of Program R funds is limited to direct cost of maintenance and minor repairs of building components. It is not meant for new work that alters or renovates areas or upgrades systems to higher standards. The Facility Sustainment Model (FSM) is the basis for generating the funds for the Program R distribution. Program R funds shall not be used to fund core facility management branch staffing positions unless they are directly assigned to maintenance activities or quality assurance inspections of maintenance activity. Facility Management Branch employees assigned and authorized on the TDA are Program M funds and are not paid out of R Line. Program R funds should be allocated and monitored by the Regional Facility Director.

(3) Scheduled Major Repairs. The use of Program S funds is limited to scheduled major repairs of building components that have reached their life expectancy. Program S includes major repair projects funded from the RMC $25-300k funds. RMC $25-300k funds that are used by the region for restoration or modernization projects are converted to the X program through ACSIE&FM. The availability of the funds for major repair projects may be dependent upon the severity of the decrease in funding level. ACSIE&FM will approve funding projects above $300k based on priority ranking and availability of funds. Regional and local RMs should not fund projects greater than $300k with Program M funds without ACSIE&FM approval.

(4) FSM and Maintenance Contracts. Existing maintenance contracts that do not have separate contract line items for work other than routine maintenance and minor repair, such as plant operations or ground maintenance shall be modified with new contract line items. Any changes to existing maintenance contracts shall not cause an increase in the approved Program R funding level. New maintenance contracts shall also be designed accordingly to be within Program R funding levels. OSD FSM model does not have a requirement for plant operations, grounds maintenance OSD specifically excludes: "custodial services, grass cutting, landscaping…." from the Sustainment definition and states it should be part of facility operations.

d. Real Property Services. Real Property Service includes the cost of utilities, plant operations, municipal services, fire and emergency response services, and facility engineering services. Facility managers should consult their respective Resource Manager to ensure utility payments are based on actual metered costs for those buildings that are metered.

e. Environmental Program. Environmental dollars are “fenced” and can be used only for environmental projects. This program has high visibility. Execution is monitored against programmed requirements identified in the Environmental Program Requirements-USAMEDCOM (EPR-M) and the Environmental Program Requirements (EPR) data submittal for DHP dollars, respectively. DHP environmental dollars are distributed through Program E of the Resource Summary and are based on requirements identified in the EPR-M. Movement of Program E dollars between activities will be coordinated with the ACSIE&FM Environmental Office.

f. Prior Year Funding. Projects awarded but not completed in the same year may require prior year dollars for within scope modifications. Send requests for prior year funds to your local resource manager. If funds are available, your resource manager will use the documentation to fund the increase. If funds are not available locally, forward the request to ACSIE&FM, or contact ACSIE&FM POC at 210 221-8077 or DSN 471-8077.

g. Site Preparation. Refer to section 8-9e for financial limitations of equipment site preparation.

8-11. REGULATORY CONTROLS AND ACCREDITATION

a. General. The FM shall be responsible for insuring that all buildings are in compliance with the Life Safety Code, NFPA 101. And that all buildings that house patients or in which patients receive treatment are in compliance with the JCAHO. For research facilities, the FM shall reference all applicable accreditation organizations, such as the CAP, and the AAALAC. Regardless of whether the facility has a JCAHO requirement or not, the FM shall be responsible for the development of a utility management performance plan and coordination of pertinent sections of all other required performance plans. It covers:
FM Responsibilities, Organization, & Staffing
Systems Overview and description
Facility Training program and requirements
Critical Systems List and inventory
Maintenance procedures
Emergency preparedness procedures
Testing Requirements
Performance Indicators

b. Environmental Management:

(1) Refer to *AR 200-1* and *AR 200-2*. Within the context of the facility manager’s organizational span of control, the facility manager, the Chief of Logistics, the Safety officer, and the ESO are the primary personnel responsible for environmental compliance in USAMEDCOM facilities. Environmental compliance at the installation is the responsibility of the installation Environmental Division who often is part of the Directorate of Public Works. All regulatory issues should be coordinated through the ESO.

(2) Environmental Compliance on Projects: It is the facility manager’s responsibilities to make sure that scope of all major repair projects include environmental

abatement, such as asbestos, lead paint, etc. where required. If not sure of the extent of environmental mitigation, the facility manager should have test performed for verification.

8-12. MEASURING PERFORMANCE

In addition to FLCM, the USAMEDCOM Facility Strategy is influenced by the practice of management via a "Balanced Score Card" (BSC). The Surgeon General of the Army/ USAMEDCOM Commander has instituted the use of the BSC as the strategic management tool. It is the bridge to operational actions that realize strategic goals and objectives. Facility management performance is based on both internal program review and external benchmarks. Internal program review for facility management operations is accomplished through the CLRP, as prescribed by *AR 11-1* and USAMEDCOM *Pam 700-1*.

8-13. FACILITIES/LOGISTICS COMMAND REVIEW PROCESS

a. General. Facility managers are responsible for facilitating, providing input into, and follow up actions related to this process and other required staff assistance visits. The Facility Assistance and Assessment Support Team (FAAST) is the link between ACSIE&FM and this process with respect to the assessment of facility management operations.

b. FAAST Objectives. The FAAST provides assistance, assessment, feedback, and oversight relative to FLCM. The FAAST's services are not limited to just the CLRP and include the following:

(1) Provides comprehensive expertise to FMs and Commanders of USAMEDCOM MTFs in support of the Facility Management function.

(2) Supports Commanders against liabilities from outside agencies, such as OSHA, EPA etc.

(3) Assists and trains the FM organization at the MTF level on how to meet and/or exceed the required standards, and to prepare for the JCAHO and other accreditation surveys.

(4) Provides organized management tools to identify, prevent or eliminate problem areas. Those tools include a roll up of systemic issues and problems to the Facility Directors and Command staff.

(5) Record and communicate the successes of the MTF so other MTFs can benefit.

c. Types of Visits. Types of visits include the Command Logistics Review Team (CLRT), the Organizational Assistance Program (OAP), the Organizational Inspection Program (OIP), Staff Assistance Visits (SAV), Facility Manager Support Visits and other visits, as required.

(1) CLRT: The objective of the CLRT is to periodically review facilities on 36 months or less basis. Visits are both unscheduled and requested.

(2) Facility Manager Support Visit: It is required that a visit be scheduled between 4 and 6 months after a new FM is hired.

(3) OAP/OIP: Organizational Assistance and Inspection Programs are requested by various agencies, such as the Inspector General. These requests can be generated at the USAMEDCOM or regional level.

(4) SAV: Staff Assistance Visits may be requested by facility managers, or facility directors through ACSIE&FM. SAVs may also be directed by ACSIE&FM.

d. Survey Process.

(1) Preparation for a visit: Approximately 60 days prior to a FAAST visit, an introduction e-mail will be sent directly to the FM from the FAAST. The email will provide an

itinerary, a copy of the last visit's report, and checklist for the FM to review. If the visit is in conjunction with a formal review team, such as a CLRT, OAP, etc, the OIC of the team will send a formal letter to the C, LOG or the Command Group through proper channels depending on what type of visit will take place. It is the responsibility of the facility manager to self-assess their organization using the prescribed checklist. The self-assessment should be completed and returned two (2) weeks prior to the visit along with any issues the FM may have so the FAAST can be prepared to address them and work to help solve them during the visit. In addition to the copy of the previous report, checklist and the self-assessment, the FAAST will also review other reports prior to visiting a site such as:

- The current "Vanderweil Facility Advisors" (VFA) assessment to include the FCI
- TRACER
- The current Installation Status Report (ISR)

(2) Checklist

(a) The first part of the visit is spent going through a comprehensive checklist, not just to answer the questions, but to go over the self assessment in detail, review the supporting documentation, such as testing/inspection logs, DMLSS report and other records, and address any issues that the FM or FAAST may have.

(b) The objective of the checklist is to measure the success of USAMEDCOM facility management programs. The checklist focuses on efficiency, effectiveness, and adherence to USAMEDCOM accepted business practices and regulatory compliance. It also provides guidance in the implementation of facility management programs at the activity level, and helps to determine the root cause of a given situation, problem or issue. The checklist is meant to be a working document that is periodically reviewed and modified as required.

(c) The checklist is divided into the following categories:

- Organization Administration and Training
- Resource/Financial Management
- Operations and Maintenance
- DMLSS-FM
- Project Management
- Physical Plant and Site Survey

(3) Building Tour. The Physical Plant and Site Survey consists of a building tour of the primary MTF and the outlying facilities as needed to validate, benchmark and document the current situation concentrating on:

- Mechanical & Electrical Rooms
- Equipment Condition (limited visual assessment)
- Communications Closets
- Roof
- Interior / Exterior
- Life Safety Code Compliance
- Project/Construction Areas
- Areas of concern based on the latest condition assessment, or the last FAAST visit

(4) Interviews. In addition to going over the checklist with the FM, the FAAST will need to interview other people such as those responsible for DMLSS data input, maintenance management, project execution, ISSA/MOA, Budget/Funding, and the possibly organizations outside the MTF, such as the DPW.

(5) Out Briefs. An out brief to the appropriate Command staff, and others, based on findings, is always required. It is the responsibility of the MTF to make sure that the appropriate command staff is available for the out brief. The FAAST will perform a detailed pre-brief to the FM followed by a summary brief to the C, LOG (or the FM's immediate supervisor). Then, the Commander (or representative) is briefed on the overall condition of the facility, the FM organization and any deficiencies and/or advisories that need command emphasis and/or support.

(6) Final Reports

(a) The objective of the final report is to demonstrate the level of efficiency and effectiveness of the facility management organization. The report will identify what the organization does exceptionally well so the success may be shared with the rest of the AMEDD. The report will also indicate where the organization is not meeting USAMEDCOM standards and provide recommendations for improvement. The report consists of:

- Checklist with comments
- Executive summary
- Detailed report
- Photos with captions (as needed)
- A separate DA form 4965 for each deficiency (as needed)

(b) The timeline on developing, staffing and disseminating the final report is as follows:

- Within two (2) weeks of the completion of a visit, a comprehensive draft of the report, executive summary, checklist and photos will be provided to the ACSIE&FM and to the Subject Matter Experts (SMEs) at USAMEDCOM and HFPA for review and comments.
- The SMEs will then have one (1) week to complete the review and provide any comments back to the FAAST.
- Within 30 days of the completion of a visit, the FAAST will send out the final report (to include the executive summary, checklist, photos and 4965s as needed). If the FAAST visit is in conjunction with a formal review team such as a CLRT, OAP, etc, the final report will be sent to the OIC of the review team to be rolled into the official final report and then sent through channels to the MTF. If the FAAST visit is just an assistance visit, the final report will be sent directly to the FM. Copies of the final report will also be sent to the Facility Directors and SMEs.

(c) CLRT Finding Categories.

- Positive: Exceeds published standards and best business practices. Plans, programs or Ideas that qualify will be collected to share with the rest of the AMEDD.
- Advisory: Issue that is not in direct violation of a Code, Regulation or Policy, however requires immediate attention and remediation before it becomes a bigger issue and/or violation.
- Deficiency: Regulatory non-compliance or deviation from DA, USAMEDCOM or other established policy or regulation.
- Deficiency with potential liability: Regulatory non-compliance that could result in a potential liability such as non-accreditation, a monetary fine to either the organization or to the individual, or a potential legal claim.
- Outside Finding: A finding that is outside the control of the MTF.
- Repeat: Uncorrected finding (Advisory or Deficiency) identified in previous survey. Emphasis is brought to the fact that nothing has improved.

(d) CLRT Deficiency Tracking. A separate DA form 4965 detailing each deficiency as to what regulation, code or standard was in violation will be provided with the final report. Each 4965 will require a “Reply by Endorsement” from the MTF Commander to ensure the deficiency and the solution have command emphasis and support. The proposed solution will then be reviewed by the FAAST (or sent to the appropriate SME as needed) for concurrence. The MTF will be notified as to the concurrence or non-concurrence with the solution, and the deficiency and solution will be tracked. If repeat findings are observed during subsequent visits, the uncorrected finding will be noted as such.

8-14. TRAINING AND CAREER DEVELOPMENT

a. Purpose. Requirements of accreditation agencies, such as the JCAHO, places significant emphasis on physical plant management and reinforce the need for a comprehensive facilities career enhancement and educational program.

b. Facility Management Responsibilities. Facility managers are responsible for the development and implementation on all aspects of training associated with their core responsibilities. Facility mangers are required to develop an annual training program for all personnel within the facility management branch. The program includes the nature of the training, whether the training is a regulatory requirement, the personnel assigned the training, the budgeted amount for the training, and the funding source. Training plans will be submitted to ACSIE&FM, Training Coordinator, as requested, on an annual basis, so that the Training Director can consolidate, budget, and schedule training events associated with the USAMEDCOM facility management corporate program for career enhancement.

c. ACSIE&FM Corporate Training Program. The USA USAMEDCOM ACSIE&FM Healthcare Facilities Branch provides assistance to MSCs, Regional, and MTF Facilities personnel in areas of facility management training, and educational career enhancement guidance, and policy determination. These areas are addressed through the Facilities Management Training Coordinator and the Facility Management Support Operations Center. The Healthcare Facilities Branch also offers technical guidance to MSCs, RMCs, and MTFs on O&M issues. The USAMEDCOM facility management corporate program for career enhancement analyses functional skills required for facility managers and FMB staff members, identifies primary training, continuing education, and developmental requirements, and develops staffing methodologies to maintain a high level of expertise in all USAMEDCOM facilities. Many functional skills sets and core competencies have been identified, and are being addressed in basic and advanced facility management courses. The objective of the USAMEDCOM facility management corporate program for career enhancement is to maintain a high competency rate for personnel within the facility management branches.

d. Training and Educational Programs.

(1) A DoD Tri-Service Medical Logistics Facilities Management training program has been established to cover the basis areas necessary to manage health care facilities. The purpose of the course is to provide a broad overview of DoD Medical facility management, and to insure that facilities are operated and maintained in accordance with applicable standards, such as JCAHO, NFPA, OSHA, and EPA.

(2) The Facility Management Applied and Continuing Education course (FM-ACE) is offered through the USAMEDCOM ACSIE&FM Healthcare Facilities Branch on an annual basis. The course is an applied continuing education course. The purpose of this course is to provide facility managers with an advanced level of continuing education and state-of-art

information on a wide range of facility issues, such as CMMS, reliability-based maintenance, and enhancement of customer service.

(3) The U.S. Army Corp of Engineers, Huntsville Division, offers many training courses related to facility management through the Proponent Sponsored Engineer Corps Training course. Facility managers can contact U.S. Army Corp of Engineers directly for application to courses.

(4) The USAF Material Command, School of Aerospace Medicine, Brooks AFB offers environmental courses in hazardous waste and emergency response, as well as other environmental courses. Also, Fort Sill, OK, Directorate of Environmental Quality offers a comprehensive program for environmental training.

(5) Some universities offer degree programs and short courses in facility management related subjects. At the time of this publication, a listing of these programs and courses is not available.

e. Facility Certification Courses:

(1) The American Hospital Association offers a Certified Health Care Facility Manager certification exam for qualified facility managers.

(2) Certification as a Facility Management Administrator is offered through BOMI Institute, Arnold, MD.

(3) Other facility management certification programs include the Certified Plant Maintenance Manager course through the Association for Facilities Engineers and the Certification in Health Facility Management, offered through the American Society of Healthcare Engineers (ASHE).

(4) Funding. Funding for training, education, and certification is the responsibility of the activity. In some cases, sustainment funds can be used for this purpose (refer to the latest USAMEDCOM Facility Information Bulletin for limitations).

f. Career Development

(1) Facility Management Training

(a) Facility Management Basic Course: The objective is to introduce Facility Managers to the basic overview of the Medical Facilities Management and to teach the Integrated Facility Life Cycle Management philosophy.
Location: Sheppard Air Force Base Wichita Falls, Texas
Frequency: Four times per year. Duration: Three-week course

(b) Facility Management Applied and Continuing Education Course: The objective is to provide state of the art managerial and technical information for facility managers and facility directors.
Location: Varies Frequency: Annually Duration: One week

(c) Health Facility Planning Agency Post Graduate Short Course: The objective is to enhance tri-service and interagency collaboration and synergy on execution processes and lessons learned to realize improved efficiencies and quality in all phases of health facility planning, design, and construction.
Location: Varies. Frequency: Biannually Duration: One week

(d) Joint Services Facility Management Symposium: The objective is to provide gain critical insight into external organizations from all services and the DVA with the goal of becoming competitive and proficient managers of our healthcare infrastructure. Whenever practical, this symposium is held in conjunction with the ASHE Annual Conference.
Location: Varies
Frequency: Bi-Annually, sponsorship rotates between services

Duration: One Week

(e) ASHE. The objective is to promote professional facility management through a recognized institution for health care facilities planning and sustainment, and to provide a means for structured professional development and facility management certification. ASHE provides up-to-the-date information on healthcare engineering.
Location: Varies Frequency: Annually Duration: Five Days

(f) Corps of Engineers, Huntsville, AL; Corps of Engineers DFWPROSPECT Courses: The objective is to provide facility management personnel at all levels with access to current courses and areas of interest that may not be available though the Corporate Career Enhancement Programs. See Purple Book for details.
Location: Varies Frequency: Varies Duration: Four hours

(g) Health Services Medical Materiel Management Course: The objective is to familiarize Logisticians with the organization and responsibilities of the Facility Management Branch in a Medical Treatment Facility.
Location: AMEDDC&S Frequency: Varies Duration: Two hours

(h) Intern Program. The objective is to supplement the attrition of USAMEDCOM's current inventory of professional facility managers and facility manager staff with newly trained staff. This program is operated through Madigan Army Medical Center Engineering Department. Applications are accepted on a bi-annual basis. Contact USAMEDCOM for detailed information.

CHAPTER 9. MEDICAL MATERIEL READINESS

9-1. AGENCIES SUPPORTING MEDICAL MATERIEL READINESS

a. **MACOM** (FORSCOM/USARPAC-EUSA/USAREUR): Sourcing Unit MACOMs will provide Unit funding and identify requirements for all medical (SRC 08) Units under their commands. MACOMs are responsible for supporting the required Contingency Plan and OPLANs with Units that are adequately resourced to meet the warfighting combatant commander's requirements.

b. **USAMEDCOM/OTSG**: Programs, budgets, and executes central management of the CL VIII commodity, to include DA-funded, centrally managed programs (APS, MCDM, UDP, Installation Support Package) and commercial business interaction. They also provide the doctrine, regulations, and policy for the medical force.

c. **MRMC**: Serves to integrate the testing, research, and materiel developer to identify the future medical threat, treatment requirements, and provide the standardized support for MTOE organizations. MRMC commands the USAMMA and the USAMMCE. These two USAMEDCOM materiel agencies provide assembly management and other centrally-managed support to CONUS and OCONUS theaters.

d. **The USAMMA**: Serves as the designated central medical materiel manager for USAMEDCOM/OTSG. The USAMMA manages strategic and operational medical materiel programs that support MTOE Units in all components. Serves as the materiel developer for Army standardized sets.

e. **Medical Logistics Support Team (MLST)**: Represents the USAMMA capability to handoff APS and other TSG contingency stocks to deploying units falling in on APS. The MLST operates under the operational control of the Army Materiel Command's (AMC's) Logistics Support Element and IAW the command surgeon guidance.

f. **RMC**: RMCs shift assets to support major mobilization requirements and provide resource management and contracting support to adequately support installation and deploying Unit requirements at the direction of USAMEDCOM/OTSG. RMC directs IMSA actions to support mobilization, deployment, and redeployment activities.

g. **IMSA** [Power Projection Platform {PPP}/Power Support Platform {PSP}]: Provide direct support for all standard and non-standard requests for medical materiel and equipment maintenance.

(1) IMSAs will provide the following support for deploying units:

(a) The M3PT tool will provide a listing of all MES/MMS that each installation supports by building a scenario for all supported units. Once the scenario is built, run the unit assemblage report to produce all NSNs that must be mapped to a SOS part number.

(b) Establish accounts for COMPO 1 units and map shortages to available sources of supply. Maintain customer files either, electronic or paper for COMPO 1 units. These files will contain unit contact information, a log detailing interactions between the unit and IMSA, and a listing of all authorized CL VIII items

mapped to a source of supply part number with a record of this number built into the local MTF catalog.

(c) Maintain customer files either electronic or paper for COMPO 2/3 units. These files will contain unit contact information, a log detailing interactions between the unit and IMSA, and a listing of all authorized CL VIII items. The authorized CL VIII items are obtainable by running a unit assemblage listing in M3PT.

(2) Assist with storage and distribution of USAMEDCOM/OTSG centrally managed programs. Mobilization stations provide the support to deploy TO&E forces, fill deploying Units to meet Combatant Command (COCOM) force requirements, expansion of medical facilities and transition support to reserve elements to sustain the Mobilization station missions for continuing support through all phases of Army operations.

h. **DSCP**: Provide DLA/DoD interface for the CL VIII commodity. Provide commercial contracting and medical materiel support capability through the Defense Wide Working Capital Operating Fund.

i **MLMC**: Provides an automated Single Integrated Medical Logistics Manager (SIMLM) support function for the COCOM (CINC is no longer an operational term) collecting and providing detailed medical materiel management functions allowing real-time commodity management and feedback to the force provider to ensure complete logistics coverage for a theater of operations.

j **AMEDDC&S**: Develops the doctrine, validates the current standards of care, and trains the medical logistician. Additionally, AMEDD&S Coordinates the training and modernization of the medical force with other Services and within the DA.

k. The Directorate of Combat and Doctrine Development (**DCDD**) serves as the combat developer, integrating doctrine and standardizing requirements in conjunction with the expressed capability requirements of the combat force.

9-2. BACKGROUND ON MEDICAL MATERIEL READINESS

a. Class VIII materiel support for Army Units is divided into several categories:

(1) **Non-Unit Assemblage (UA) Materiel** (clinician or mission specific, non-standardized)

(2) **Non-Centrally Managed UA Materiel** (Unit funded, centrally standardized)

(3) **Centrally Managed** (the USAMMA and DSCP-managed, standardized)

(4) **Medical Chemical, Biological, Radiological, and Nuclear (CBRN) Defense Materiel (MCDM)**(OTSG-owned, USAMEDCOM/USAMMA-Managed)

(5) **Army Pre-Positioned Stocks** (APS – geographically distributed, DA-owned, USAMMA-managed)

(6) **Army Emergency First Responder Program** (AEFRP) and the joint **Installation Protection Program** (IPP) (USAMEDCOM owned and managed)

(7) **Radioprotectants** (DoD owned)

b. The USAMMA is responsible for the initial fielding of the MMS and MESs that comprise a Unit Basic Load (UBL). These SKOs are currently fielded as outlined in *AR 40-61*. The IMSA is the source of supply to fill Unit-generated shortages (consumed items, Unit assemblage updates, expired items, and field losses) for all

Units. In order to maintain readiness, all supplies must be on hand, on order, or part of a pre-arranged agreement where previously identified items may be obtained through Prime Vendors or other contract sources. Based upon unit deployment timelines, it is the unit's responsibility to maintain their basic load, unless covered by a centrally managed program. Units must submit funded requisitions to procure these items. The IMSA will map requirements to ensure that there is a viable acquisition tool in place to procure these items. The Unit is required to make annual coordination with the IMSA to identify shortages and coordinate sources of supply.

c. All medical Units must coordinate their requirements for medical materiel to their supporting IMSAs annually. Reserve Units will maintain only the non-expendable and durable components of their UBL. The IMSA will be the source of supply to acquire the Class VIII expendable UBL items to support Reserve Component (RC) Units upon mobilization. The IMSA will match these requirements to a source of supply to ensure rapid acquisition. All Units will validate that the acquisition timeline supports their wartime mobilization mission.

d. Managed Materiel

(1) Non Centrally Managed: Division And Below (DAB) Units must maintain their basic loads and fill Unit generated shortages, UA updates, and mission-specific items. Commanders will maintain Unit Assemblages (UAs) per guidance in this SB 8-75-11, Chapter 10. The AMEDD does not centrally manage materiel for active component divisional Units. DAB medical units are expected to deploy with their entire Class VIII UBL.

(2) Centrally Managed: For rapid deployment/contingencies, however, DA Deputy Chief of Staff Operations may identify and direct that a DAB Unit will be supported by centrally managed Brigade sets from APS (reference SB 8-75-S7 dated 20 July 2006). These directions will be published in the applicable Operations Order (OPORD).

e. The USAMMA centrally manages Class VIII materiel for early deploying Active and Reserve Medical Units at the level above Division. This materiel serves as initial deployment medical UBL for deploying Units. The materiel contained in this program is identified in the SB 8-75-S7. The USAMMA, USAMEDCOM, and the deploying Unit will coordinate for acquisition and hand off of class VIII materiel in a contingency. The MLST is the medical materiel hand-off team that is an integral part of the Army Materiel Command Logistics Support Element (LSE). The MLST will hand off Class VIII Unit Deployment Packages (UDP) and APS as directed by the USAMMA in coordinated effort with the deploying Unit.

9-3. COMMON READINESS MATERIEL ITEMS

CTA 8-100 is the source for all deployable Unit common medical items (Chap Stick™, foot powder, first-aid kits, etc.). These items are requested through the supporting IMSA. CTA 8-100 provides a basic guideline for the quantity of items to order for a given Unit. Unit supply personnel order these items using OMA funds.

a. Combat Lifesaver (CLS) Bags/Training: These are service-regulated items. They are ordered through the supporting IMSA with a justification memorandum attached detailing the personnel who will receive the MES, and their current training qualification. Only currently certified CLS personnel will receive the MES. Units will store the controlled components of CLS bags to prevent misuse IAW *AR 190-51* (Unit

safe, with designated/controlled access; inventoried quarterly). MES CLS is accounted for as a durable item and hand receipted to the user level.

b. Patient Movement Items (PMI): PMIs are initially issued with SKOs to Units identified during contingency operations. Replenishments are done by line-item requisition or direct exchange on a one-for-one basis with other Units during patient transfer. PMIs are service-certified for Air-Worthiness Standards based on Service specific airframes and intended to be used on the service associated evacuation platforms. Hand receipted durable items are accounted for by item, not serial number or other marking method. Non-expendables are controlled by serial number except where transferred for patient evacuation (ambulance exchange).

c. Moulage: Casualty simulation sets, or moulage sets, are CTA-authorized items. Typically, the supporting installation Training Aid Support Center will maintain sets for use. Otherwise, Units will order the sets according to CTA 8-100 through their servicing IMSA. The sets are durable items and replenished by line item requisition.

9-4. LEVELS OF SUPPORT FOR MEDICAL MATERIEL READINESS

a. Division Units: For Units in Divisions, Regiments, and Separate Brigades, medical materiel support is provided by the Division/Brigade/Regiment Surgeon's Office via either the Division Medical Operations Center/DMSO (legacy system) or the Division Materiel Management Center (DMMC) Medical Supply section (current system). Medical materiel in combat units is highly standardized, decentralized (controlled and managed by operational funds at the lowest level), and sustained by the owning Unit.

(1) Fielding of UBL: Units are fielded their MESs and other authorized medical items by the USAMMA. The USAMMA Fielding Team conducts scheduled fieldings of Unit MES and other centrally managed SKOs within the Division. The USAMMA provides a one-time fielding for the SKO and upon completion of fielding, transfers accountability to the Unit to maintain and provide status on the SKO through command channels.

(2) Unit shortages/Sustainment of UBL: Units are funded and expected to maintain their sets to the highest level of fill to ensure readiness of the sets. Initial fielding shortages are filled by follow on ship short packages or direct funding to the Unit to order locally to fill any SKO shortages. Sustainment of the sets is the responsibility of the Unit commander and Division Surgeon (DS). Units will have materiel available within 72 hours. This means that materiel will either be accounted for as on hand, on order with a valid status, or directly available from the source of supply (for unfunded requirements). Units will validate annually through their source of supply (DMSO, DMMC, and IMSA) the availability of all materiel requirements that are currently not on hand. Sets with specialty items (Chemical Patient Decontamination) or short shelf-life items (Field Laboratory) will be closely managed to avoid expiration of vital components.

(3) The MCDM:

(a) Deployable Force Package assets of MCDM are centrally managed to support initial issue Individual Service Member requirements for Army personnel deploying to high threat areas. See SB-8-75-S7 for details on management and release of this matereil.

(b) MES, Chemical Agent Patient Trmt, LIN: M23673 Potency and Dated (P&D) items are centrally managed for early deploying units plus forward deployed, See SB-8-75-S7 for detail on management and release of this materiel.

(4) Mobilization/deployment instructions: Upon deployment or mobilization notification, Units will validate their deployment CL VIII DODAAC and order all shortages from the supporting IMSA/SSA for receipt and packaging. Unit UBL is typically considered To Accompany Troops (TAT) and loaded with other Unit equipment. It is essential that these Units deploy with 100 percent of the required capability as sustainment is based upon that planning assumption.

b. Levels Above Division: For Corps and higher level units, the typical structure of a Medical Brigade or Command will have medical logistics elements specifically designated to support the medical materiel and equipment requirements for those Units. Unit medical supply personnel will integrate via automated systems into the MEDLOG Company Combat Automated Support Server - Medical system to order shortages and validate status. Units will order and maintain their basic load except where covered by a centrally managed program as discussed below. Where Units are not supported in garrison by their MEDLOG Company, they will maintain active accounts with their IMSA for all deployment and training CL VIII requirements.

(1) Fielding of UBL: the process for these Units is essentially the same as Divisional Units; the key difference for selected early deploying (D-Day through D+30) EAD Units is the coverage by UDP for various Unit types (see SB 8-75-S7 dated 20 July 2006). For Units covered by UDP, only select materiel is fielded to accompany the non-expendable and durable ARC N and D components of Medical SKOs. Potency and Dated items between 1 and 60 months of shelf life are centrally managed in the UDPs associated with those Units, and the Units are not required to maintain or sustain those lines. For Units not covered by a UDP, the requirement for those Units is no different from Divisional Units – maintain sets to 100 percent on hand, on order, or validated as available from the local source of supply.

(2) Unit shortages/Sustainment of UBL: Units covered by UDP will maintain only designated “non UDP” covered lines at 100 percent fill. Units not covered by UDP will maintain highest level of fill funded and validate all unfunded requirements through source of supply to ensure acquisition capability subsequent to deployment funding supplements or project codes.

(3) MCDM: Units will draw/issue/turn-in their MCDM in the same manner as Divisional Units. Hospitals with a DS support requirement will also order and distribute MCDM in accordance with their DS support instructions. (For example, a CSH that supports three (3) Forward Surgical Teams (FSTs), provides MCDM and other supply support).

(4) Mobilization/deployment instructions: Per SB 8-75-S7, Units supported by UDP will maintain current contact information with the USAMMA and support fielding and issue plans for that materiel. Except for early deploying Units falling in on APS (UDP and other items), Units will plan and coordinate the transportation of CL VIII through their ITO. The level above Division medical units is typically more diverse than Divisional Units, and acquisition strategies to cover the greater range of requirements must occur annually between the IMSA and the unit.

(5) Redeployment: Units redeploying will either conduct a transfer of centrally-managed assets to the relieving Unit (in place) or turn in the centrally-managed assets to the supporting Medical Logistics Unit for return to centrally managed programs. Retention of those centrally managed assets requires further accountability by those Units until they turn-in those items.

c. MTOE Hospitals (Active Component): Medical Force 2000 and Medical Reengineering Initiative hospitals represent the Level 3 and 4 [North Atlantic Treaty Organization (NATO) Role 3] requirements for surgical stabilization and intensive care management of casualties. They also provide direct support for subordinate assigned and attached units, and Area Support for medical logistics when not co-located with MEDLOG Detachments or Companies.

(1) Fielding of UBL: The USAMMA provides centralized fielding and modernization of MTOE hospitals. Units are fielded to the current Program Objective Memorandum budget for that year, typically resulting in a 90 percent fill of non-UDP covered MMS and MESs. Additionally, APS cover early strategic hospitalization requirements due to the large transportation requirement required to move Hospitals.

(2) Unit shortages/Sustainment of UBL: Units are expected to maintain the fielded level of fill for their sets regardless of their designation as an early deployer (required to fall in on APS).

(3) MCDM: Units will draw/issue/turn-in their MCDM in the same manner as Divisional Units. Hospitals with a DS support requirement will order and distribute MCDM in accordance with their DS support instructions. (For example, a CSH that supports three FSTs will provide MCDM and other supply support.)

(4) Mobilization/ deployment instructions: Upon confirmation of deployment orders, the designated Unit will either receive augmentation in the form of UDP at mobilization station (assisted by the USAMMA Materiel Fielding Team {MFT}) if they are deploying with the first thirty (30 days) or (for early deploying Units) move via airlift (TAT only) and fall in on APS (assisted by the USAMMA MLST).

d. MTOE Hospitals (Reserve Component)

(1) Fielding of Mission Essential Equipment Training (MEET) sets: MEET sets are the non-expendable and durable components of selected MMS modules that make up a reserve hospital. MEET sets allow reserve hospital commanders the opportunity to perform the major tasks of setting up (complexing) hospitals and establishing the physical layout without buying and maintaining a vast amount of potency dated or maintainable items. MEET sets are fielded by the USAMMA to reserve component medical hospitals. Units conducting normal Reserve training drill or annual training are expected to purchase expendable components with training funds to make the MEET sets capable of supporting training objectives.

(2) Reserve Component Hospital Decrement (RCHD) Program: RCHD augments the MEET sets to fill out the remaining requirements to make the hospital fully operational for mobilization and deployment. RCHD assets are stored at Sierra Army Depot and fielded to the Unit at the mobilization station. The Unit and the USAMMA MFT field RCHD.

(3) MCDM: Units will draw/issue/turn-in their MCDM in the same manner as Divisional Units. Hospitals with DS requirements will support in the same manner as Active MTOE hospitals.

(4) Mobilization/deployment instructions: Upon receipt of an alert order, Unit Reserve Support Center liaisons should initiate contact with the OTSG to begin the process of identifying the Unit RCHD requirements to augment MEET sets. Reserve Units, deploying after D+30, are expected to bring their full equipment load to the mobilization station, to further augment with RCHD to the full capacity of their respective MTOE strength. Units will also receive any supporting UDPs at this time and flow with full equipment. Selected Reserve Units may fall in on active component sets that were released by Active APS supported hospitals.

(5) Re-deployment: RC Units will redeploy with their equipment. Federal Law requires that RC Units maintain accountability within their component – meaning

that Active Component (AC) Units cannot fall in on RC equipment unless they exchange equipment or receive exception consideration from DA G-3/G-4 via sourcing MACOM FORSCOM, USARPAC/EUSA, and USAREUR]. Upon redeployment, Units will return RCHD elements to the RCHD program with assistance from the USAMMA MLST or MFT.

e. All Units

(1) COMPO 1 Units will establish, at a minimum, an account with valid Assumption of Command orders and current DA 1687-Delegation of Authority Signature Card. Units will provide a copy of their CL VIII shortages.

(2) COMPO 2/3 units will provide valid unit contact information. This information should include at a minimum, unit name, Commander's name, address, phone number, email address of medical supply POC. This information must be updated biennially or upon unit relocation.

(3) Units are expected to maintain the highest level of readiness for which they are funded. Units are expected to deploy at greater than 90 percent of MTOE required strength for equipment in order to be certified by an installation commander.

(4) Units will receive applicable centrally managed materiel (typically MCDM) upon receipt of valid deployment orders or by Surgeon General directed and approved release (contingency support requirements).

9-5. MEDICAL CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR (CBRN), DEFENSE MATERIEL (MCDM)

MCDM is centrally managed by the OTSG and executed by the USAMMA. See SB-8-75-S7 for details on management and release of this materiel.

9-6. ARMY EMERGENCY FIRST RESPONDER PROGRAM AND THE INSTALLATION PROTECTION PROGRAM

a. The Army Emergency First Responder Program (AEFRP) and the joint Installation Protection Program (IPP) provide CBRN pharmaceutical countermeasures (CPCs)to protect and treat emergency first responders and mission critical personnel who are exposed to CBRN agents, as a result of a CBRN incident on a installation.

b. Procedures for managing this materiel are still being developed. Draft guidance has been sent to the RMC. Final procedures will be published as an addendum in a future SB.

9-7. RADIOPROTECTANTS

a. The Radioprotectants are pharmaceutical countermeasures for use after an nuclear incident.

b. Procedures for managing this materiel are still being developed. Final procedures will be published as an addendum in a future SB.

9-8. MEDICAL MATERIEL READINESS SPECIAL CONSIDERATIONS

These categories of items require special attention and management beyond what has been addressed previously. Additionally, these are specific readiness items that

affect Unit deployments and sustainment due to acquisition restrictions and distribution controls that are not regulated by USAMEDCOM/OTSG policies. (Controlled substances are discussed in other chapters of *AR 40-61* and *AR 190-51*.)

a. Lab Reagents: Lab reagents are characterized by three important factors:

Limited Shelf Life	**Temperature Regulation**	**Limited Commercial Production**

As such, laboratory reagents are typically acquired by either local purchase or utilizing DSCP E-CAT web ordering tool from a vendor. Lab reagents may have long lead times for acquisition utilizing standard ordering procedures. The expected means of acquiring these items is through utilization of the DSCP ESOC for deploying and deployed medical Units requiring lab reagent support.

b. Cold Chain management: Temperature controlled (cold storage and frozen items) requires specific transportation controls to ensure that they maintain their viability between source and patient delivery. For items requiring cold chain management functions, the supporting SIMLM or the USAMMA Distribution Operations Center (under the USAMMA Force Sustainment Directorate) will support all packing and transportation instructions to ensure that adequate cold chain management measures are performed. Suspect medical materiel will be segregated and reported using Medical/Dental Product Quality Deficiency Report (M/DPQDR)--formerly SF380--Medical Complaint procedures to prevent patient injury or death.

c. Hazardous Materiel (HAZMAT): HAZMAT will be transported according to DOT and DoD requirements for safe movement. HAZMAT will be stored according to specific storage instructions for each item and category of HAZMAT. Additionally, applicable MSDS and other OSHA requirements will accompany all HAZMAT items for storage, shipment, and usage. HAZMAT is packed and shipped separate from other supplies and equipment and specific instructions on handling will be clearly marked on each package or container. Personnel who handle HAZMAT will be certified according to MACOM and OSHA requirements before transporting, packing, or handling HAZMAT items.

9-9. OCONUS MEDICAL LOGISTICS SUPPORT

a. **USAMMCE**: This TDA organization serves as the SIMLM for European Command, Africa, and South West Asia (SWA). Provides medical materiel management, depot level medical maintenance, and multi-vision optical fabrication for all services.

b. **16th MEDLOG BN**: This TDA-augmented MTOE organization serves as the SIMLM for Korea. Provides medical materiel management, GS medical maintenance, and multi-vision optical fabrication for all services on the Korean peninsula.

c. **226 MEDLOG BN**: Provides Medical Logistics support to European units and ongoing contingency operations throughout the European theater.

9-10. SOLDIER READINESS PROCESSING (SRP)

a. The USAMEDCOM responsibility for SRP/Predeployment Processing (PDP) is to provide screening checks for medical, dental, and visual readiness. Personnel are given updated medical examinations, dental examinations, vaccinations, eye examinations and medical appointments to ensure that all necessary standards of fitness are achieved prior to deployment. IMSAs are funded to provide those basic services and are coordinated by the hosting installation for Unit SRP functions.

b. Supplies are ordered from the supporting IMSA and paid for by that activity for all SRP requirements.

(1) Theater prophylactic requirements are defined by the sourcing and requiring commands. Vaccinations and other forms of prophylaxis are distributed prior to deployment and managed by the Unit surgeon for continued treatment upon deployment. Personnel medical records are updated during SRP to show initial vaccination and issue of prophylactic medicines.

(2) Optical devices will be prescribed and issued prior to deployment of personnel from the Mobilization station. The basic requirement will be one pair standard eyewear and one protective mask insert, one combat eye protection insert and one Land Operations (LO) frame for those personnel who meet the vision readiness requirement for corrective eyewear as determined by competent medical authority.

CHAPTER 10. PROCEDURES FOR MANAGEMENT OF MEDICAL ASSEMBLAGES

10-1. ACCOUNTING, MANAGEMENT, AND UPDATE OF MEDICAL ASSEMBLAGES

a. Accounting and managing for components of Medical Assemblages.

1. MTOE commander responsibilities.

(a) Establish and maintain property accounting records on each authorized non-expendable item using the manual property accounting procedures, or an approved DA automated property accounting system (see *DA PAM* 710-2-1).

(b) Establish a viable Quality Control program for all dated items.

(c) Under the inventory provisions of *AR 710-2* and *DA PAM 710-2-1*, manage expendable and durable ARC "X" or "D" components of MESs on hand-receipts (Supply Catalog (SC) 6545-8 series), or as part of the Unit Assemblage Listing (UAL). These components are listed in the SC or UAL to identify authorized quantities. When using the SC and/or the UAL, use the most recent document.

(d) Medical items are classified as durable because users do not expend them in the first use. Unless there is evidence of pilferage, treat the loss of these items as if they were expendable. Commanders are not required to account for durable losses from MES/MMS under the provisions of AR 735-5, paragraph 14-25, unless the commander suspects negligence, theft, or willful misconduct

(e) Commanders will inventory MES components against the fielded UAL at least every six months (12 months in RC) to measure readiness. Units may perform this inventory in conjunction with other required inventories as long as it meets the requirements stated above.

(1) Commanders of Medical Reengineering Initiative (MRI) Hospitals with equipment in long-term storage under the AMEDD Hospital Optimization Standardization Program (HOSP) will follow procedures outlined by their MACOM.

(2) Items listed in the Section II of the fielded UAL and in Section III of the SC 6545-8 series are Associated Support Items of Equipment (ASIOE) end items dedicated to the operation and maintenance of the medical assemblage. The listing is for information purposes only and does not constitute an additional authorization. The unit's MTOE/TDA reflects total authorizations.

(f) Record and account for inventories as follows:

(1) For assemblages with published hand-receipts, use the preprinted hand-receipt lists provided to record the results of inventories and maintain accountability.

(2) For assemblages without published hand-receipts, prepare a DA Form 4998-R (Quality Control and Surveillance Record for TO&E Medical Assemblage) for each expendable and durable item in the medical assemblage. See Table 10-1 for instructions on how to complete DA Form 4998-R.

(3) Use DA Form 4998-R to record and manage QC information. Reproduce the DA Form 4998-R locally on 8X5-inch card stock.

(4) Automated procedures. Whenever practical, use the DA approved automated medical materiel management systems that provide assemblage management and QC capabilities instead of the DA Form 1296 and 4998-R. Those systems include DMLSS, TAMMIS, TEWLS, M3PT, or ULLS-S4.

(2) MTOE hospitals and division/brigade/regimental Medical Supply Officers (MSOs) will manage ASL items in anticipation of a resupply mission.

(a) Establish a DA Form 1296 for each item for which you expect demands. Use the component listing of the authorized MES and CTA 8-100 as a guide. Detailed instructions for using stock accounting records are in DA PAM 710-2-2. Use

these forms, with support records, to informally manage supply activities upon mobilization. Advance preparation will enhance your operational readiness upon mobilization or deployment.

(b) Establish a DA Form 4998-R for each medical item with a shelf-life and for which you expect demands. This form will help you manage required QC actions.

TABLE 10-1. STEPS TO PREPARING DA FORM 4998-R

STEP	DESCRIPTION
1	NO: Number sequential, for example 1, 2, 3 (Pen)
2	LOCATION: Where is the item stored for example, box, ISO, cabinet, or drawer. (Pencil)
3	MANUFACTURER: Name of manufacturer (Pen)
4	CONTRACT NO: Contract number/purchase order/document number, if available (Pen)
5	LOT/BATCH NUMBER: Lot number/batch number from item (Pen)
6	EXP/MFR DATE: Manufacturer date and/or expiration date (month-year) (Pen)
7	QTY ON HAND: Amount you have on hand as of the most recent inventory for that manufacturer, lot number, and expiration date (Pencil)
8	DATE LAST INSPECTION: Date of last inventory (Pencil)
9	DATE OF NEXT INSPECTION: A minimum of 6 months (12 months RC) from the date of last inspection (Pencil)
10	NSN: National Stock Number, Universal Product Code, or Management Control Number of the item (Pen)
11	DESCRIPTION: Name of the item plus characteristics, for example 2 ml, sharp point, tapered, and 6/pg (Pen)
12	UNIT OF ISSUE: Unit the item is ordered in, i.e., EA (each), PG (package), or BX (Pen)
13	NOTES: Special shelf life notes, for example Note Q – control substance and Note P – needs refrigeration. See UDR/FEDLOG. (Pen)
14	INSPECTION FREQUENCY: How often does the item need to be look at? Based on *AR 702-18*, UDR, or DOD Medical Category, Volumes I & II (Pencil)
15	SHELF LIFE/ESTIMATED SHELF LIFE: Based on expiration date *AR 702-18* (Pencil)

b. Medical Assemblage Updates

(1) Non-hospital commander responsibilities.

(a) Maintain your assemblages in the UAL configuration based on the set NSN you were fielded.

(b) There is no requirement to purchase OMA-funded components for cyclic MES changes. Units will move forward to the new UAL configuration, and corresponding NSN, when fielded by USAMMA.

(c) (c) Units are not precluded from selectively upgrading OMA-funded set components to the most current configuration if unit funding is available. If commanders selectively upgrade set components, they will inform USAMMA of any changes.

USAMMA
ATTN: MCMR-MMO-S
1423 Sultan Dr., Suite 100
Fort Detrick MD 21702-5001
DSN 343-7161 or COMM 301-619-7161

Or

Customer Relations Management (CRM) Office
DSN 343-4301/4316 or Commercial 301-619-4301/4316
E-Mail: USAMMACRM@amedd.army.mil

(d) Execute an NSN change IAW DA PAM 710-2-1 to property-accountable records for sets the unit fully upgraded to the new UAL configuration.

c. Commanders of Deployable Medical Systems (DEPMEDS) equipped units will inventory the medical assemblage against the UAL (Assemblage Control Number (CAN)/Build Directive Number (BDN) – specific) that is provided when fielded to the unit until authorized for update by the USAMMA.

10-2. PROCEDURES FOR LOAN OF MTOE MATERIEL (EQUIPMENT) IN SUPPORT OF PROJECTS AT HEALTHCARE ACTIVITIES (HCAS)

a. For guidelines for temporary loan of MTOE Assemblies/Equipment to HCAs/TDA facilities see AR 700-131 para 2-2 and applicable local command guidelines.

b. Procedures for Loan of medical equipment to units from USAMMA

(1) Policy. Army Regulation (AR) 700-131, Loan, Lease, and Donation of Army Materiel, sets forth the policies and procedures for loan of Army materiel to both Department of Defense (DOD) and non-DOD activities of the Federal Government and loan, lease or donation of materiel to non-Federal civilian activities and agencies. It outlines when loans, leases, or donations of Army materiel can be made.

(2) Responsibility. The Surgeon General is responsible for loans of medical materiel IAW Table 2-1, AR 700-131. The Commander, USAMMA, is responsible for approving requests for loan or lease of principal medical end items IAW, AR 700-131 (Table 2-1) and AR 40-61, Medical Logistics Policies. The Commander, USAMMA, may approve principal medical end items in wholesale level inventories for loan unless the loan would at any time interfere with issue against the Army Resourcing Priority Listing. In such cases, requests will be forwarded for approval to

Office of the Surgeon General (OTSG)
ATTN: DASG-LOZ,
5109 Leesburg Pike, Falls Church, VA 22041-3258.

The Commander, USAMMA, may approve minor medical materiel in wholesale inventories for loan.

(3) Types of equipment available for loan. Medical materiel available for loan include, but are not limited to, Computer Tomography (CT) Scanners, Deployable Medical Systems (DEPMEDS), ISO Shelters, Non-Medical Associated Support Items of Equipment (ASIOE), Environmental Control Units (ECUs), and Heaters.

(4) Duration of loan agreements. Loan agreements with USAMMA are typically one year in length; however, agreements for periods of less than one year, but greater than six months are also available.

(5) Submitting requests for loan of equipment. Requests for loans of equipment will be approved or disapproved based on the purpose, duration of the loan, and consideration of the following factors that can take precedence over any loan or lease:

(a) Military requirements and priorities.
(b) Stocks and programmed Army requirements.
(c) Type classification with pending changes.
(d) Minimum diversion of Army stocks.
(e) Adequacy of the borrower's resources.
(f) Availability of alternative sources such as commercial leases.
(g) Eligibility of the recipient.

Units must complete DA Form 4881-6-R, using DA Form 4881-2-R if more than one item is required and forward with a memorandum of justification, signed by a Colonel O-6) or higher through command channels to Headquarters, U.S. Army Medical Command (USAMEDCOM) for approval. If a MFT is required to field the materiel, the requesting unit is responsible for travel and per diem expenses (military and civilian) for the initial set up and their return upon termination of the loan agreement. In addition, the requesting unit is responsible for packing, crating, handling, and shipping of materiel from supply source to destination and return. This includes port handling and off loading, if applicable. The requesting unit must pay for the refurbishment cost to bring the equipment back to condition code "B".

(6) Points of contact.

(a) The mailing address and point of contact at USAMEDCOM is:
Department Of The Army
Headquarters, US Army Medical Command
ATTN: MCLO
2050 Worth Road
Fort Sam Houston TX 78234-6000
POC DSN: 471-7066

(b) The mailing address and point of contact at USAMMA is:
US Army Medical Materiel Agency
ATTN: MCMR-MMO-S
1423 Sultan Drive, Suite 100
Fort Detrick MD 21702-5001
POC DSN: 343-4448

CHAPTER 11. OPTICAL FABRICATION

11-1. OPTICAL FABRICATION AUTHORITY AND OVERVIEW

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 responsible for management of the OFE.

a. The OFE was created to manage the DoD's optical fabrication assets, and meet optical fabrication requirements of all services. The OFE charter includes all DHP supported laboratories.

b. The Navy Surgeon General in turn designated the Commander of Naval Ophthalmic Support and Training Activity (NOSTRA) to provide day-to-day oversight of the enterprise. To manage and maintain DoD optical fabrication, an Optical Fabrication Advisory Board (OFAB) was established.

c. The OFAB acts as the primary advisor to the OFE. The OFAB operates with a combined staff consisting of members from the Army, Air Force, Navy and one representative from DoD's Secretariat. The chairman of the OFAB is either the U.S. Army Medical Command's Chief of Staff for Logistics or Assistant Chief

d. The Army Optical Fabrication Laboratories (OFL) and Units fabricate prescription eyewear that includes spectacles, protective mask inserts, Military Combat Eye Protection inserts and similar ocular devices for eligible personnel under *AR 40-63/NAVUSAMEDCOMINST 6810.1/AFR 167-3*.

e. This chapter identifies requirements used for the management of Army optical fabrication laboratories located at both Modified TDA (MTDA) and MTOE activities/Units.

11-2. OPTICAL FABRICATION ENTERPRISE REPORT

The Consolidated Optical Fabrication Enterprise Report provides data on optical devices fabricated by optical laboratories. It is used in:

- Planning mobilizations
- Preparing budgets
- Assigning opticians (91H/68Hs)
- Analyzing inter-service support
- Utilization of manpower
- Analyzing cost/production efficiency

11-3. COMPLETING OPTICAL FABRICATION ENTERPRISE REPORT WORKSHEETS

a. General information and instructions for completing and submitting the OFE Report worksheets are available from the USAMEDCOM, ACSLOG, Logistics Plans and Readiness Division, or NOSTRA.

b. The report is located on **https://www.medlogspt.army.mil** and is a fully integrated, online, data-reporting tool. The OFE Optical Fabrication Web-tool consists of four reports with content-sensitive instructions integrated within each metric. The reports metrics are titled: Production, Financial, Staff, and Performance. These on-line reports have been developed to capture data and additional information required by OFE and USAMEDCOM.

c. To access from the web, use **https://www.medlogspt.army.mil** and personnel must register on the site then contact USAMEDCOM ACSLOG, Logistics Plans and Readiness Division for access to the OFE optical Fabrication web-tool. Once verification and user-level is determined, access will be granted to the OFE Web-tool. Clicking on the OFE button (top menu) will bring you to the OFE page. Afterwards, click on the left display menu bar click on Programs. Thereafter, click on the top display areas for the various reports metrics titled, Production, Financial, Staff, and Performance. Once input is made, click on submit. The information will be stored on an archived retrievable database.

d. All MTDA optical laboratories and 16th Med Log Bn will:

(1) Submit a monthly, consolidated optical fabrication enterprise report located on **https://www.medlogspt.army.mil**.

(2) The submitted report will be staffed/reviewed through command channels to the appropriate RMC or Command Surgeons. The report will then be reviewed by USAMEDCOM NLT the fifth of each month.

(3) If additional information or guidance is required on optical issues, please contact:

USAMEDCOM
ATTN: MCLO-P
2050 Worth Road
Fort Sam Houston TX 78234-6008

CHAPTER 12. PATIENT MOVEMENT ITEMS (PMI)

12-1. PATIENT MOVEMENT ITEMS (PMI) EQUIPMENT

a. **DEFINITION**: PMI is the specific medical equipment and durable supplies that must be available to support the patient. Examples of PMI include ventilators, litters, patient monitors, and pulse oximeters. The mission of the PMI system is to support patients' in-transit, to exchange in-kind PMI without degrading medical capabilities, and to provide prompt recycling of PMI. It is the originating MTF's responsibility to provide the PMI required in support of the patient during movement. PMI accompanies a patient throughout the chain of movement, from the originating MTF to the destination MTF, whether it is an intra-theater or inter-theater transfer. Planners must ensure that PMI is available at the correct location and ready for use.

b. **AIR-WORTHINESS RELEASE (AWR)**: AWR has been approved for the primary PMI used during evacuation of patients on military aircraft. Requests to add items to the AWR list should be sent to the Commandant, AMEDDC&S, ATTN: HSMC-FC, Fort Sam Houston, TX 78234 IAW *AR 40-61, section 3-22, paragraph 6d*.

c. **PMI Tracking System (PLEXUS-D)**: Plexus-D is a software system used to keep track of moveable medical assets such as PMI. It was developed by the Program Management Office DMLSS. Plexus-D keeps track of equipment by collecting scans and sharing the information with other Plexus-D users; thereby making the data available to those managing re-supply. The software is installed on a laptop computer and uses a barcode scanner to load the label readings into a network providing the PMI type, ownership, and location. There is a special printer available for those units that need to create bar code labels to apply to their equipment. Not all units or MTFs will have a PLEXUS-D system. Those who do not have PLEXUS-D will need to track the PMI manually, as described in paragraph 12.2.

12-2. **PROCEDURES FOR PROCESSING PMI**.

a. **THEATER UNITS**.
Combatant Commander. Intra-theater movement of PMI is the responsibility of the theater commander. Theater policy for PMI will be established and distributed to the applicable units, as required.

b. **CONUS MTFs**

(1) As patients are evacuated back to MTFs closer to home station, their care is the first priority. Once they are stabilized and transitioned to a ward at the MTF, the PMI is no longer needed for those patients. The PMI will be used again, therefore, must be returned to the AF transportation channel.

(2) The three divisions within the MTF that coordinate the patient's movement with PMI are; Patient Administration Division (PAD), the Emergency Division (ED) and the Logistics Division (LOG). PMI is affected by the following process as responsibilities distributed to the above divisions;

(a) Chief of PAD will ensure that the timely notification of all inbound and outbound patients is provided to ED and LOG. PAD will also provide them a copy of the Patient Movement Request (PMR).

(b) Chief of ED will manage the patients and the PMI that accompanies them. Once the PMI is no longer needed for the patients, PAD will notify LOG that the PMI is available for pick up.

(c) Chief of LOG will ensure that PMI is picked up, as required, from ED and delivered to the nearest PMI Center location. Managing this PMI includes tracking each item by using manual transfer documents or scanning the items using PLEXUS-D or both.

(3) The TMO can assist in determining which AFB is closest. TAC (F144) is authorized to fund military air. TAC (A1LD) is authorized to fund routine ground transportation. PMI Center Shipping Locations are;

(a) 89th Medical Group/SGSL PMI Center
PMI Center (DSN 857-7951)
ATTN: SSgt Matthew Bacanskas
3244 Tennessee Ave
Andrews Air Force Base, MD 20762, MD 20762-5184

(b) 375th Medical Group/SGSL PMI Center
PMI Center (DSN 576-1173)
ATTN: Ms. Iva Merritt
120 South Adams Street, Bldg 4020
Scott AFB, IL 62225-5300

(c) 60th Medical Support Squadron/SGSL PMI Center (DSN 799-3755)
PMI Center (DSN 799-3755)
ATTN: SSgt Ramirez
101 Bodin Circle, Bldg 795
Travis AFB, CA 94535-1800

(d) 435th Medical Group/SGSL PMI Center
PMI Center Ramstein (DSN 314-479-2437)
ATTN: TSgt Michael Scott
Unit 3215
APO AE 09094-3215

(e) Air Force Medical Support Agency (AFMS/SGSLW)
Mark For: Patient Movement Items (PMI)
ATTN: Mr. Steve Messer (DSN 945-6061)
601 Davy Crockett Road, Bldg 1534
Kelly USA, TX 78226-1885

(f) 374th Medical Support Squadron/SGSL
Yokota PMI Center (DSN 315-225-4932)
ATTN SSgt Sergio Chinchilla
Building 4145, Unit 5225
APO AP 96328-5225

12-3. PRINTING PROTOCOL.

Protocol for printing labels has a specified process. The specific information outlined below describes the required alphanumeric positions for the PLEXUS-D label. The label can be printed by the owning unit, if they have a barcode printer, or can be ordered from the contractor, at no charge to the unit. You don't need to have a barcode printer or even a PLEXUS-D system to label your PMI. The primary reason to put labels on MTOE PMI is in case

float PMI is not available and the unit has to use property book PMI to send with an evacuated patient. The contractor will mail the labels to the unit for application. However, prior to printing or requesting labels, the unit shall contact this office for number assignment in blocks 5-7. The identification code on the label contains 14 positions, as listed below. Examples are listed in para 12-5.

12-4. REFERENCES.

For additional information refer to the below listed documents or contact ACSLOG representatives at 210 221 6044/6435.

a. Army Regulation 40-61, Chapter 5, Medical Logistics Policies and Procedures, dated 25 January 1995.
b. Air Force Instruction (AFI) 41-209, Chapter 8, Patient Movement Items (PMI) dated 10 March 2004
c. Joint Pub 4-02, Doctrine for Health Service Support in Joint Operations dated 30 July 2001.
d. Joint Pub 4-02.1, Joint Tactics, Techniques, and Procedures for Health Service Logistics Support in Joint Operations dated 6 October 1997.
e. Joint Pub 4-02.2, Joint Tactics, Techniques and Procedures for Patient Movement in Joint Operations dated 30 December 1996.
f. FM 4-02.1, Combat Health Logistics, Appendix F-Patient Movement Items dated 28 September 2001.

12-5. PRINTING PROTOCOL SAMPLES

Bar Coding Methodology and Codes

(20 Dec 05, check for latest version at: https://private.amc.af.mil/sg/sgsl/sgslpmi)
PMI will be identified and tracked by a bar code system. The item identification code has 14 positions to identify the type of item and its unique number.

- Positions 1-3 are alpha characters and identify the type of equipment item.
- Position 4 is a character to identify a specific manufacturer/model for that type.
- Positions 5-7 will be a numerical indicator of the PMI Center that issued the bar code label and entered the item into the database.
- Positions 8-14 will be the last seven characters (number or letter) of the item's serial number.

Some older bar codes may exist using the five digit index number (ECN). Those will continue to work and will eventually be changed.

a. Positions 1-3 are the item codes as listed below.

Equipment Item Codes

DEF	Defibrillator	STR	Stryker Frame
IVC	IV Controller	SXN	Suction Apparatus
MON	Vital Signs Monitor	OAN	Oxygen Analyzer
POX	Pulse Oximeter	VEN	Ventilator

b. Position 4 for each equipment item will have an alpha character to specify the manufacturer and model (see para 12-6). This means that each type of equipment (i.e. DEF or VEN) can have up to 26 combinations of manufacturer and models in the PMI program. For example, an oxygen analyzer manufactured by MSA such as Miniox 3000 would be

“OANA”, while the same manufacturer’s older model, the Miniox III that is still in use, would be an “OANB.” The fourth position would be a separate table of manufacturers and models for each equipment type. The codes for an OAN would not be the same for an MON or VEN. Air Mobility Command/Surgeon General (AMC/SG) would establish and maintain the list and ensure coordination with the PMI Centers.

c. Positions 5-7: PMI Centers and owning units have a three digit number (positions 5-7) assigned. This will allow for all current and future PMI Centers and owning units (that will be making bar codes) to be identified. To start, numbers will be assigned as PMI Centers come on line; for example, 001-Scott, 002-Andrews, 003-Travis, 004-Ramstein, 005-Yokota. Users that are part of the PMI tracking system have their assets bar coded with unique identifiers that differentiate between War Reserve Materiel (WRM) and unit ownership. Army units shall contact the MEDCOM ACSLOG office POC to obtain an assigned code for positions 5-7.

d. Positions 8-14 are the last 7 characters (numbers or letters) of the item’s serial number (self explanatory).

e. Of the 15 items formally in the PMI program, seven will be tracked as “groups” and will be counted as lot quantities versus by serial number. These items (litters, blankets, etc.) will use a 12 position combination of alpha characters and spaces.

NSN	ITEM	UNIT OF ISSUE	Groups	SOS
1670-00-725-1437	Tie Down, Cargo, Aircraft	Each	Yes	SMS
1670-00-820-4896	Pallet, Cargo, Aircraft, 108x88	Each	No	FLZ
6530-01-431-5146	Ventilator, Portable (Impact 754)	Each	No	S9M
6515-01-452-0625	IV Controller (IVAC MS III)	Each	No	S9M
6615-01-435-0050	Suction Machine (CISU)	Each	No	S9M
6515-01-516-1519	Defibrillator Zoll CCT	Each	No	S9M
6515-01-440-9394	Oxygen Analyzer (Miniox 3000)	Each	No	S9M
6515-01-432-2707	Vital Signs Monitor (Propaq 206EL)	Each	No	S9M
6515-01-446-6766	Pulse Oximeter (BCI 3303)	Each	No	S9M
6530-00-783-7905	Litter, NATO, Standard	Each	Yes	S9M
6530-00-137-3016	Litter, mattress pads	Each	Yes	S9M
6530-00-784-4205	Litter Straps	Each	Yes	S9M
7210-00-139-5779	Blanket, Cotton (or Wool)	Each	Yes	S9M
6530-00-792-6000	IV Poles	Each	Yes	S9M
6530-00-788-4010	Restraint Set	Set	Yes	S9M

Changes or additions will be coordinated through ACSLOG and allow for variations or items unique to a particular Service or PMI Center.

LITTER_NATO	LITTER_OTHER	LITTERSTRAPS
LITTER_PADS	I_V_POLES	RESTRAINTSET
BLANKETCOTTN	BLANKET_WOOL	SPINAL_BOARD

The opportunity exists for other items to be coded, for example:

ARMY_LITTER	YOKOTAUNIQUE	NAVYSCOOPLIT

f. As the inventory (bar code items for AE, not necessarily PMI) grows, there will be extra equipment types to be established. These represent the supplementary items used in AE that can be tracked. AMC/SG will keep this list current:

BSS	battery support system	CAR	car seat
CMP	air compressor	CMT	computers
ECS	electrical cable assembly system	FRQ	frequency converter
INC	infant incubator	LOX	converter, liquid oxygen, portable
OWL	overweight litter	PAL	pediatric advanced life support
PCA	patient controlled analgesic pump	PRT	printers

12-6. SAMPLE EQUIPMENT ITEM- AND MANUFACTURER/MODEL NUMBER CODES

Below are all of the current codes in effect for digit 4, manufacturer's code. They are listed in alphabetical order by code.

Battery Support System
BSS_
Manufacturer/Model Number Code

Y	Zoll Single Unit Charger	6515-01-518-6016
Z	Zoll 4 Bay Charger/Conditioner	6515-01-509-2920UM

Car Seat, Child
CAR_
Manufacturer/Model Number Code

A Cosco or Fisher-Price

Air Compressor
CMP_
Manufacturer/Model Number Code

A Timeter/Allied Health, AriDyne 3500

Computer, PMI Center or WRM
CMT_
Manufacturer/Model Number Code

A	Laptop Computer (LapNote)	
B	Laptop Computer, Dell, Latitude, P100mHz	**BEING DELETED**
C	Laptop Computer, Micron Millenia	**BEING DELETED**
D	Laptop Computer, Micron Transport XPE	**BEING DELETED**
E	Laptop Computer, Toshiba	
F	Laptop Computer, Compaq Presario, Model 1620	
J	Handheld Computer, Hewlett-Packard Jornada 680/720	**BEING DELETED**

Critical Care Platform System (also called SMEED**)**
CSSP
Manufacturer/Model Number Code

CSSP	SMEED – Critical Care Platform	6530-01-500-1989

Defibrillator/Monitor
DEF_
Manufacturer/Model Number Code
(W NSN is 6515-01-389-6740)

A	Physio-Control Lifepak 10-59 without case	6515-01-439-6694
	Lifepak 10-59 AAC-X	6515-01-429-9872
	Lifepak 10-59	6515-01-453-4003
B	Physio-Control Lifepak 10-43 AAC-W	6515-01-354-3150
C	Physio-Control Lifepak 10-47	
E	Physio-Control Lifepak 10-62	6515-01-464-2820 or 6515-01-441-9717
P	Physio-Control LifePak 10-59PMI (dual certified – fixed and rotary)	
T	Training Defibrillator - Not For Use On Patients (model recorded in serial # field)	
Z	Zoll CCT Defibrillator/Monitor, Biphasic	6515-01-516-1519

(ECAS) Cable Assembly Set, Electrical
ECS_
Manufacturer/Model Number Code

A	Technical Services Laboratory (X8564030)	6150-01-222-1725

Expeditionary Deployable Oxygen Concentration System (EDOCS**)**
EDOX
Manufacturer/Model Number Code

X	EDOCS	to be assigned

Frequency Converter
FRQ_
Manufacturer/Model Number Code

B	Avionics Inc, 4B3500-1AA-MV-735	6130-01-433-3718
C	Avionics INC, Modified for KC-135 use	6130-NCM-040691

Incubator
INC_
Manufacturer/Model Number Code

A	International Biomed, ALSS, Model 185	6530-01-131-1396
B	International Biomed, ALSS, Model 185A	
T	Training Incubator - Not For Use With Patients	

In-Flight Kit
IFK_
Manufacturer/Model Number Code

A	Main Drug Supply	6515-01-473-8678
C	ACLS Drug Supply	6515-01-477-6078
D	Airway Support Bag # 1	6515-01-477-6128
E	Airway Support Bag # 2	6515-01-477-6128
F	IV Supply Bag # 1	6515-01-477-6124
G	IV Supply Bag # 2	6515-01-477-6124
H	Bulk Supply Bag # 1	6515-01-477-6146
I	Bulk Supply Bag # 2	6515-01-477-6146

J	Patient Comfort Roll Pack # 1	6515-01-477-6134
K	Patient Comfort Roll Pack # 2	6515-01-477-6134
L	Dressing Roll Pack # 1	6515-01-477-6141
M	Dressing Roll Pack # 2	6515-01-477-6141
N	Ventilator Support Bag	6515-01-477-6165

IV Controller
IVC_
Manufacturer/Model Number Code
(W NSN is 6515-01-381-4456)

A	IVAC/Alaris MedSystem III (Model 2863/2863B)	6515-01-452-0625
C	IMED Products, Model 960A	6515-01-328-1244
D	IVAC/Alaris MedSystem III (Model 2865/2865B)	6515-01-486-4310
T	Training IV Controller - Not For Use With Patients (record model in serial # field)	

Flight Support Kits
KIT_ TO BE DELETED
Manufacturer/Model Number Code

A Orange Tackle Box
B C-21 Flight Support Kit
C Westover ARB Flight Kit (439th AES)
D Contingency Kit (459 AES, Andrews)
E Ambulatory Oxygen Kit (459 AES, Andrews)
F Patient Linens Kit (459 AES, Andrews)
O Mini-Mission Kit (459 AES, Andrews)
P Medical Kit (459 AES, Andrews)

Laboratory Analyzer
LAB_ TO BE DELETED
Manufacturer/Model Number Code

A	i-STAT, Portable Clinical Analyzer	6630-01-411-2405

Liquid Oxygen Converter, Portable
LOX_ TO BE DELETED
Manufacturer/Model Number Code

A	Essex Cryogenics CRU-87/U (PTLOX) **BEING DELETED**	3655-01-222-9494
N	New Generation PTLOX, Essex Cryogenics	**TO BE DELETED**
T	Training PTLOX - Not For Use With Patient Care	**BEING DELETED**

Mobile Oxygen Storage Tank (for AE use**)**
MOST
Manufacturer/Model Number Code

T	MOST-2B	6530-01-511-2702

Vital Signs Monitor
MON_
Manufacturer/Model Number Code
(W NSN is 6515-01-418-2346)

A	Protocol Propaq 206EL - Encore	6515-01-432-2707
B	Protocol Propaq 106EL	6515-01-423-5872
C	Protocol Propaq 206EL - Encore with CO2 capnography	6515-01-432-2711
D	Protocol Propaq 206EL - Encore with printer	
E	Protocol Propaq 206EL without expansion module	
T	Training Vital Signs Monitor	

Narcotics Drug Kit
NAR_
Manufacturer/Model Number Code

A (not used)

Oxygen Analyzer
OAN_
Manufacturer/Model Number Code

A	Mine Safety Appliances (MSA) MiniOX 3000	6515-01-440-9394
B	Mine Safety Appliances (MSA) MiniOx III	6515-01-314-6721
T	Training Oxygen Analyzer	

Overweight Litter
OWL_
Manufacturer/Model Number Code

A Scott AFB, 375th AES
B Ramstein AB, 86th AES
C March ARB, 452nd AES

Oxygen Blender
OXB_
Manufacturer/Model Number Code

A Bird Air-Oxygen Blender (P/N 3500A)
B Bird Air-Oxygen Blender (P/N 3800A)

Patient Controlled Analgesic Pump
PCA_
Manufacturer/Model Number Code

A TBD

Pediatric Advanced Life Support Bag
PAL_
Manufacturer/Model Number Code

A TBD
S Broselow/Hinkle, PALS

Pulse Oximeter
POX_
Manufacturer/Model Number Code
(W NSN is 6515-01-248-5984)

A	Nonin 8600 or 8600-USAF	6515-01-386-2978 or 6515-01-449-9707
B	BCI International 3303	6515-01-453-2174
C	BCI International 3304	6515-01-454-3269 or 6515-01-446-6766
T	Training Pulse Oximeter	

Printers
PRT_
Manufacturer/Model Number Code

A Okidata, OL 810e
B Datamax Thermal Printer, Allegro 2
E Hewlett-Packard LaserJet 1012

Publications Kit
PUB_

A Publications Kit

Respiratory Equipment
RES_
Manufacturer/Model Number Code

A	Bird Corporation, Model 5900	6530-00-149-1475
B	DELETED (Wright Respirometer)	
C	Bird Corporation, Mark 7A	6530-01-119-7679
D	DELETED (Wright Respirometer)	

Stryker Frame
STR_
Manufacturer/Model Number Code

K	Stryker Spinal Turning Frame Model 965MO	6530-01-498-1889

Suction Apparatus
SXN_
Manufacturer/Model Number Code
(W NSN is 6515-01-284-8704 or 6515-01-460-9174)

A	Continuous/Intermittent, Impact 326M	6515-01-435-0050
D	Impact 325M	6515-01-435-5350
T	Training Suction Apparatus	

Ventilator
VEN_
Manufacturer/Model Number Code
(W NSN is 6530-01-431-5146)

A	Impact 754M (Eagle)	6530-01-455-1653 or 6515-01-464-0267
C	Impact 750 (Univent)	6530-01-292-1049 or 6530-01-327-0686
D	Bio-Med Devices MVP-10 Neonatal/Pediatric	
T	Training Ventilator (model recorded in serial number field)	

APPENDIX A.
SIMILAR ASSET/ESTIMATED FMV WORKSHEET

INSTRUCTIONS

The Similar Asset/Estimated FMV Worksheet is used to document the estimated acquisition cost and acquisition date for capital assets lacking proper source documentation. This worksheet, when properly completed, serves as a substitute for original acquisition documentation and should be used when all attempts to locate actual documentation have been exhausted.

Section A (Capital Asset General Information):
This information is required to accurately identify the asset. This information should be obtained through physical examination, observation, and inquiries with using personnel.

Section B (Similar Asset Comparison):
This section allows the activity to estimate the acquisition cost and useful life of the capital asset. It is important that every effort is made to ensure that the similar asset is a close match.

Once a similar asset is found, source documentation, if available, should be obtained to substantiate acquisition cost and date.

If a similar asset cannot be located, Step 2 of Section C should be completed.

Section C (Determine Acquisition Cost):
If copies of the source documentation of the similar asset are available, record the acquisition cost in Step 1. Include Other Costs (installation, site prep, training, etc.) if known or listed on the similar asset source documentation.

If a similar asset cannot be located, estimate the fair market value of the asset by using other sources of pricing information (e.g., FEDLOG, GSA acquisition schedules, vendor quotes). Obtaining this information mat require consultation with other activity personnel (e.g. Resource Management, Contracting, Materiel Management).

Document the source of the estimated fair market value information and record the value amount in Step 3 of this section.

Section D (Determine Acquisition Date):
If source documentation for the similar asset was available, record the acquisition date on the lines listed in Step 2.

If source documentation could not be obtained for the similar asset, the acquisition date will be determined by judgmentally selecting the most appropriate date from Step 2.

Section E (Documentation Requirements):
File this worksheet and all supporting documentation in accordance with SB 8-75-11, Chapter 5. The file is maintained until the asset is disposed. The file must accompany the equipment upon transfer or turn-in.

Certification:
The PBO will sign and date this form to certify the accuracy of this information.

SIMILAR ASSET/ESTIMATED FMV WORKSHEET

The Similar Asset/Estimated FMV Worksheet is used to document the estimated acquisition cost and acquisition date for capital assets lacking proper source documentation. This worksheet, when properly completed, serves as a substitute for original acquisition documentation and should be used when all attempts to locate actual documentation have been exhausted.

A. Capital Asset General Information

UIC/Activity Name: _____

Location: _____

Hand Receipt/Customer: _____

Document Number: _____

Nomenclature: _____

Stock Number/Item ID: _____

Serial Number: _____

Manufacturer: _____

MMCN/ECN: _____

Method of Acquisition:

Local Purchase ____ Requisition ____ Transfer _____ Donated _____ Found _____

B. Similar Asset Comparison:

Location of similar asset: _____

Activity owning similar asset: _____

Similar asset comparison:

	Capital Asset	Similar Asset
Nomenclature:	_____	_____
Stock Number/Item ID:	_____	_____
Serial Number:	_____	_____
Manufacturer:	_____	_____
Model:	_____	_____
Model Year:	_____	_____

Description of Function: _____ _____

_____ _____

Acquisition Cost: _____ _____

Receipt Date: _____

C. Determine Acquisition Cost:

1. If the assets are similar, obtain copies of the acquisition documentation for the similar asset and attach to this form. Record the following information below:

Acquisition Cost: _____

Other Costs: _____

Total: _____

2. If a similar asset cannot be located, estimate the fair market value for the capital asset as of the date acquired. Use one or more of the following sources in determining a fair market value:

Source	Company	Contract #	Acq. Cost	Date
FEDLOG Price	FEDLOG	N/A	_____	_____
GSA Schedule Price	_____	_____	_____	_____
Vendor Quote:	_____	_____	_____	_____

3. Record the following information below:

Estimated FMV: _____

Other Costs: _____

Total: _____

D. Determine Acquisition Date

1. If similar assets are found, obtain copies of the acquisition documents for the similar asset. Record the information below.

2. If source documentation is not available, obtain the acquisition date in the following order:

	Document #	Date
Source Document	_____	_____
Transfer Date on DD Form 1149/DA Form 3161 for transfers	_____	_____
Shipping Date	_____	_____

Inspection Date _____ _____

Date Found _____ _____

Determined Acquisition Date _____ _____

E. Documentation Requirements

File this document as the original source documentation in accordance with SB 8-75-11, Chapter 5. The following documentation should be included:

Similar Asset

Procurement Documentation | Invoice | Receiving Report

FMV Research

Printout of FEDLOG Entry | Copy of relevant GSA Schedule | Copy of vendor quote

Acquisition date

Transfer Document | Shipping Invoice | Inspection work order | Copy of physical inventory

CERTIFICATION:

I certify that the capital asset information recorded above is accurate to the best of my knowledge.

_____	_____	_____	_____
Name	Activity	Signature	Date

APPENDIX B. INSTRUCTIONS FOR RECORDING DIN-PACS MEDICAL SYSTEMS ON THE ACTIVITY PROPERTY BOOK FOR SITES USING DMLSS

DMLSS users will adhere to the following procedures to establish DIN-PACS as a system on the property book.

1. Establish a due in for the item in accordance with DMLSS procedures.

2. Receive the system in accordance with DMLSS and local procedures. . Establish the Equipment Type as “System” (System ECN). This is an actual item and should be the major item of the system. For DIN-PACS, this item will be one of the main servers as identified by the Army PACS Program Management Office (APPMO), phone301-619-3322. Ensure that the total system acquisition cost, including all PACS components, is reflected on this system ECN.

3. Gain the other components of the system using the DMLSS ETM Gain module with the reason “Component Gain” and Equipment Type of “Component” with an acquisition cost of $O.00. Ensure the components are associated with the system ECN. The device nomenclatures for the components are listed in Table B-1.

Table B-1. Device Nomenclatures

Nomenclatures	Guideline (if any)
Diagnostic Work Stations (4 monitor)	Account for using the CPU serial number
Diagnostic Work Stations (2 monitor)	Account for using the CPU serial number
Review Workstations (2 monitor)	Account for using the CPU serial number
Review Workstations (1 monitor)	Account for using the CPU serial number
Quality Control Workstations (2 monitor)	Account for using the CPU serial number
Quality Control Workstations (1 monitor)	Account for using the CPU serial number
Color QC Lite Workstations	None
RIS Terminals	None
Network Printer	None
Web Server	None
Teleradiology Gateway	None
NT Domain Controller	None
Archive	None
H70 (AIX) Server	None
H50 Server	None
RIS NT Server	None
RIS NT Server	None
C68 Archive	None
C66 Archive	None
Telemaintenance Server	None
Color Review Workstations (2 monitor	Account for using the CPU serial number
DICOM IT (at sites that capture ultrasound images)	

4. Finally, ensure components requiring medical maintenance services have a Maintenance Requirements Indicator of “YES” in the catalog record and appropriate services scheduled.

5. If the DIN-PACS system is already on the property book, then the following is required:

a. Confirm the system ECN is the major item of the system. For DIN-PACS, this item will be one of the main servers as identified by the Army PACS Program Management Office (APPMO), if necessary, change the Equipment Type of the identified major end item to “System.” Do this by opening the appropriate equipment record and selecting “System” in the Equipment Type drop down window found on the Main tab.

b. Validate the total system acquisition cost, including all PACS components is reflected on the system ECN. Update the system acquisition cost by opening the equipment record for the system ECN and click on the Acq. Cost icon on the vertical tool bar. In the Acquisition Cost Change window, adjust the values as necessary. Click OK. Click Save in the Equipment Detail window.

c. Ensure all component equipment records have an Equipment Type of “Component,” the appropriate System ECN and an acquisition cost of $0.00.

d. Identify components requiring medical maintenance services. Update the catalog record to signify which components require maintenance services.

APPENDIX C. DRAFT COPY OF

TB MED 750-1,

OPERATING GUIDE FOR TOE MEDICAL EQUIPMENT MAINTENANCE

Technical Bulletin

NO. MED 750-2

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 30 SEPTEMBER 2006

Operating Guide for TOE Medical Equipment Maintenance

You can help improve this bulletin. If you find any mistakes or if you know a way to improve procedures, please let us know. Mail a memorandum to: U.S. Army Medical Materiel Agency, ATTN: MCMR-MMO-SM, 1423 Sultan Drive, Suite 100, Fort Detrick, MD 21702-5001. A reply will be furnished directly to you.

Contents

Chapter 1
Introduction 1
Section II. Responsibilities *1*
Section III . Maintenance Publications and Directives *3*
Section IV . Maintenance Management *3*
Chapter 2
Maintenance and Repair Procedures 5
Section I. Maintenance Procedures *5*
Section II. Workload Control *6*
Section III. Forms and Records Management *7*
Chapter 3
Man-hour Accountability 11
Chapter 4
Repair Expenditures 14
Section I. Repair Eligibility and Evacuation *14*
Section II. Maintenance Expenditure Limits *15*
Section III. Waivers *17*
Section IV. Life Expectancy *17*
Chapter 5
Scheduled Services 20
Section I. General *20*
Section II. Preventive Maintenance Checks and Services *20*
Section III. Calibration/Verification/Certification *21*
Section IV. Electrical Safety *21*
Chapter 6
Management and Control of Diagnostic X-Ray 22
Chapter 7
Technical Inspection For Issue 23
Section I. General *23*
Section II. Technical Inspections *23*
Chapter 8
Technical Inspection for Turn-In or Transfer 25
Section I. General *25*
Section II. Technical Inspections *25*
Section III. Serviceability Inspection Checklist *25*
Section IV. Condition Coding Medical Equipment *27*

Chapter 9
Repair Parts, Tool Control, and Test, Measurement, and Diagnostic Equipment (TMDE) 28
Section I. Repair Parts Management *28*
Section II. Tool Control *30*
Section III. Test, Measurement, and Diagnostic Equipment *30*

Appendixes

Appendix A
References 32
Appendix B
Medical Equipment Reporting Procedures 35
Appendix C
Maintenance Standing Operating Procedures 40
Appendix D
Desk Reference Manuals 41
Appendix E
Standard Army Management Information System 42
Appendix F
Safe Medical Devices Act 43
Appendix G
Battery Maintenance Program 44
Appendix H
Equipment Requiring Calibration/Verification/Certification 45
Appendix I
Warranty/Contract Program 46
Appendix J
Medical Equipment Maintenance Evaluation and Assessment 47
Appendix K
Preventive Maintenance Inspection Checklists 49
Appendix L
Sample Combat Support Hospital Internal Standing Operating Procedures 51
Appendix M
Sample Combat Support Hospital External Standing Operating Procedures 60
Appendix N
Medical Standby Equipment Program 70
Appendix O
Army Prepositioned Stocks 71

Glossary

Abbreviations 72
Terms 73

List of Illustrations

Figure 2-1.
Sample DA Form 2404 used to document a deficiency identified during operator PMCS 8
Figure 2-2.
Sample DA Form 2407 used to request maintenance support 9
Figure 3-1.
Individual direct labor man-hours worksheet. 12
Figure 3-2.
Instructions for preparing the individual direct labor man-hours worksheet. 13
Figure 4-1.
Decision matrix for condition coding medical equipment. 16
Figure 4-2.
Sample maintenance request depicting equipment coded H 18
Figure 4-3.
Uneconomically reparable equipment disposition memo. 19
Figure 7-1.
New equipment issue flow chart. 24

Figure 8-1.
Equipment turn-in flow chart. 26
Figure B-1.
Sample of a completed DA Form 2406. 38
Figure B-2.
Sample of a completed DA Form 2406—Continued. 39
Figure J-1.
Commander's Medical Equipment Maintenance Assessment Checklist. 47

This page intentionally left blank

CHAPTER 1

Introduction

Section I. General

1-1. Purpose

a. This operating guide provides policy and procedures used to manage and operate Table of Organizational Equipment (TOE) medical maintenance operations. Use it in concert with the directives and policies prescribed by Army regulations (ARs) and other regulatory guidance.

b. This operating guide also provides uniform guidance and direction to standardize operating procedures. Paraphrased in this bulletin are major policies and responsibilities established in other regulations to afford an understanding of their interaction with medical equipment maintenance procedures.

1-2. Applicability

This operating guide applies to all Army TOE organizations authorized Medical Equipment Repairers (MER), Military Occupational Specialty (MOS) 68A.

1-3. References

Appendix A lists related publications in addition to prescribed and referenced forms. These references provide the regulatory basis for the guidance contained in this bulletin. Maintenance activities will maintain a library of those publications used on a frequent basis, and be knowledgeable of the locations of less frequently used publications.

1-4. Explanation of abbreviations and terms

The glossary contains abbreviations and explains special terms used in this operating guide.

1-5. Standards of medical maintenance

Equipment used by medical personnel is of critical importance since its purpose is to save lives and prevent suffering of the sick and wounded. Therefore, the highest standards of maintenance for medical equipment are mandatory.

Section II. Responsibilities

1-6. Commanders

Maintenance of equipment is a command responsibility. Adequacy and completeness of a unit's maintenance program are a reflection of command interest. Maintenance operations, regardless of the unit size or mission, are analyzed on nine factors that can affect maintenance: command, personnel, time, tools, repair parts, records, publications, facilities, and communications. Command is the most critical factor since it is the only factor that has direct influence on each of the others. Commanders will:

a. Publish and make compulsory a directive emphasizing the responsibilities of equipment operators to perform effective operator maintenance, and the accountability of supervisors and leaders to ensure operators are properly trained and competent in the use and care of medical equipment.

b. Allocate adequate time for equipment operators (EO) to perform operator preventive maintenance services on a scheduled basis. Operator level maintenance should be included in the unit's training schedule.

c. Ensure current operator manuals for all medical equipment are on hand and readily available to the operators.

d. Evaluate the performance of operator and unit maintenance programs through inspections. Correct deficiencies found during inspections.

e. Establish periodic in-service and/or formal training in operator maintenance programs for operators.

f. Prevent the abuse of materiel under user control. Investigate the evidence of abuse and take corrective action.

g. Program periodic in-service training, formal Army training, and/or manufacturer training for equipment maintainers, particularly for new equipment introduced into the activity.

h. Use assigned MERs for medical maintenance duties. The MER should not be assigned additional duties that may adversely affect the maintenance posture and readiness of medical equipment.

i. Make available the resources (i.e. tools, parts, and test equipment) necessary to maintain the organization's medical equipment.

j. Provide maintenance services to associate and subordinate activities on a scheduled basis.

k. Provide the best maintenance facilities possible. Arrange maintenance facilities to efficiently use the allotted space. The shop should be as centrally located as possible, be accessible, and have ample, secure, storage space for repair parts, supplies, tools, test equipment, and equipment awaiting repair and/or parts.

l. Maintain the appropriate medical equipment maintenance records IAW TB 38-750-2, *Maintenance Management Procedures for Medical Equipment*, or approved automated equipment management system.

m. Maintain organization's medical equipment in a fully mission capable status IAW AR 220-1, *Unit Status Reporting* and AR 700-138, *Equipment Readiness Reporting*.

n. Medical equipment repairers should be included in the Medical Proficiency Training (MPT) program. Participation should not detract from the unit's medical maintenance posture.
o. Provide communication capability to ensure DA approved automated medical equipment maintenance and performance reporting procedures are achieved. To the maximum extent possible, medical maintenance automation systems should be provided broadband access to ensure effective communication is attained.

1-7. Maintenance managers
The senior medical equipment repairer will accomplish organizational maintenance for medical equipment in a timely, economical, and professional manner. Due to ever-changing operational requirements and conditions, effective maintenance management requires leadership, planning, organization, assignment of responsibilities, functions and resources, direction, and flexibility. Management of resources (tools, test equipment, standby equipment, repair parts, time, and personnel) should be a daily concern. All resources must be present in sufficient quantity when needed to accomplish the maintenance mission. The establishment of priorities is a primary task. Managers will:
a. Attain the basic concepts, objectives, and policies of The Surgeon General for the maintenance of medical equipment.
b. Effectively achieve the maintenance of Army-owned or supported medical materiel throughout the equipment's life cycle.
c. Execute maintenance programs for the repair, preventive maintenance checks and services (PMCS), electrical safety testing and calibration/verification/certification (CVC) of medical materiel.
d. Establish Standing Operating Procedures (SOPs) for the operation of the maintenance activity IAW command guidance. See appendix C which addresses SOP requirements and the applicable appendix for a sample SOP depending on the type of unit assigned.
e. Review internal and external SOPs minimally every 18 months and update to reflect changes in DA maintenance policies.
f. Provide planning, guidance, and assistance to other organizational elements that impact on the maintenance mission. This includes providing guidance and assistance to:
(1)Commanders and staff in the development of medical maintenance related educational and training programs for equipment operators and assigned MERs;
(2)Personnel Division (S-1) in the timely reporting of projected personnel losses.
g. Establish a system for identifying defective equipment to alert potential users. Use of equipment serviceability tags DD Form 1577 and DD Form 1577-2.
h. Keep Commanders and staff informed on the status of medical equipment maintenance and associated programs.
i. Establish a master file of both operator and maintenance manuals in the maintenance activity for all medical equipment. Maintenance literature can be in either paper or electronic format.
j. Establish a functional file system to ensure maintenance records are maintained.
k. Establish and maintain a library of current administrative publications needed in the management of the maintenance activity.
l. Facilitate medical equipment repairer participation in a Medical Proficiency Training (MPT) program.
m. Identify activities requiring medical maintenance support from your activity.
n. Identify the activity responsible for providing your next level of medical maintenance support.

1-8. Supervisory/leader personnel
Although supervisory duties and responsibilities are inherent in the management of all sub-functions of a medical equipment maintenance activity, those listed herein pertain primarily to maintenance and repair operations. Supervisors will:
a. Ensure the assignment of scheduled and unscheduled workloads to qualified repairers commensurate with their training and skill level.
b. Maintain timely and informative communications with medical equipment operators/hand-receipt holders concerning maintenance services.
c. Ensure the interpretation and application of maintenance service procedures are according to manufacturer's specifications and instructions.
d. Ensure individuals are knowledgeable of regulatory requirements such as Center for Devices and Radiological Health (CDRH), Codes of Federal Regulation (CFR) and National Fire Protection Association (NFPA) codes.
e. Ensure MERs are knowledgeable of hazard communications (HAZCOM), lockout/tagout and other applicable Occupational Safety and Health Act (OSHA), Department of the Army (DA), U.S. Army Major Commands (MACOMs), and local safety program requirements.

1-9. Medical Equipment Repairers
Maintenance services must be accomplished within established guidelines in a timely, professional manner. Repairers will:
a. Adhere to safety procedures during maintenance operations.
b. Bring unsafe equipment operations to the attention of user/operator personnel and their supervisors, by identifying defective equipment and alerting potential users.
c. Maintain accountability of entrusted resources. Of significant importance is the availability and accountability of time and effective man-power utilization. See chapter 3 for instructions on accountability of time and use of timesheets.
d. Perform PMCS and CVC services according to the manufacturer's instructions or Army technical manuals (TMs). Perform electrical safety inspections and testing IAW NFPA 99 and this bulletin.

e. Ensure documentation and associated maintenance forms are legible and in compliance with local SOPs and other applicable directives.
f. Assume personal responsibility for identifying and pursuing professional or technical training and career development.

1-10. Equipment Operators
The range and complexity of medical equipment used to provide healthcare requires that operators and their supervisors be responsible for their portion of the activity maintenance program. The operators and/or supervisors will:
a. Perform before, during, and after operation maintenance tasks according to TMs and manufacturers' instructions utilizing DA Form 2404. Operator tasks usually consist of the care and cleaning of exterior surfaces, components, and accessories. Operator tasks also include the replacement of bulbs, tubing, etc., that are easily accessible and do not require tools or test equipment.
b. Promptly report malfunctioning equipment to immediate supervisor and the supporting medical maintenance activity.
c. Initiate a maintenance request for any maintenance services beyond those authorized as part of the operator's daily operations.
d. Maintain operator manuals for all medical equipment.
e. Maintain accountability of medical equipment and sets.

Section III. Maintenance Publications and Directives

1-11. Commander's implementing directives
Commanders will publish a maintenance support directive for use by their customers and supported activities.

1-12. Standing operating procedures
a. Each activity having an organic medical maintenance capability will publish an internal SOP The internal SOP will designate individual responsibilities and, as a minimum, will provide instructions for the performance of maintenance tasks related to the areas identified in appendix C.
b. Each maintenance activity will develop and publish an external SOP. This SOP will establish the procedures a customer must follow when acquiring maintenance support.

1-13. Desk reference manuals
a. In addition to the internal SOP, the maintenance activity should develop a desk reference for each MER's use. Consider the development of a desk reference manual for repair parts, tool room operations, and automated record keeping procedures.
b. Desk reference manuals give a person performing routine day-to-day tasks the detailed instructions necessary to complete the tasks with the least amount of supervisory assistance. The manual should contain step-by-step procedures in sufficient detail to enable a newly assigned repairer to perform assigned duties.
c. Providing adequate instructions and sample formats in a desk reference manual results in less time being required by the supervisor to train new personnel. Appendix D lists suggested items for inclusion in each desk reference manual.
d. The repair parts and automated record keeping procedures desk references provide details to the extent that other personnel could assume these duties in the event assigned personnel are replaced.

Section IV. Maintenance Management

1-14. Management
a. Maintenance management is the process of establishing objectives to carry out maintenance responsibilities. Maintenance management consists of those continuing actions of planning, organizing, directing, coordinating, controlling, and evaluating the use of personnel, funds, and facilities to accomplish missions and tasks.
b. A prime management objective is to ensure optimal managerial control of critical maintenance resources. Accomplish this objective by establishing standards of performance for operational elements and a management data collection and reporting system for measuring and evaluating each medical maintenance activity's performance.

1-15. Management sub-functions
Shop management is composed of three basic sub-functions: supervision and administration, workload control, and maintenance and repair operations.
a. Supervision and administration.
(1) Supervision is the element of management that makes the organizational maintenance facility productive by effectively managing the resources available to accomplish the maintenance mission. It consists of forecasting requirements and planning for the acquirement of resources used in the performance of the maintenance mission (i.e., funds, personnel, supplies, repair parts, tools, TMDE, publications, and facilities).
(2) Administration includes the tasks related to obtaining resources, maintaining equipment historical records, providing performance evaluation and reporting, man-hour accounting, and maintaining

reference files. Also included are those tasks that are indirect to the physical performance of maintenance services and/or repair actions.

b. Workload control.

(1) Maintenance managers determine work requirements and prioritize workload in accordance with the resources and capabilities available.

(2) The automation maintenance system should allow retrieval of maintenance reports and outputs to forecast scheduled and unscheduled services requirements. The types of reports available should include:

(a) Unscheduled Work Order Register (Listing) - Provides maintenance data used to prioritize the workload and sufficient information to determine repair limitations;

(b) Monthly Scheduled Service Work Order Listing - Provides a list of monthly scheduled service work orders for equipment due services;

(c) Cancelled/Delinquent Work Order – Provides a list of monthly scheduled service work orders that were not accomplished IAW the regulatory guidance; and

(d) Maintenance Performance Report - Provides statistical data to evaluate overall maintenance performance.

c. Maintenance and repair operations. Chapter 2 encompasses the aspects of maintenance and repair operations in detail.

(1) Maintenance and repair operations are the physical performance of those tasks involved in completing scheduled and unscheduled maintenance services.

(2) The effectiveness of the maintenance and repair operation program is dependent on the other maintenance management sub-functions. Administrative tasks must be accomplished before and after the performance of maintenance services.

1-16. Authorized automated maintenance management system

a. All TOE medical activities with an organic maintenance capability will utilize the authorized Standard Army Management Information System (STAMIS) to manage their equipment maintenance program. See appendix E for additional information concerning STAMIS.

b. All maintenance activities will establish historical records for maintenance significant medical equipment. Historical records are produced by the medical maintenance automation system.

c. The system-produced medical equipment historical records are the official records of the activity and will satisfy the requirements of AR 750-1.

CHAPTER 2

Maintenance and Repair Procedures

Section I. Maintenance Procedures

2-1. Authorized maintenance

a. Units authorized a 68A IAW their unit MTOE are authorized a maintenance capability. Exceptions are the Medical Logistics Management Centers (MLMC) and Medical Commands.

b. Maintenance operations consist of any action taken to retain or restore materiel to operational serviceability. The scope of maintenance tasks ranges from PMCS to wholesale maintenance.

(1) Defective/unserviceable medical equipment will only be repaired or serviced by school trained medical equipment repairers, MOS 68A. Specialized trade requirements for medical equipment, i.e. welding and refrigeration support will be performed under the direct supervision of a medical equipment maintainer.

(2) Medical equipment repairs will be completed IAW the manufacturer's literature, 10/20 standards, and Maintenance Allocation Chart (MAC). All equipment should be 100% fully mission capable (FMC) upon completion of repair services.

(a) Perform electrical safety testing after repairs or modifications have been made to the equipment's electrical or electronic circuitry.

(b) Verify calibration after replacement of any circuit boards or when repairs or adjustments have been made to the electronic circuitry.

2-2. Equipment management

a. Equipment management is a command responsibility. Each commander must provide for the maintenance of equipment issued to or under the responsibility of his or her unit to include the efficiency of programs established for this purpose.

b. The maintenance of medical equipment includes:

(1) Equipment operator PMCS, and medical equipment repairer PMCS, electrical safety inspections and tests, and CVC services.

(2) Remedial maintenance (unscheduled repairs).

(3) Overhaul and rebuild will be preformed at MRMC Medical Maintenance Divisions or at associate maintenance activities designated by USAMMA.

2-3. Levels of maintenance

a. The levels of maintenance are defined in AR 750-1. Organizational leadership must continuously emphasize a comprehensive medical equipment maintenance program.

b. The keystone to any successful unit maintenance program is effective equipment operator maintenance. Operator level maintenance includes thoroughly checking the operation of the equipment and all accessories. A disciplined operator level maintenance program will ensure operators maintain familiarity with their equipment and that all equipment and accessories are available for use during times of deployment.

c. Unit level maintenance – The unit's medical maintenance activity (comprised of assigned medical equipment repairers (MOS 68A)) perform maintenance on their unit's medical equipment. Unit level maintenance includes cyclically scheduled maintenance and limited unscheduled/repair services. Extent of maintenance services, as well as limitations, for each type/item of equipment that should be performed by the maintenance activity is identified in the MAC.

d. Direct support level maintenance - Medical maintenance activities perform direct support maintenance on medical equipment in the possession of their supported activities. Supported activities include:

(1) Medical teams/units/elements (i.e. Forward Surgical Team, Eye Surgery Team, Pathology Medical Team, etc..) augmented to the organization;

(2) MTOE organizations authorized medical equipment located within their geographical area of responsibility IAW MACOM directives.

e. Depot level maintenance. The refurbishment or restoration of medical equipment to like-new condition for return to the wholesale supply system.

2-4. Automated medical equipment maintenance management database

a. TOE medical maintenance activities will use the authorized medical maintenance management automation system. Standardization of automation is critical for instilling familiarity with equipment and maintenance management procedures, as well as providing visibility of medical equipment mission capability status throughout the chain of command to the national level.

b. Include all medical equipment authorized and on hand at the organization. Medical equipment and quantities authorized are identified in the MTOE either as distinct items by line item number (LIN) or as components of medical equipment sets or medical materiel sets (MES/MMS). MES/MMS (Unit Assemblage (UA)) Listings may be obtained from USAMMA.

c. Include all medical equipment requiring calibration services. Appendix H identifies types of equipment requiring calibration services. Calibration services should be scheduled and completed IAW the criteria listed in the manufacturer's literature or the equipment's -20 standards and MAC.

d. All equipment listed in the equipment master data file will be included in the automated maintenance management system. The maintenance manager has the responsibility of making the determination as to what additional items are included in the equipment database. Consider the following when determining inclusion into your database.

(1) All electrical equipment.

(2) All equipment intended for use in critical patient care areas.

(3) All equipment that the manufacturer recommends, or has written procedures for the performance of routine periodic calibrations or verifications.

(4) Any equipment item you feel could pose a risk to a patient's safety or health. This would ensure maintenance tracking if an incident occurred.

(5) Any equipment item you deem should have a separate maintenance history.

e. Establish cyclic (scheduled) maintenance service intervals consistent with the published TM, MAC, or manufacturer's literature. When determining the service intervals for medical equipment, utilize the most stringent.

(1) PMCS – minimum annual;

(2) Safety – minimum annual;

(3) CVC – minimum annual.

2-5. Performance standards

a. The performance objective for scheduled service is to complete 100 percent of those services scheduled during each maintenance period. Minimum acceptable performance levels are:

(1) PMCS - 95 percent.

(2) CVC - 95 percent.

(3) Electrical Safety - 95 percent.

b. Chapter 5 of this publication contains additional guidance concerning the performance of scheduled services.

2-6. Medical materiel complaints

a. Report medical equipment determined to be harmful or defective to the extent that use has caused or may cause serious injury, serious illness, and/or death as a medical materiel complaint IAW AR 40-61. Also report equipment that is unsatisfactory because of malfunction, design, defects (attributable to faulty materials, workmanship, and/or quality control), or performance. Submit a SF 380 to the Defense Supply Center Philadelphia (DSCP).

b. Medical maintenance will assist medical staff in the completion of appropriate actions to meet the requirements of the Safe Medical Devices Act (SMDA) of 1990 (See Appendix F).

2-7. Modification, alteration, and fabrication of medical equipment

a. Modification or alteration of Army materiel is forbidden, except as authorized IAW AR 750–10. Modification of equipment outside of the factory must be accomplished via a documented, official Modification Work Order (MWO). Commanders will not allow their equipment to be modified except under the provisions of a valid MWO.

b. Forward suggested medical equipment modifications directly to the USAMMA. Local commanders will not implement a suggested modification until the suggestion is reviewed and approved by the USAMMA.

c. Medical maintenance activities will not modify equipment that results in the equipment being altered to perform a function for which it is not designed or advertised by the original equipment manufacturer (OEM).

d. Medical activities will not fabricate, without prior approval, any item of medical equipment or component to be used on existing medical equipment. Forward requests for approval, based on unique one-time requirements, to the USAMMA.

Section II. Workload Control

2-8. Scheduling and deferring maintenance

a. The authorized automated system will produce a listing of monthly scheduled services work orders to be performed. Resources should be allocated as required to perform the scheduled maintenance services.

b. When available resources are inadequate to complete all required services, contact the regional manager (CONUS – USAMMA MMODs Hill, Toby, Tracy; Europe – USAMMCE; Korea – 16th MEDLOG) responsible for your geographic location. Adequate planning should allow you to forecast personnel shortages in advance to ensure arrangement of appropriate direct support assistance.

c. While deployed to an area of operation or theater of operation (AO/TO), the priority/focus changes from that of performing scheduled services to completing repair services and returning broken or non-mission capable equipment to a FMC status. Contact the MEDLOG battalion/company responsible for providing support within your AO/TO to request manpower augmentation or support.

d. To the maximum extent possible, service all critical or lifesaving equipment first. Typically, these items will also require calibration services.

e. As a last resort, deferment of maintenance may be required due to non-availability of manpower due to personnel shortages or other extenuating circumstances.

2-9. Equipment priorities - Priorities are based on:
a. Equipment Readiness Code (ERC) Code. Refer to Appendix B.
b. Commander's guidance.

Section III. Forms and Records Management

2-10. General
a. TOE medical maintenance activities will use the approved automated system or the manual system IAW DA PAM 750-8, TAMMS User Manual, and TB 38-750-2, Maintenance Management Procedures for Medical Equipment to manage their medical equipment maintenance. See appendix E for specific guidance on maintenance management reports required when an automated system is available.
b. AR 25-30, chapter 3, prohibits the creation of a form for a purpose for which a higher echelon form exists. Maintenance activities will use existing DA, DOD, and Food and Drug Administration (FDA) forms and labels.

2-11. Automated outputs
a. Maintenance managers will ensure that copies of the latest automated outputs/reports, applicable to equipment maintenance management, are available to maintenance personnel. See DA PAM 750-8 for guidance on available reports.
b. The DA Form 2406, Materiel Condition Status Report, or automated report equivalent will be forwarded to the Commander monthly. See appendix B, figure B-1 and figure B-2 for completion instructions and sample form.
c. Reconcile the work order register at least monthly. Physically account for all maintenance requests on the register and establish entries for those work orders on hand and not on the register.

2-12. Maintenance requests
When using manual procedures, DA Form 2404 (Equipment Inspection and Maintenance Worksheet) or DA Form 2407 (Maintenance Request) may be utilized to request maintenance services.
a. Complete a maintenance request for each scheduled and unscheduled work item performed.
b. Complete manual maintenance requests (DA Form 2404 or DA Form 2407) IAW DA PAM 750-8, TB 38-750-2, this bulletin, and local procedures when adequate automated maintenance procedures are not available. See figures 2-1 and 2-2 for sample DA Form 2404 and DA Form 2407.
c. See the ULLS-G user's manual when utilizing the ULLS-G.
d. Maintenance activities will keep a copy of all maintenance request forms for one year following the close date.

EQUIPMENT INSPECTION AND MAINTENANCE WORKSHEET

For use of this form, see DA PAM 738-750 and 738-751; the proponent agency is DCSLOG

1. ORGANIZATION	2. NOMENCLATURE AND MODEL
A Co, 429th CSH, ICW #5	Ventilator, 754M

3. REGISTRATION/SERIAL/NSN	4a. MILES	b. HOURS	c. ROUNDS FIRED	d. HOT STARTS	5. DATE	6. TYPE INSPECTION
ICW5A11/8310044					12 Sep 01	Daily

7. APPLICABLE REFERENCE

TM NUMBER	TM DATE	TM NUMBER	TM DATE
Mfg Literature	25 Dec 00		

COLUMN a – Enter TM item number.

COLUMN b – Enter the applicable condition status symbol.

COLUMN c – Enter deficiencies and shortcomings.

COLUMN d – Show corrective action for deficiency or shortcoming listed in Column c.

COLUMN e – Individual ascertaining completed corrective action initial in this column.

STATUS SYMBOLS

"X" – Indicates a deficiency in the equipment that places it in an inoperable status.

CIRCLED "X" – Indicates a deficiency, however, the equipment may be operated under specific limitations as directed by higher authority or as prescribed locally, until corrective action can be accomplished.

HORIZONTAL DASH "(-)" – Indicates that a required inspection, component replacement, maintenance operation check, or test flight is due but has not been accomplished, or an overdue MWO has not been accomplished.

DIAGONAL "(/)" – Indicates a material defect other than a deficiency which must be corrected to increase efficiency or to make the item completely serviceable.

LAST NAME INITIAL IN BLACK, BLUE-BLACK INK, OR PENCIL - Indicates that a completely satisfactory condition exists.

FOR AIRCRAFT - Status symbols will be recorded in red.

ALL INSPECTIONS AND EQUIPMENT CONDITIONS RECORDED ON THIS FORM HAVE BEEN DETERMINED IN ACCORDANCE WITH DIAGNOSTIC PROCEDURES AND STANDARDS IN THE TM CITED HEREON.

8a. SIGNATURE *(Person(s) performing inspection)*	8b. TIME	9a. SIGNATURE *(Maintenance Supervisor)*	9b. TIME	10. MANHOURS REQUIRED
Kenny Conard SPC		Jason Williams SFC		

TM ITEM NO. a	STATUS b	DEFICIENCIES AND SHORTCOMINGS c	CORRECTIVE ACTION d	INITIAL WHEN CORRECTED e
		10 Sep 01 None		KC
		11 Sep 01 None		KC
pg. 24	X	Total Flow Backup Error/Alarm	Replaced O-Ring Bench Stock	BR

DA FORM 2404, APR 79 Replaces edition of 1 Jan 64, which will be used USAPPC V1.10

Figure 2-1. Sample DA Form 2404 used to document a deficiency identified during operator PMCS

MAINTENANCE REQUEST
For use of this form, see DA PAM 738-750 and 738-751; the proponent agency is DCSLOG

PAGE NO | NO OF PAGES | REQUIREMENT CONTROL SYMBOL CSGLD-1047(R1)

SECTION I - CUSTOMER DATA

1a. UIC CUSTOMER: W0H45
1b. CUSTOMER UNIT NAME: Dental Clinic 1
1c. PHONE NO: x 7377
2a. SAMS-2 UIC/SAMS-I/TDA: W03H51
2b. UTILIZATION CODE: ON
2c. MCSR:

SECTION II - MAINTENANCE ACTIVITY DATA

3a. WORK ORDER NUMBER (WON): 709911039
3b. SHOP: Dental
3c. PHONE NO: x 7361
4a. UIC SUPPORT UNIT: W03H11
4b. SUPPORT UNIT NAME: Medical Maintenance Branch

SECTION III - EQUIPMENT DATA

5. TYPE MNT REQ CODE: TI
6. ID:
7. NSN: 6520-11173-3443
8. MODEL: 660
9. NOUN: Ultrasonic Unit
10a. ORG WON/DOC NO:
10b. EIC:
11. SERIAL NUMBER: 6143 2
12. QTY: 1
13. PD:
14. MALFUNCTION DESCRIPTION (for DSU, GSU/AVIM, DEPOT use):
15a. FAILURE DETECTED DURING/WHEN DISCOVERED CODE (Enter code) See DA Pamphlets 738-750 and 738-751:
15b. FIRST INDICATION OF TROUBLE/HOW RECOGNIZED CODE (Enter Code) See DA Pamphlets 738-750 and 738-751:
16. MILES/KILOMETERS/HOURS/ROUNDS: M | K | H | R
17. PROJECT CODE (if assigned):
18. ACCOUNT PROCESSING CODE:
19. IN WARRANTY? (enter Y or N):
20. ADMIN NO:
21. REIMBURSABLE CUSTOMER (if intransit customer enter Y or N):
22. LEVEL OF WORK:
23. SIGNATURE:
24. DESCRIBE DEFICIENCIES OR SYMPTOMS ON THE BASIS OF COMPLETE CHECKOUT AND DIAGNOSTIC PROCEDURES IN EQUIPMENT TM (Do not prescribe repairs): No water from handpiece MEL - $150.75
25. REMARKS: Supply condition code H
26. TECHNICAL REFERENCES: Estimated repair costs - $162.00 $102.00 (parts list) + $60.00 (labor)

SECTION IV - TASK REQUIREMENTS DATA

27a. FILE INPUT ACT CD	27b. TASK NO	27c. ACT CODE	27d. TASK DESCRIPTION	27e. QTY TO BE RPR	27f. WORK CENTER	27g. FAILURE CODE	27h. MH PROJ	27i. MH EXP

SAMPLE

SECTION V - PART REQUIREMENTS

28a. FILE INPUT ACT CD	28b. TASK NO	28c. ID NO	28d. NSN OR PART NUMBER	28e. SFX CD	28f. QTY RQD	28g. QTY ISSUED	28h. NMCS CD	28i. FAILURE CODE	28j. STORAGE LOCATION	28k. INITIALS	28l. COST $

28m. TOTAL MANHOURS: 0.5
28n. TOTAL MANHOURS COSTS $: 10.00
28o. TOTAL PARTS COSTS $: 0.0

SECTION VI - COMPLETION DATA

29. QTY RPR:
30. QTY CONDEMN:
31. QTY NRTS:
32. EVAC WON:
33. EVAC UNIT NAME: John Doe CW2, USA C, Medical Maint. Branch

SECTION VII - ACTION SIGNATURES

34a. SUBMITTED BY:
35a. ACCEPTED BY:
35c. DATE:
36a. WORK STARTED BY:
37a. INSPECTED BY:
38a. PICKED UP BY: Branch

34b. DATE	35b. STATUS	35d. TIME	36b. STATUS	36c. DATE	36d. TIME	37b. STATUS	37c. DATE	37d. TIME	38b. STATUS	38c. DATE	38d. TIME

DA FORM 2407, JUL 94 CONTROL COPY 3

Figure 2-2. Sample DA Form 2407 used to request maintenance support

Section IV. Shop Safety

2-13. Shop safety procedures

Each maintenance activity will practice safe operating procedures, ensuring a safe environment for the repairer. Important points of shop safety are:

a. Following general safety procedures as outlined by AR 385-10, MACOM directives, and the activity safety program.

b. Preventing electrical shock by noting and labeling hazards and following safe repair procedures.

c. Following safe handling and disposal rules for items containing radioactive or toxic material. Safe handling and disposal rules are identified in the Material Safety Data Sheet (MSDS) received from the manufacturer with the hazardous materiel.

d. Being knowledgeable of fire protection rules, plans, and evacuation routes.

e. Ensuring compliance with the activities respiratory protection program while performing any task where the use or productions of toxic materials, fumes, or mists occur.

f. Making available those items of occupational foot protection and protective clothing authorized by common table of allowance (CTA) 50-900.

g. Following radiation health protection procedures as outlined by TB MED 521.

h. Preventing eye and skin injuries by noting and labeling hazards and using protective devices. Optical sources such as arc lamps (mercury, xenon, etc.), lamps with quartz envelopes (since they can emit ultraviolet rays), infrared and germicidal lamps, welding arcs, and lasers can pose a hazard.

i. Complying with microwave radiation procedures as outlined in TB MED 523.

j. Complying with lockout/tagout procedures IAW OSHA Regulation 29 CFR, Part 1910, Control of Hazardous Energy Sources (Lockout/Tagout).

CHAPTER 3

Man-hour Accountability

3-1. General
a. Supervisors are responsible to ensure manpower utilization is documented and accurate.
b. Man-hour accounting provides a uniform system to identify and account for the utilization of duty hours for assigned medical repairers.

3-2. Use of direct labor worksheet A direct labor worksheet and instructions for completing the worksheet are provided in figures 3-1 and 3-2.
a. Use the individual direct labor man-hours worksheet or an equivalent method to capture man-hours expended by assigned personnel.
b. Maintenance managers will ensure that all direct labor personnel are familiar with and understand these instructions.

3-3. Individual direct labor man-hours worksheet preparation The following instructions should be followed when preparing the individual direct labor man-hours worksheet.
a. Assigned Hours – Eight hours per normal working day (Monday thru Friday); five days per week less holidays. Applies to 68A Medical Equipment Repairers assigned to the unit.
b. Overtime Hours – Man-hours expended in excess of eight hours per day.
c. Borrowed Hours – Man-hours borrowed from another unit i.e. support from a MEDLOG, IMSA, or USAMMA medical maintenance operations division.
d. Loaned Hours – Man-hours loaned outside of the maintenance shop/activity. Examples include commander's driver; reenlistment, training, or NBC NCO; or some other permanent or semi-permanent duty or detail.
e. Nonproductive – Unable to perform medical maintenance functions due to uncontrollable circumstances or restricted from performing medical equipment repairs and/or services by persons or conditions beyond your control.
f. Productive Indirect Labor – Alert duty, maintenance meeting, maintenance shop or activity cleaning and policing.
g. Duty Absence – Military training, organizational or installation duties, TDY – training, or personnel processing.
h. Non-Duty Absence - See figure 3-2.
i. Travel - See figure 3-2.
j. MEDCASE – Non-applicable.
k. Miscellaneous – All other documented direct labor man-hours expended but not otherwise mentioned.

INDIVIDUAL DIRECT LABOR MAN-HOURS WORKSHEET

NAME: _____ Entered By: _____ DATE: _____

REPORT MONTH: _____ WCC: _____ TECH-CD: _____

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Totals
1	Assigned Hours																																
2	Overtime Hours																																
3	Borrowed Hours																																
4	Loaned Hours																																
5	Nonproductive Hours																																
6	Productive - Indirect																																
7	Duty Absence																																
8	Non-Duty Absence																																
9	Travel Time																																
	Ancillary Services																																
10	MEDCASE																																
11	Miscellaneous																																
12																																	
13																																	
14																																	
15																																	
16																																	

Figure 3-1. Individual direct labor man-hours worksheet.

INSTRUCTIONS FOR PREPARING THE INDIVIDUAL DIRECT LABOR MAN-HOURS WORKSHEET

Line 1 **ASSIGNED HOURS** - 8 Hours per normal working day (Monday thru Friday) 5 days per week less holidays.

Line 2 **OVERTIME HOURS** - Man-hours expended in excess of the normal 8 hours per day.

Line 3 **BORROWED HOURS** - Hours borrowed from another work center or source.

Line 4 **LOANED HOURS** - Man-hours loaned outside the basic work center to another work center, or loaned to indirect labor.

Line 5 **Nonproductive:**

- Lag - Awaiting Assistance
- Lag - Awaiting Equipment, Tools, etc.
- Lag - Awaiting Transportation
- Lag - Weather
- Lag - Parts
- Lag - Break

Line 6 **Productive Indirect Labor:**

- Alert Duty
- Maintenance On-Installation Tech Training
- Maintenance Meeting
- Plant/Equipment Maintanance and Clean-up
- Cleaning and Policing

Line 7 **Duty Absence:**

- Military Training
- Organizational or Installation Duties
- TDY - Training
- Personnel Processing

Line 8 **Non-Duty Absence:**

- Compensatory Time Off
- Excused from Duty (Pass)
- Leave - Official
- Sick Leave - Civilian
- Medical Absence (Sick Call, Hospital, etc.)
- Personal Affairs
- AWOL, LWOP
- Job Related Injury

Line 9 **Travel:** - Time expended traveling to and from maintenance jobs. Time traveling to, from, or between jobs which exceeds three-tenths (3/10) of an hour will be documented on this line. Travel which takes three-tenths of an hour or less will be charged to the job (work order). Time spent awaiting transportation will be charged to nonproductive labor (Line 5).

Line 10 **MEDCASE** - Man-hours expended in support of MEDCASE Projects.

Line 11 **MISCELLANEOUS** - All other documented direct labor man-hours expended but not otherwise mentioned.

Figure 3-2. Instructions for preparing the individual direct labor man-hours worksheet.

CHAPTER 4

Repair Expenditures

Section I. Repair Eligibility and Evacuation

4-1. Cost elements

a. There are four elements of cost that must be identified to job orders. The elements for estimating the cost of repair are:

(1) Direct labor;
(2) Direct materiel;
(3) Packaging and freight;
(4) Miscellaneous.

b. Include all required repairs in the cost estimate to prevent expending essential resources maintaining uneconomically reparable equipment. Do not defer or omit repairs to reduce the total estimated cost.

c. Do not charge the following elements to an item of equipment as part of a repair, or when performing repair cost estimates:

(1) The labor cost of applying manufacturer directed modifications to eliminate hazardous or unsuitable conditions.

(2) Operating and user expense (operator replaceable) items; e.g., electrocardiograph paper; electrosurgical apparatuses electrodes; medical equipment filters; routine service items, etc.

(3) Preventive and periodic services to include calibration or verification of medical equipment.

(4) Man-hours expended in the technical inspection (TI) and condition coding of the medical equipment.

(5) Equipment installation.

(6) Replacement of components that are normally considered to be used-up during normal operation. These items include:

(a) X-ray tubes.
(b) Batteries, rechargeable or non-rechargeable (not from bench stock).
(c) Light bulbs (not from bench stock).
(d) Heat sealer heating elements (not from bench stock).
(e) Sieve beds and product tanks for oxygen concentrators.

(7) Dental handpieces.

(8) Bench stock.

d. For additional guidance identifying the elements of cost and estimating the cost of repair, see TB MED 7.

4-2. Responsibility of a Medical Equipment Repairer

a. A primary responsibility of the MER is inspection of materiel to determine repair eligibility.

(1) MERs are required to perform a TI to determine specific repair requirements before repairs are started.

(2) MERs are required to accomplish a mental condition coding before starting repairs.

b. The MER must included all cost elements when estimating the cost of repair, or when condition coding equipment.

c. Do not include the cost of the items listed in paragraph 4-1c this bulletin when determining repair eligibility.

d. An important aspect in determining economic reparability of equipment is the MER's individual judgment. In the absence of valid historical data, the MER will completely inspect the item and use his or her best judgment in making the reparability determination.

4-3. Repair eligibility

To assist in determining repair eligibility, use figure 4-1 to ensure that fundamental steps are not overlooked.

4-4. Historical information

Establish local procedures, either the authorized automated maintenance management system (STAMIS) or manual procedures (DA PAM 750-8) that ensures equipment historical records are available to the MER. Basic historical data required to determine repair eligibility are:

a. Date put in service.
b. Current unit price.
c. Life expectancy.
d. Maintenance expenditure limit.

4-5. Appearance of medical equipment

a. Medical equipment is an essential element of the healthcare delivery system. As such, it must operate effectively, and its appearance must reinforce and support the high military standards for patient care.

b. Consider equipment used in patient care or treatment areas for refurbishment if its appearance has deteriorated.

c. Include the costs associated with refinishing an item of medical equipment when determining the repair cost estimate for the item.

4-6. Uneconomically reparable equipment
Do not repair unserviceable, uneconomically reparable equipment without a waiver IAW TB MED 7, and Section III of this chapter.

4-7. Evacuating equipment
a. Organizations evacuating equipment to support maintenance activities and/or MRMC's Maintenance Operations Divisions will ensure that adequate packaging and packing methods are applied to prevent loss or damage.
b. End items evacuated to support maintenance activities and/or MRMC's Maintenance Operations Divisions will include all major components and accessories required for the equipment to perform its designed functions (include operator and maintenance literature).
c. End items evacuated to support maintenance activities and/or MRMC's Maintenance Operations Divisions for repair and return will adhere to any special instructions required by the support element's external standard operating procedures.
d. The unit evacuating the equipment will establish procedures to ensure equipment accountability is maintained. The activity will ensure a signature is obtained from the shipper when evacuating equipment to another activity.

Section II. Maintenance Expenditure Limits

4-8. General
a. TB MED 7 contains guidance to determine Maintenance Expenditure Limits (MEL) for medical materiel.
b. Subsequent paragraphs in this publication explain equipment repair eligibility and the requirement for determining the MEL.
c. Maintenance is not authorized when the estimated repair cost of a repair would exceed the MEL, unless the servicing maintenance activity has obtained a waiver IAW TB MED 7 and this bulletin.

4-9. Computing maintenance expenditure limits
a. The MEL is based on a percentage of the current acquisition price and remaining life expectancy.
b. Use the MEL factor graph and the factor computation formula located in TB MED 7 to assist in determining whether unserviceable medical equipment is economically reparable.
c. Computations of MEL are based on the current acquisition price of an item of medical equipment. The current acquisition price may be obtained from the Army Master Data File (AMDF).
d. The percentage of current acquisition price for medical equipment ranges from 65 percent to 10 percent for those items not having an indefinite life. Determine the percent of useful life remaining for each item by applying the following formula. Years should be converted to months for simplicity.

$$\frac{\text{LIFE REMAINING IN MONTHS}}{\text{LIFE EXPECTANCY IN MONTHS}} = \text{PERCENT OF USEFUL LIFE REMAINING}$$

Or

$$\frac{60 \text{ MONTHS}}{120 \text{ MONTHS}} = .50 \text{ OR } 50\% \text{ USEFUL LIFE REMAINING}$$

e. Medical equipment that has reached or exceeded its life expectancy will have a maintenance expenditure limit of 10 percent of the current unit price. This will remain constant regardless of its age.
f. Do not include expenditures for the following when calculating the MEL:
(1) Scheduled services;
(2) Modifications;
(3) TIs;
(4) Warranty actions at no expense to the Government.

4-10. Indefinite life factors
a. Use a factor of 90 percent of current acquisition price, regardless of the item's age, when computing the MEL on the following items:
(1) Dental and surgical hand pieces.
(2) Fiber optic scopes (flexible and rigid).
b. Use a factor of 80 percent of current acquisition price when computing the MEL on the following items, regardless of the item's age:
(1) Hospital furniture (nurses' desks, narcotics and/or medicine cabinets, stainless steel surgical stands, tables, and stools, etc.).
(2) Basic electrical, mechanical, or electro-mechanical materiel (mechanical beds, over-bed tables, gooseneck lamps, etc.).

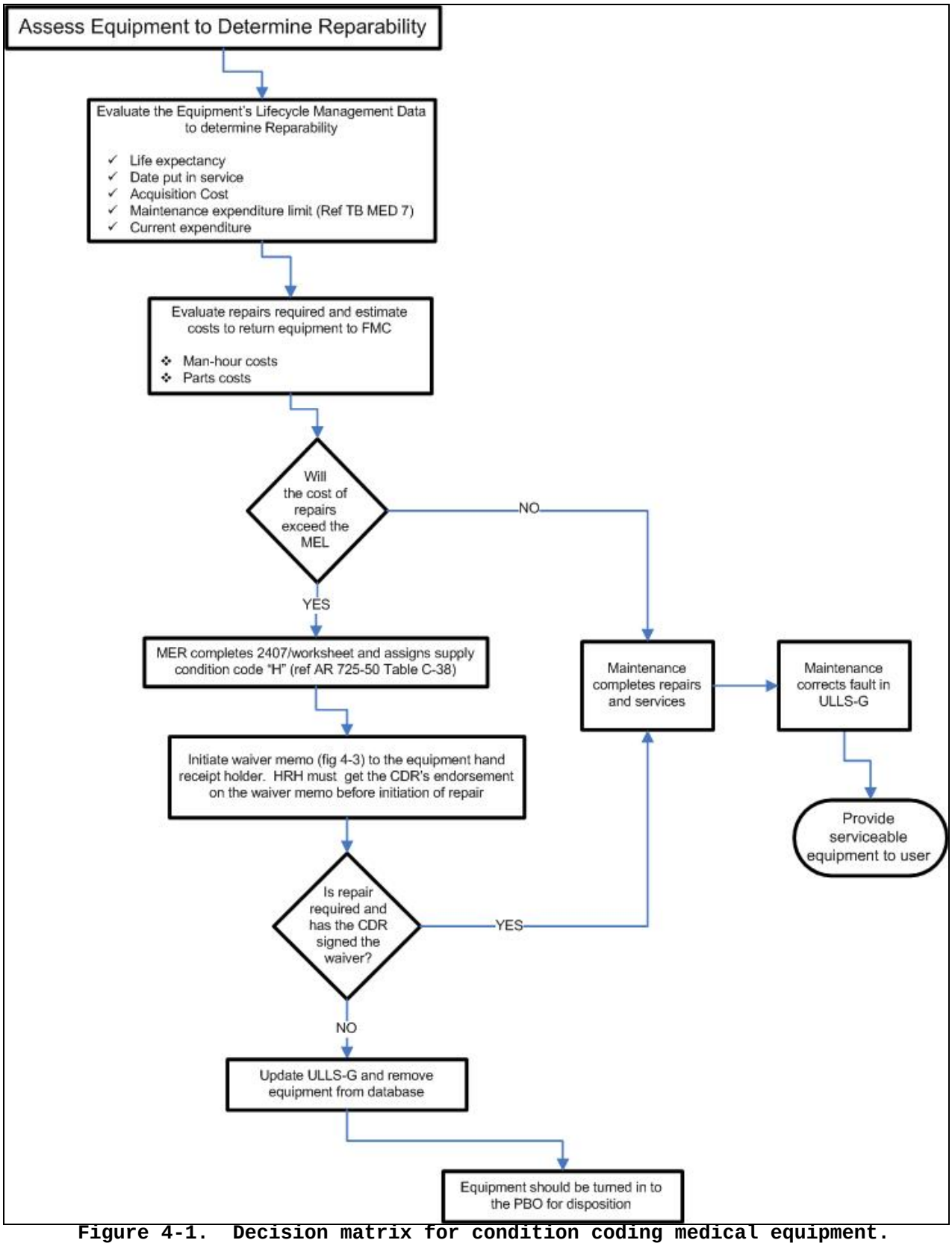

Figure 4-1. Decision matrix for condition coding medical equipment.

Section III. Waivers

4-11. Policies

a. The basic philosophy of the waiver policy is to ensure the best use of Government funds when equipment repair costs exceed normal repair limits, to provide controls to preclude the routine expenditure of resources for uneconomically repairable equipment, and to maintain command visibility of resource expenditures that are exception to established directives.

b. The unit commander may approve a waiver to exceed the MEL for TOE medical materiel when it is determined that:

(1) An urgent need for the medical equipment item exists to save life or limb or prevent distress, and that a replacement item will not be available to satisfy the professional requirement;

(2) The unit's readiness will be significantly impacted by the equipment shortage and a replacement item is not available.

c. Exceptions to standard waiver procedures for medical equipment must be approved by USAMMA. USAMMA may grant "blanket" and or one time repair waivers for designated equipment types, i.e. specific make and model X-ray apparatus or particular equipment items depending on circumstances. Circumstances include:

(1) Specific equipment items that may no longer be in production with no replacement item identified;

(2) Equipment item is Other Procurement Army (OPA) funded for which the unit does not receive funding, thus the unit is unable to obtain a replacement;

(3) Immediate availability of a replacement item to support a National Emergency does not exist;

(4) Further guidance concerning USAMMA waivers may be obtained by contacting the USAMMA.

d. In an AO/TO, the designated MEDLOG operating in the capacity of the single integrated medical logistics manager (SMLIM) is the authority for approving deviations to these guidelines and limits.

4-12. Responsibility for requesting waivers

a. The Medical Maintenance section has the responsibility for condition coding medical equipment and notifying the user (ward, clinic, service, etc.) when the item is uneconomical to repair.

b. Responsibility for obtaining a waiver rests with the equipment user and/or hand receipt holder. They have knowledge of the clinical requirement and are in the best position to justify why the item should be repaired.

c. When maintenance has determined an item of equipment is uneconomical to repair, the following actions are required:

(1) The MER annotates the work accomplished section of the maintenance request by following the example at figure 4-2:

(a) Estimated parts cost to return the item to a serviceable condition.

(b) Estimated man-hours to complete the repair.

(c) Supply condition code of "H".

(2) The senior maintenance manager will:

(a) Verify and authenticate the condition code assigned by the MER by placing his or her signature on the maintenance request.

(b) Notify the user and/or hand receipt holder by initiating a memorandum (sample provided at figure 4-3).

(c) Attach a copy of the Maintenance Historical Record and applicable work request to the memorandum.

(d) Close the maintenance request regardless of the user's intent to acquire a waiver. Include repair costs incurred up to the point of making the determination that a waiver was required to complete the repairs.

(3) The user/hand receipt holder (ward, section, service, etc.) will:

(a) Consult and coordinate with the PBO and maintenance manager.

(b) Prepare an endorsement to the commander when a waiver is requested and provide the necessary justifications. If it is determined that repair is not desired, endorse the memorandum back to the maintenance branch indicating that disposal action is desired.

(4) The commander will endorse the memorandum back through the user (requester) to maintenance indicating approval or disapproval.

(5) Upon receipt of an approved waiver, the maintenance activity will initiate an unscheduled work order with action code WA.

(6) The PBO will arrange for proper disposal if a waiver has not been approved.

4-13. Waiver file

Establish and maintain a waiver file in the Medical Maintenance Branch.

a. The file will contain the original of the waivers authorizing the MEL to be exceeded.

b. Destroy the file copy of the waiver when the PBO disposes of the equipment item.

Section IV. Life Expectancy

4-14. Life expectancy of medical equipment

a. The life expectancy classifications for medical materiel are indefinite life, definite life, and exempt materiel. TB MED 7 defines these classifications.

MAINTENANCE REQUEST
For use of this form, see DA PAM 738-750 and 738-751; the proponent agency is DCSLOG

PAGE NO | NO OF PAGES | REQUIREMENT CONTROL SYMBOL CSGLD-1047(R1)

SECTION I - CUSTOMER DATA

1a. UIC CUSTOMER: W03H45
1b. CUSTOMER UNIT NAME: Dental Clinic 1
1c. PHONE NO: x 7377
2a. SAMS-2 UIC/SAMS-I/TDA: W03H51
2b. UTILIZATION CODE: ON
2c. MCSR:

SECTION II - MAINTENANCE ACTIVITY DATA

3a. WORK ORDER NUMBER (WON): 709911039 9
3b. SHOP: Dental
3c. PHONE NO: x 7361
4a. UIC SUPPORT UNIT: W03H11
4b. SUPPORT UNIT NAME: Medical Maintenance Branch

SECTION III - EQUIPMENT DATA

5. TYPE MNT REQ CODE: TI
6. ID:
7. NSN: 652013-11 7-3443
8. MODEL: 660
9. NOUN: Ultrasonic Unit
10a. ORG WON/DOC NO:
10b. EIC:
11. SERIAL NUMBER: 6143 2
12. QTY: 1
13. PD:
14. MALFUNCTION DESCRIPTION (for DSU, GSU/AVIM, DEPOT use):
15a. FAILURE DETECTED DURING/WHEN DISCOVERED CODE (Enter code) See DA Pamphlets 738-750 and 738-751:
15b. FIRST INDICATION OF TROUBLE/HOW RECOGNIZED CODE (Enter Code) See DA Pamphlets 738-750 and 738-751:
16. MILES/KILOMETERS/HOURS/ROUNDS: M | K | H | R
17. PROJECT CODE (if assigned):
18. ACCOUNT PROCESSING CODE:
19. IN WARRANTY? (enter Y or N):
20. ADMIN NO:
21. REIMBURSABLE CUSTOMER (if intransit customer enter Y or N):
22. LEVEL OF WORK:
23. SIGNATURE:

24. DESCRIBE DEFICIENCIES OR SYMPTOMS ON THE BASIS OF COMPLETE CHECKOUT AND DIAGNOSTIC PROCEDURES IN EQUIPMENT TM (Do not prescribe repairs): No water from handpiece MEL - $150.75

25. REMARKS: Supply condition code H

26. TECHNICAL REFERENCES: Estimated repair costs - $162.00 $102.00 (parts list) + $60.00 (labor)

SECTION IV - TASK REQUIREMENTS DATA

27a. FILE INPUT ACT CD	27b. TASK NO	27c. ACT CODE	27d. TASK DESCRIPTION	27e. QTY TO BE RPR	27f. WORK CENTER	27g. FAILURE CODE	27h. MH PROJ	27i. MH EXP

SAMPLE

SECTION V - PART REQUIREMENTS

28a. FILE INPUT ACT CD	28b. TASK NO	28c. ID NO	28d. NSN OR PART NUMBER	28e. SFX CD	28f. QTY RQD	28g. QTY ISSUED	28h. NMCS CD	28i. FAILURE CODE	28j. STORAGE LOCATION	28k. INITIALS	28l. COST $

28m. TOTAL MANHOURS: 0.5
28n. TOTAL MANHOURS COSTS $: 100.00
28o. TOTAL PARTS COSTS $: 0.0

SECTION VI - COMPLETION DATA

29. QTY RPR:
30. QTY CONDEMN:
31. QTY NRTS:
32. EVAC WON:
33. EVAC UNIT NAME:

John Doe
CW2, USA
C, Medical Maint. Branch

SECTION VII - ACTION SIGNATURES

34a. SUBMITTED BY:
35a. ACCEPTED BY:
35c. DATE:
36a. WORK STARTED BY:
37a. INSPECTED BY:
38a. PICKED UP BY: Branch

34b. DATE	35b. STATUS	35d. TIME	36b. STATUS	36c. DATE	36d. TIME	37b. STATUS	37c. DATE	37d. TIME	38b. STATUS	38c. DATE	38d. TIME

DA FORM 2407, JUL 94 CONTROL COPY 3

Figure 4-2. Sample maintenance request depicting equipment coded H

S:

OFFICE SYMBOL DATE:

MEMORANDUM FOR (APPLICABLE HR HOLDER)

SUBJECT: Uneconomically repairable equipment, Nomenclature, ADMIN Number

1. Equipment identified on the attached maintenance request (End 1), and maintenance record (End 2) is not economically repairable and should be disposed of for the reason indicated below:

[ ] Repair will exceed the maintenance expenditure limit (MEL).
MEL = $_____
Estimated cost of repair = $_____

[ ] Equipment is declared professionally undesirable.

[ ] Equipment is considered hazardous for use on human patients.

2. If it is determined that this item is critical, with no replacement capability available, and must be repaired, endorse this memorandum to the (Commander/DOL/C,Log), providing justification as to why the item should be repaired.

3. The commander, or the commander's designated representative (DOL) if designated in writing, must authorize the expenditure of resources to maintain uneconomically reparable equipment.

2 Encls

SIGNATURE BLOCK
OF THE SENIOR
MAINTENANCE MANAGER

Figure 4-3. Uneconomically reparable equipment disposition memo.

b. TB MED 7, appendix B, lists life expectancies for medical equipment with a definite life. The predetermined life expectancy in years is based on an average normal usage.

c. The life expectancy for medical equipment begins on the date the item is placed in service at the unit. All medical equipment is considered in service when the item is ready for use in the care and treatment of patients.

CHAPTER 5

Scheduled Services

Section I. General

5-1. Policy

a. In garrison, the performance of scheduled preventive maintenance services on medical equipment will take priority over routine repairs.

b. When deployed in an AO/TO (combat operations), repair of non-mission capable lifesaving equipment will take priority.

(1) Scheduled preventive maintenance services will be completed as the mission and time permits.

(2) Assistance should be requested from the supporting MEDLOG activity when maintenance requirements exceed manpower capability.

c. Scheduled services for medical equipment include preventive maintenance (PM), electrical safety (ST), and calibration/verification/certification (CVC).

5-2. Performance standards

The performance objective for scheduled preventive maintenance service is to complete 100 percent of those services scheduled during each maintenance period. Minimum acceptable performance levels are:

a. PMCS - 95 percent.

b. CVC - 95 percent.

c. Electrical safety - 95 percent.

5-3. Automated medical maintenance documentation

a. The authorized STAMIS must be accessed in order to automatically generate requirements for the performance of scheduled services.

(1) Schedules for services are contingent on the base date and maintenance interval the maintenance activity keys into the database.

(2) A Monthly Scheduled Services Work Order Listing is generated during the monthly performance report cycle (usually the 15th) of the month prior to the scheduled month.

(3) Record the completion of scheduled services using the generated monthly scheduled work order (listing).

(4) Maintenance managers should adhere to the generated schedule for performing scheduled services.

b. Maintenance managers must ensure that scheduled services are completed in a timely manner and entered into the automated database.

(1) Minimal repair requirements (approximately 15 minutes) discovered during scheduled services deemed necessary to ensure the equipment is 100% FMC will be completed as part of the scheduled service.

(2) The scheduled service work order listing completed by the MER and signed by the hand receipt holder of the activity serviced will maintained on file until superseded.

c. Provide a copy of the Monthly Scheduled Service Work Order Listing to the hand receipt holders to ensure they have their equipment readily available when the maintenance personnel arrive.

(1) Give the hand receipt holder a copy of the completed Monthly Scheduled Work Order Listing. These listings document the completion of scheduled services or the maintenance managers written explanations for nonperformance. The hand receipt holder should retain their copy for 1 year or until provided with an update by Medical Maintenance Branch.

(2) The hand receipt holder will sign the maintenance copy acknowledging the MER's performance of the scheduled services. This acknowledges equipment not located or equipment requiring repairs.

Section II. Preventive Maintenance Checks and Services

5-4. Frequency

Initially inspect all medical equipment prior to use (pre-issue inspection/TI). Medical equipment should then receive a PMCS at a minimum semiannually. In the event the manufacturer’s literature specifies a more stringent maintenance criterion, use the more stringent criterion.

5-5. Equipment operator preventive maintenance checks and services

a. An effective operator maintenance program is critical to a successful unit level maintenance program.

b. Equipment operators must be trained and proficient on all equipment for which they are responsible. Operators must be:

(1) Capable of performing before, during, and after operation PMCS requirements;

(2) Familiar with all accessories and expendables used during the operation of the equipment. Defective accessories should be identified during operator maintenance services.

c. The unit training program should include an operator level training requirement to ensure operators are proficient in the operator check out procedures and operation of the equipment. Local procedures will determine who provides this training.

5-6. Repairer preventive maintenance checks and services

a. Medical equipment repairers will perform equipment services in accordance with the manufacturer's literature, USAMMA published technical manuals and maintenance allocation charts, and the guidelines of appendix K this publication.

b. Maintenance services should be performed with the components and accessories designated to the item being serviced.

Section III. Calibration/Verification/Certification

5-7. General

a. CVC services are defined as the comparison of a medical system or medical device of unverified accuracy to a measurement system or device of known accuracy to detect, and correct if necessary, any deviations from required performance specifications of the medical system or medical device. This comparison may be accomplished using one or more of the following measuring systems:

(1) An instrument or device, the accuracy of which is directly traceable back to the National Institute of Standards and Technology (NIST). This would include all authorized TMDE with a valid calibration.

(a) All TMDE used to calibrate or service medical equipment will have a DA Label 80 or manufacturer's label certifying the last time the TMDE calibration was certified and when it is due again.

(b) TMDE which has exceeded its calibration interval or for which a calibration interval cannot be verified will not be used to calibrate medical equipment.

(2) A natural physical constant such as the oxygen content of air at normal pressure and temperature.

(3) Other material with known performance characteristics. An example is oxygen of 100 percent purity.

b. The CVC services on medical equipment will be IAW Federal requirements, manufacturer's recommendations, and other applicable guidance. At a minimum, maintenance activities will include the medical equipment listed at appendix H for CVC services.

c. Review the manufacturer's literature for the requirement to perform CVC services. When so indicated, annotate the applicable STAMIS record and schedule the item for service.

d. The CVC services, except those services restricted to designated general support (GS) units, will normally be performed as unit maintenance.

e. Affix a DD Form 2163 (Medical Equipment Verification/Certification) to the calibrated equipment upon completion of CVC services. TB 38-750-2 contains instructions for the use and completion of DD Form 2163.

f. Schedule CVC services IAW the MAC or manufacturer's recommendation. The minimum interval for calibration schedules is annually.

5-8. Defibrillators

a. Evaluate and performance test defibrillators semiannually using a defibrillator analyzer.

b. Use DA Form 5624-R (DC Defibrillator Inspection Record) located in TB 38-750-2 to record the results of the evaluations. Maintain the completed form on file for 6 months pending the next CVC service or until superseded.

c. Affix a DA Label 175 (Defibrillator Energy Output Certification) to the defibrillator upon completion of the CVC. A DD Form 2163 is not required.

5-9. X-ray equipment

Chapter 6 of this bulletin describes the calibration requirements for diagnostic x-ray systems.

Section IV. Electrical Safety

5-10. General

a. Make a continued effort to provide an electrically safe environment within the medical unit.

b. Establish an electrical safety program in accordance with AR 40-61, NFPA 99, and this bulletin.

(1) After the initial testing, test medical equipment intended or likely to come into contact with a patient semiannually. Test all other medical equipment annually.

(2) The STAMIS entries documenting the completion of an electrical safety test are sufficient documentation for equipment that passes safety testing.

(3) Do not use commercially procured labels, stickers, or forms to document or record the performance of safety tests. Use only those forms listed in TB 38-750-2.

c. When any item or system is fails an electrical safety test, the following actions are required:

(1) Complete a medical equipment electrical safety sheet (DA Form 5621-R or DA Form 5622-R) as appropriate. See TB 38-750-2 for form use.

(2) Affix a DD Form 1577 (Unserviceable (Condemned) TAG - Materiel) to the equipment noting the safety defect. Do not remove the tag until the defect has been corrected.

(3) Notify the user/hand receipt holder of the potential hazard.

(4) Initiate a repair maintenance request to correct the defect. Upon completion of the repair, attach a copy of the completed maintenance request to the appropriate DA Form (see paragraph 5-10c(1) above). Maintain these forms in the maintenance section for 1 year.

(5) When the safety defect has been corrected, initiate an unscheduled safety work order to document the passing of the safety test on the item's maintenance record.

CHAPTER 6

Management and Control of Diagnostic X-Ray

6-1. Calibration/verification/certification requirements

a. Calibrate x-ray systems at the frequency specified by the manufacturer. Use a frequency of annual if the manufacturer does not specify an interval.

b. X-ray systems will be calibrated/verified IAW the manufacturer's specifications.

c. Only MERs will accomplish x-ray equipment calibrations. They will be knowledgeable of the specific requirements of the Radiation Control for Health and Safety Act.

d. Invasive or noninvasive type TMDE may be used to perform x-ray CVC.

6-2. Calibration/verification/certification records requirements for diagnostic x-ray systems

a. Use DD Form 2164 (X-Ray Verification/Certification Worksheet) to record the results of CVC for all x-ray equipment, including computer tomography (CT).

b. Complete DD Form 2164 IAW TB 38-750-2 and the following:

(1) A separate sheet of paper will be attached to the DD Form 2164 to indicate the manufacturer, model, serial number, and date of calibration expiration of all items of TMDE used to perform the CVC.

(2) Maintain the completed DD Form 2164 in the RPPF for 1 year pending completion of the next x-ray calibration.

c. When performed by a contractor, file the contractor's calibration worksheet (which specifies actual services performed) and associated service report in the x-ray RPPF for 1 year pending completion of the next x-ray calibration.

d. Individuals performing the CVC service, whether contractor or DA personnel, will complete the DD Form 2163 and display it prominently on the system.

CHAPTER 7

Technical Inspection For Issue

Section I. General

7-1. Purpose
This chapter provides guidance required for compliance with AR 40-61, AR 750-1, AR 725-50, TB MED 7, and discusses performing technical inspections (TIs) for issue.

7-2. Objectives
The overall objectives of condition coding are to ensure that units receive equipment that is either serviceable or reparable.

7-3. Implementation
Maintenance managers will take immediate action to implement the contents of this chapter into shop procedures. All MERs perform TIs and classification of medical equipment; therefore, the requirement exists that each MER have a thorough understanding of this directive.

Section II. Technical Inspections

7-4. General
Medical equipment must be fully mission capable (FMC), with all necessary components and accessories prior to being issued to the patient care provider/hand receipt holder.

7-5. Pre-issue technical inspection
a. Only MERs (68A & 670A) will perform a TI on medical equipment.
b. Perform a pre-issue inspection (TIs) of all medical equipment before acceptance and issue into the healthcare delivery system per the requirements of AR 40-61. Figure 7-1, this bulletin, provides a flow chart for accomplishing the inspection.
c. MERs will perform a TI of all new medical equipment to ensure the equipment is operational and safe prior to patient use.
d. Perform a TI on medical equipment, either new or returned from depot/commercial activities, before being issued to the using activity.
e. Inspect equipment for:
(1) Appearance (external damage).
(2) Completeness (accessories, manufacturer's literature, etc.)
(3) Internal condition (damage, leaks, broken parts, etc.).
(4) Proper performance.
(5) Compliance with provisions of the contract under which the item was requested.
f. Consider having the hand receipt holder pick up new equipment directly from the medical maintenance activity. The PBO must have completed all receipt procedures and ensured accountability before pick up.

7-6. Inspection standards
a. Medical equipment must meet the equipment manufacturer’s serviceability and performance standards to be suitable for patient care and use. The manufacturer's literature and published technical manuals will be used by the medical equipment repairer when performing a TI for condition coding/repair eligibility.
b. Annotate the inspection on one of the following forms when performing a TI:
(1) DA Form 2404 (Equipment Inspection and Maintenance Worksheet).
(2) DA Form 2407 (Maintenance Request) or automated sheet.

7-7. Categories of inspection
a. Appendix K contains a generic checklist for each category. These checklists are intended to be a guide and may vary depending on type and manufacturer of the equipment as determined by the TI.
b. Use the appropriate category of inspection when performing a TI of medical equipment.
(1) Category A - All items.
(2) Category B - Hydraulic/mechanical.
(3) Category C - Positive/negative pressure.
(4) Category D - Heating/cooling/mixing.
(5) Category E - Electrical/electronic.
(6) Category F - Electric motors.
c. More than one category may be used during the TI of an item or system.

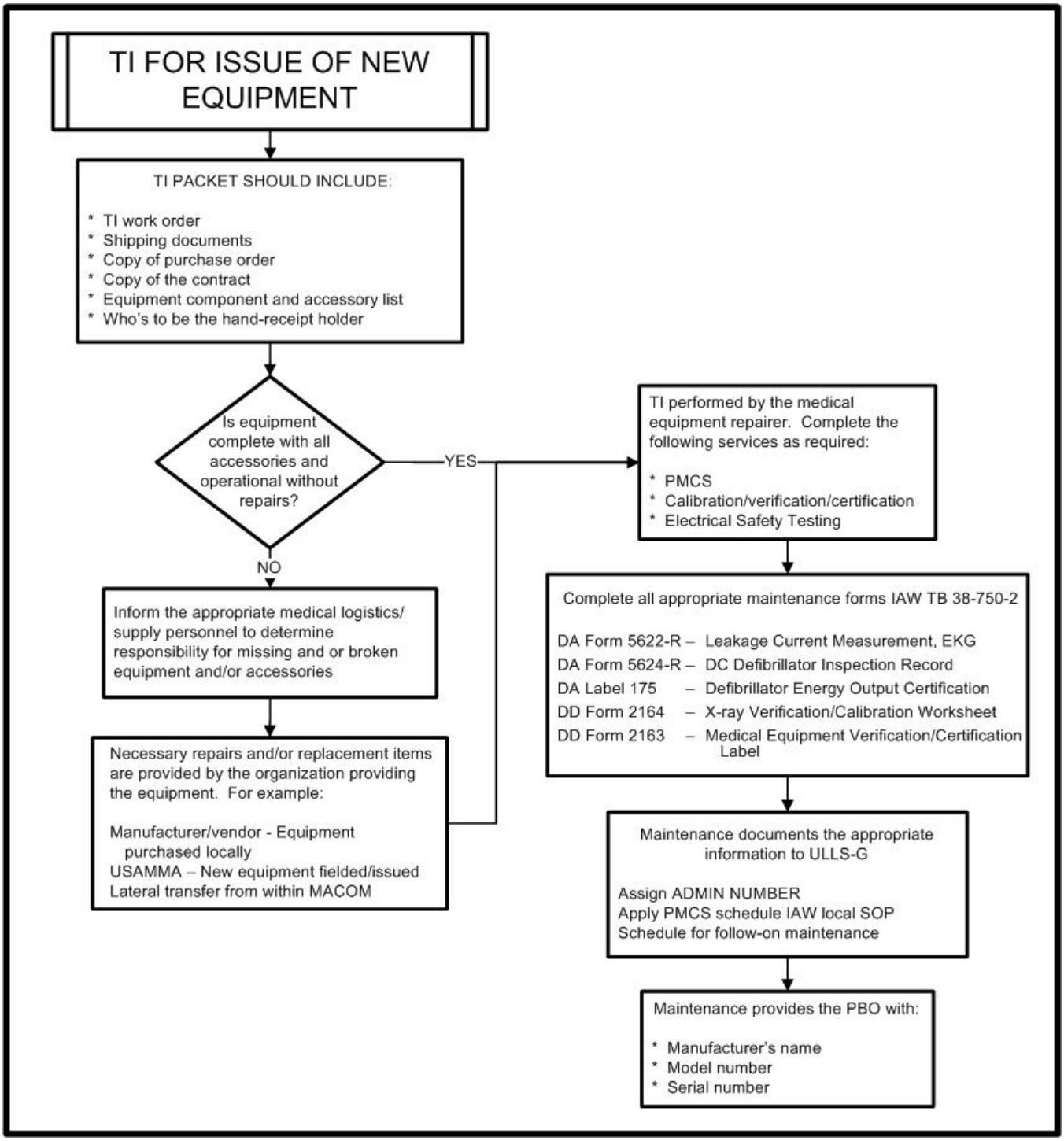

Figure 7-1. New equipment issue flow chart.

CHAPTER 8

Technical Inspection for Turn-In or Transfer

Section I. General

8-1. Purpose
This chapter provides guidance required for compliance with AR 750-1, AR 725-50, and TB MED 7, and discusses:
a. Performing Technical Inspection (TI) for turn-in or transfer;
b. Using proper condition coding procedures; and
c. Disposing of hazardous excess medical equipment.

8-2. Objectives
The overall objectives of condition coding are to:
a. Preserve the integrity of the lateral transfer redistribution system and ensure that units receive equipment as originally coded;
b. Ensure serviceability or reparability of an item removed from service by one user for re-entry into the supply system;
c. Prevent the wasteful movement of unserviceable medical equipment;
d. Standardize coding procedures; and
e. Ensure proper coding of equipment sent to the DRMO or the USAMRMC cannibalization point.

8-3. Implementation
Maintenance managers will take immediate action to implement the contents of this chapter into shop procedures. All MERs perform TIs and classification of medical equipment; therefore, the requirement exists that each MER have a thorough understanding of this directive.

Section II. Technical Inspections

8-4. General
Standardized coding procedures must be followed to ensure condition coding of medical equipment is accurately annotated and only quality equipment is retained for medical use and patient care.
a. Only technically qualified MERs (68A or 670A) will perform a TI on medical equipment.
b. The TI is used to:
(1) Determine the extent of maintenance effort and resources required to make the item fully mission capable.
(2) Classify the item as either economically or uneconomically reparable.
(3) Prevent the loss of equipment solely on the basis of age.
c. All excess medical equipment, regardless of turn-in destination, requires a TI prior to disposition. Figure 8-1 provides a flow chart for conducting TIs of excess equipment.

8-5. Technical inspection procedures
a. Ensure the equipment operator/user has decontaminated the equipment, i.e., removed of all chemicals and potentially infectious substances.
b. Visually inspect and operationally test equipment needing repair or overhaul to the extent possible as part of the inspection evaluation.
c. Make the greatest use of diagnostic techniques and available test equipment to isolate defective parts. Do not unreasonably disassemble equipment just to check serviceability of parts, components, or assemblies.
d. Inspect equipment for:
(1) Appearance (external damage).
(2) Completeness
(3) Internal condition (damage, leaks, broken parts, etc.).
(4) Proper performance.

Section III. Serviceability Inspection Checklist

8-6. Inspection standards
a. Medical equipment must meet the equipment manufacturer’s serviceability and performance standards to be suitable for patient care and use. The manufacturer's literature and published technical manuals will be used by the medical equipment repairer when performing a TI for condition coding/repair eligibility.
b. Annotate the inspection on one of the following manual forms or the ULLS-G automated form when performing a TI:
(1) DA Form 2404 (Equipment Inspection and Maintenance Worksheet).
(2) DA Form 2407 (Maintenance Request) or automated sheet.

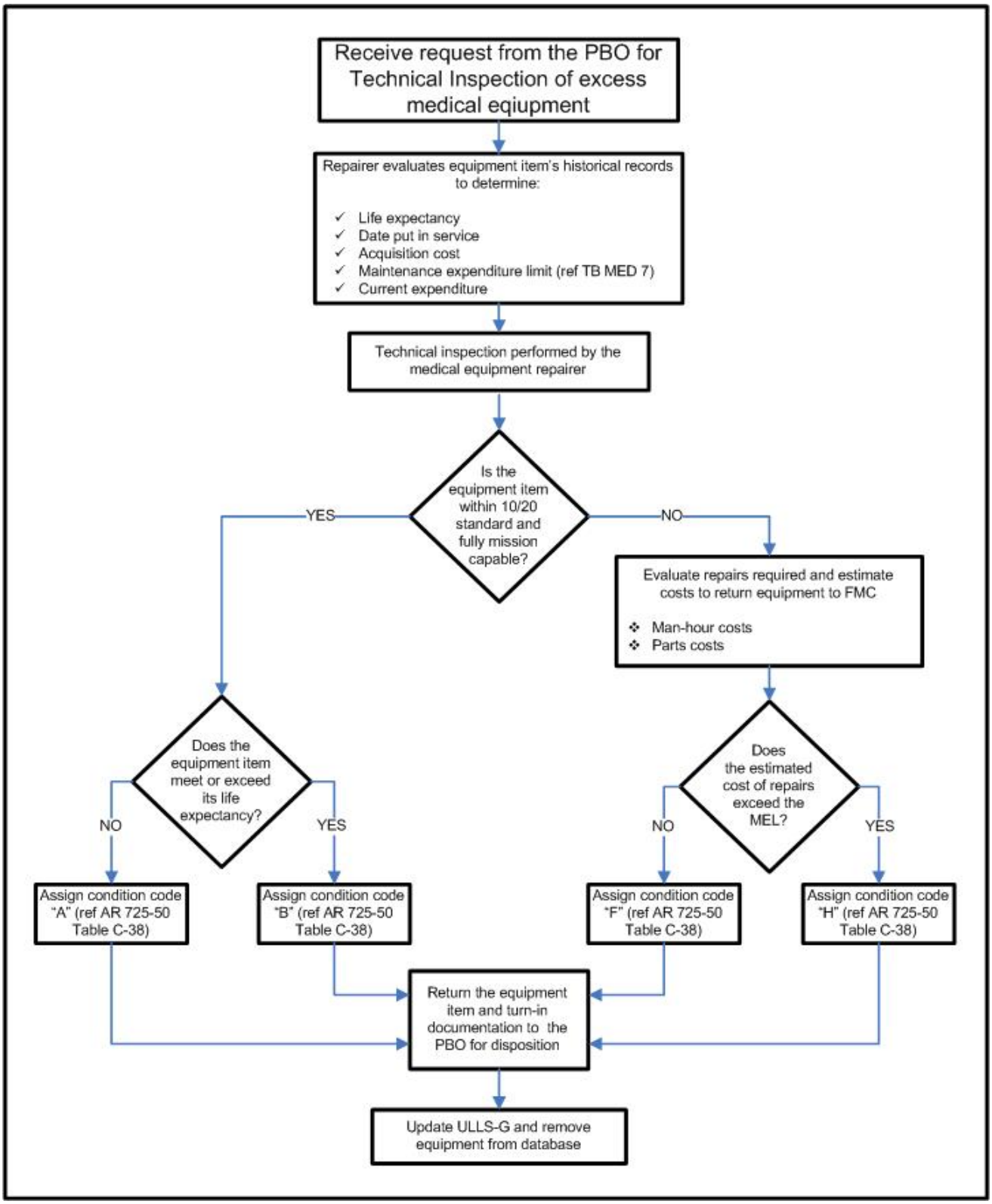

Figure 8-1. Equipment turn-in flow chart.

8-7. Categories of inspection

a. Use the appropriate inspection criteria, IAW Appendix K, based on the different categories of equipment that apply when performing a TI of medical equipment.

(1)Category A - All items.
(2)Category B - Hydraulic/mechanical.
(3)Category C - Positive/negative pressure.
(4)Category D - Heating/cooling/mixing.
(5)Category E - Electrical/electronic.
(6)Category F - Electric motors.

b. The checklist identified in Appendix K is generic for each category and may vary depending on manufacturer and type of the equipment.

c. One or more of the categories may be applicable to an item or system.

Section IV. Condition Coding Medical Equipment

8-8. Supply condition code

a. Supply condition codes are one position, composed of an alphabetic character, and used to classify materiel. They identify the degree of serviceability, condition, and completeness in terms of readiness for issue and use, or to identify actions underway to change the status of materiel.

b. Medical maintenance activities are responsible for assigning the supply condition code.

c. Use the following supply condition codes when assigning condition codes to medical equipment:

(1)A - Serviceable medical equipment with life remaining in excess of 6 months.

(2)B - Serviceable medical equipment with less than 6 months life expectancy remaining, or has reached or exceeded its life expectancy.

(3)F - Unserviceable, economically reparable medical equipment.

(4)H - Unserviceable, uneconomically reparable medical equipment that does not meet the criteria to justify repair; i.e., exceeding the MEL. Equipment for which repair parts are no longer available qualifies for assignment of this condition code (check with USAMMA's cannibalization point, Hill AFB, to determine if parts may be available).

8-9. Condition coding requirements

a. The organization's MTOE authorization quantity changes, making equipment excess.

b. During a new equipment fielding, when medical equipment items are replaced or modernized.

8-10. Responsibility for requesting condition coding

a. The PBO is responsible for submitting maintenance requests to the medical maintenance activity when it becomes necessary to condition code excess medical equipment.

b. If the unit receives disposition that directs the equipment be disposed of through the DRMO, the request will state, "Request TI for Disposal to DRMO". Recoding is not required if the item was originally condition coded within 120 days from the date of the item is being disposed of through DRMO.

8-11. Accuracy and assignment of proper condition codes

a. Condition coding must be accurate to ensure proper disposition of equipment. Improper coding may result in disposal of economically reparable equipment or incur unnecessary costs for transportation, storage, and handling of items that should have been disposed of through DRMO.

b. The assignment of a true and factual supply condition code for items turned in to DRMO will ensure the highest net return to the Government for items sold.

c. To assist in preventing the assignment of the wrong condition code, refer to the MEL factor graph and factor computation located in TB MED 7. Chapter 4, section II, of this TB further discusses maintenance expenditure limits.

d. The senior maintenance manager assigned to the medical unit will review, verify, and authenticate all condition codes being assigned by placing his or her signature on the maintenance request.

8-12. Recoding of medical materiel

a. Recode equipment when the assigned condition code is older than 120 days, regardless of the equipment's destination.

b. Recode equipment when the equipment is not available for shipment in the condition originally reported.

8-13. X-ray equipment disposal

X-ray equipment will be disposed of as directed by USAMMA guidance.

a. Contact the USAMMA MMOD responsible for regional support to your location.

b. The MMOD Tracy, CA, 209-839-4556, is USAMMA's Center of Excellence (COE) for medical imaging equipment.

CHAPTER 9

Repair Parts, Tool Control, and Test, Measurement, and Diagnostic Equipment (TMDE)

Section I. Repair Parts Management

9-1. Medical equipment parts requisitions

a. Medical maintenance activities (MMA) will requisition repair parts through their unit medical supply section. Requests for repair parts will be in accordance with the unit's standard operating procedures for manual or automated processes.

b. MMAs will maintain a document register; automated when available or manual (DA Form 2064) for all repair parts requisitions. A document register is used to:

(1) Assist in accurately tracking the status of requisitions;

(2) Anticipate annual budget requirements for repair parts.

c. The document register will be maintained IAW DA PAM 710-2-1.

9-2. Medical repair parts inventory management

a. Commanders may authorize a limited stock of expendable repair parts and supplies to ensure speedy accomplishment of the medical maintenance mission.

(1) Units that are authorized medical equipment repairers, tools, and test equipment to perform maintenance normally maintain a nominal inventory of parts (Prescribed Load List (PLL)).

(2) Units that regularly support other units without maintenance capabilities will include the supported unit's equipment in their parts PLL stockage computations.

b. Manage all repair parts IAW the guidance provided in this bulletin AR 40-61, AR 710-2, DA Pam 710-2-1, this bulletin, and local procedures.

c. Medical maintenance activities are authorized four types of maintenance related supplies:

(1) Demand supported (DS);

(2) Bench stock (BS);

(3) Mission essential (ME);

(4) Minimum order (MO).

d. Annotate repair parts used in the course of completing a repair on the associated work order.

e. Annotate repair parts used when performing scheduled services (e.g., filters) on DA Form 2404 or automated maintenance capability. These parts are not bench stock and are usually unique to an end item of medical equipment.

9-3. Demand supported

a. Selection of items for stockage is based on three demands within a control period (CP). Control periods are 180 days for Active Army and 360 days for ARNG and the USAR.

b. At least one demand must have occurred within subsequent control periods to retain a repair part on stock after initial stockage.

c. When sufficient demands accrue to qualify a part for stockage, calculate the requisitioning objective (RO) and reorder point (ROP) using procedures identified in DA Pam 710-2-1.

d. Inventories and records of the medical PLL parts must be reviewed every 180 days (USAR and ARNG: 360 days).

(1) The review includes an inventory of the PLL parts on hand.

(2) Perform the review and inventory as follows:

(a) Compare the storage location of each item with the location listed and correct any differences.

(b) Count all items listed and change the balance on hand if necessary.

e. The MTF commander or his or her designee approves and signs the shop stock inventory and authorization listing annually. Maintain the approved listing in the maintenance shop until superseded. The approved listing is the authorization for stockage of repair parts.

9-4. Bench stock

a. Bench stock is low cost, high use items used by maintenance personnel at an irregular rate.

(1) Bench stock includes items such as common hardware (nuts, bolts, washers), wire, tubing, hose, rope, webbing, thread, sandpaper, gasket material, sheet metal, seals, oil, grease, and repair kits.

(2) Class VIII repair parts kits are considered bench stock when they are purchased using one ordering catalog number and purchased as an advertised kit. An accumulation of repair parts developed by the maintenance activity is not considered a repair kit.

(3) Bench stock does not include repair parts unique to an end item of equipment, with the exception of those parts that may be in a repair parts kit.

b. Bench stock will not exceed a 30-day supply. Stock those items issued in standard packs that exceed a 30-day supply and reduce through attrition.

c. Manage and account for bench stock in accordance with DA PAM 710-2-1 and the authorized STAMIS.

d. Account for bench stock parts on individual work requests to provide an audit trail.

(1) Identify bench stock parts, used in the completion of a work order, as bench stock on the work order (except common hardware and bulk materiel like nuts, bolts, etc.).

(2) Annotate the parts cost column of the work order with N/C to indicate No Charge. No costs entry is required on the authorized STAMIS or manual maintenance record for bench stock.

e. The maintenance officer reviews, approves, and signs the authorized STAMIS automated bench stock listing semiannually. This becomes the medical maintenance activity's authorization to maintain bench stock items.

9-5. Mission essential repair parts

a. Mission essential repair parts (MERP) are repair parts unique to an equipment item, essential to the medical maintenance mission, and do not qualify for shop stock. The MERP are required to:

(1) Ensure the functioning of life saving equipment.

(2) Support equipment for which the manufacturer will no longer supply parts.

(3) Support new equipment until demand data can be established.

b. Parts requiring periodic replacement during the performance of scheduled services qualify as MERP. These parts are usually identified in the –20 manual, MAC, and manufacturer's literature as requiring replacement on a time or usage schedule.

c. Maintenance managers are responsible for using discretion in the selection of those items deemed mission essential. Although many parts may be purchased locally and available within a short time span while in garrison, consideration should be given to the availability of these items on the battlefield.

d. Keep quantities of individual MERPs to a minimum, normally enough to support 10 percent of a medical equipment items in the supported inventory. Enter this minimum quantity as the operating level into the appropriate STAMIS or manual procedures.

e. Review and inventory MERPs every 180 days. Document the completion of inventories using the appropriate STAMIS or manual procedures.

f. The commander, or his or her designee, approves and signs the appropriate STAMIS automated MERPs listing annually. Maintain the approved listing in the maintenance shop until superseded.

9-6. Minimum order (MO)

a. MO quantities are those which are in excess of the stockage objective or are not demand supported.

b. Repair parts issued in unit pack quantities, or purchased as a result of MO requirement, are authorized to be retained in shop stock and reduced through attrition.

c. Indicate the MO and the minimum dollar order required from the vendor (e.g., MO $100.00) on the expendable repair parts master record.

d. Document MO repair parts that do not qualify for DS, ME, or BS by using a repair parts management code of MO.

9-7. Operator replacement items

a. It is the responsibility of the equipment operator/hand receipt holder (wards, clinics, etc.) to requisition operator replacement items and accessories, and not a responsibility of the supporting maintenance activity.

b. DA Pam 710-2-1 states that expendable supplies and repair parts issued to medical equipment maintenance shops are maintained only to support the maintenance activity. The primary purpose of these stocks is to give quick supply response to the repairer and to avoid repair delays. Shop stocks are only for internal shop support and are not a supply source for the maintenance activity customers.

c. The following are examples of operator replacement items:

(1) Transducers.

(2) Patient leads.

(3) Batteries accessible to the operator.

(4) Oxygen fuel cells accessible to the operator.

(5) Light bulbs.

9-8. Turn-in of expendable and durable supplies

a. Turn in excess serviceable expendable and durable supplies to the unit S-4 within 10 days of the shop stock review. DA Pam 710-2-1 contains turn-in procedures. The Army Master Data File reflects RCC Codes for recoverable repair parts.

b. Primary batteries requiring special handling and disposal are treated as recoverable items but not necessarily reparable and are identified with a recoverability code (RCC) of A.

(1) Dispose of batteries with a RCC of A through the local DRMO. Army SB 11-6 and Army SB 11-30 contain specific guidance on disposal. Accomplish coordination for turn-in to DRMO through the SSA.

(2) Batteries containing hazardous materials, such as lithium and mercury are classified for disposal purposes as hazardous waste by the Environmental Protection Agency (EPA).

(3) Magnesium batteries have been determined to be non-hazardous solid waste for disposal purposes; however, they are not to be accumulated and disposal must be controlled.

(4) There are other batteries also holding a RCC of A that require special handling and disposal. They are zinc, silver chloride, certain lead acid batteries, and certain nickel cadmium (NICAD) batteries.

Section II. Tool Control

9-10. Tool control procedures

a. MERs will use tools and TMDE authorized in accordance with their unit MTOE.

b.. Hand tools, once issued to the medical maintenance activity, require internal procedures. The procedures identified herein do not eliminate the responsibility of the PBO to properly issue these items IAW AR 710-2.

(1) All tools (Federal supply classes 5110, 5120, 5130, 5133, 5136, 5140, 5180, 5210, 5220, and 5280) with a unit price greater than $5.00 are classified as durable property and will be controlled and responsibility specifically assigned. Reference AR 735-5.

(2) Durable hand tools with a unit of issue containing more than one item (e.g., box, package, dozen, etc.), and the cost of a single item (bx, pg, dz) is less than $5.00, will be treated as an expendable item at the user level, even though coded as durable in the AMDF.

(3) Control durable items that are components of sets, kits, or outfits using hand receipt annexes or component lists. Individual MER tool kits are normally issued by the PBO to the senior maintenance manager. The senior maintenance manager then issues the tool kits by sub-hand receipt to the individual MER using a component hand receipt or a hand receipt annex IAW DA Pam 710-2-1. A tool, shortage annex must be maintained to identify shortages.

(4) Durable items that are not components of sets, kits, or outfits will be controlled using hand receipts and sub-hand receipts IAW DA Pam 710-2-1. Control these items using the tool room procedures described below:

c. Use a log or temporary hand receipt for issuing tools.

(1) Use DA Form 5519-R (Tool Sign Out Log/Register) when a log is determined to be the preferred method. All tools issued on a DA Form 5519-R should be returned at the end of the day. DA Pam 710-2-1 contains instructions for completing the DA Form 5519-R.

(2) Issue tools for longer than 1 day, but less than 30 days, on a temporary hand receipt (DA Form 3161).

(a) One copy of the temporary hand receipt should be filed in a suspense file and one copy will be retained by the recipient of the tool(s).

(b) Issue tools for longer than 30 days on a permanent hand receipt (DA Form 2062, Hand Receipt/Annex Number).

(c) Destroy all copies of the hand receipt when the tools are returned.

9-11. Tool inventory

Inventory all tools on a semiannual basis. Account for lost, damaged, or destroyed non-consumable tools issued through a tool room IAW AR 735-5.

9-12. Tool security

Secure and control hand tools, tool sets, tool kits, and shop equipment according to the physical security standards of AR 190-51.

Section III. Test, Measurement, and Diagnostic Equipment

9-13. General

TMDE are those devices used to evaluate the operational condition of an end item or system, or to identify and/or isolate actual or potential malfunctions.

a. TMDE-Special Purpose (TMDE-SP) is any device, which is unique to particular items or types of equipment. Examples of TMDE-SP are:

(1) Defibrillator Analyzer

(2) Infusion Pump Analyzer

(3) Electrosurgical Apparatus Analyzer

b. TMDE-General Purpose (TMDE-GP) is common TMDE used throughout the Army. Examples of TMDE-GP are:

(1) Multimeter

(2) Oscilloscope

c. Medical equipment that measures, or indicates a physiological parameter is not TMDE.

9-14. TMDE requirements and authorizations

a. Requirements and authorizations for TMDE are controlled in accordance with the unit's MTOE.

b. Exceptions are based on new medical equipment fielded to an organization, for which appropriate TMDE has not yet been documented on the unit's MTOE.

c. A Memorandum of Authorization (MOA) published by the Major Command (MACOM) i.e. FORSCOM, PACOM, EUCOM approving a temporary authorization until the Basis of Issue Plan (BOIP) and documentation are completed is the only authorized exception.

d. Initial issue of authorized TMDE-SP is provided by the materiel developer, USAMMA. For TMDE-GP issues see your unit supply.

9-15. TMDE coordinator

Each unit that is authorized TMDE will designate a TMDE coordinator. The coordinator will act as a central point of contact for all TMDE calibration and repair issues concerning unit organic TMDE. The coordinator

will be responsible and have authority for monitoring the unit TMDE management program. This program will be consistent with AR 750-43, AR 750-1, DA Pam 750-8, and TB 750-25.

9-16. TMDE calibration

a. TMDE used in the repair of medical equipment will be calibrated at the proper intervals. Proper intervals for type classified TMDE calibration are identified in TB 43-180. TMDE not identified in TB 43-180 will be calibrated in accordance with the manufacturer's literature. TMDE not having a current calibration (DA Label 80 or manufacturer's calibration label) will not be used to perform CVC services on medical equipment.

b. TMDE-SP that is type-classified and listed in TB 43-180 with an "f" level indicated in the calibration responsibility column will be calibrated at one of USAMRMC's TMDE-SP calibration sites.

(1) USAMMA has primary responsibility to provide repair and calibration support services for type classified medical TMDE-SP for MTOE units. Units not located in Europe (US, Korea, etc.) will have their TMDE-SP shipped to the following FREIGHT address:

Medical Maintenance Operations Division
Defense Distribution Center, Tracy Site
Building T-255
Tracy, CA 95376-5050
DODAAC: W62SEV

(2) USAMMCE is the designated alternate source to provide repair and calibration support within the European Command (EUCOM) and Central Command (CENTCOM). Units located in the Europe or in an AO/TO supported by Europe will have their TMDE-SP shipped to the following FREIGHT address:

USAMMCE
Huestehoeh Kasern
ATTN: Med Maint (Med Maint)
Building 4136
66953 Pirmasens
(Germany)

(3) The TMDE-SP items shipped must be accompanied by a DA Form 2407 (Maintenance Request) completed as specified in accordance with TB 38-750-2 (Maintenance Management Procedures for Medical Equipment). All TMDE shipped will include appropriate accessories, technical manuals, and/or manufacturer's literature.

c. MEDLOG organizations responsible for providing support operations to maintenance activities deployed to an AO/TO should consider establishment and utilization of a TMDE-SP exchange program. An exchange program in theater will preclude organizations with scarce quantities of TMDE from going extended periods without the appropriate maintenance capacity.

d. TMDE-SP items that are not type classified will be repaired and calibrated in accordance with TB 43-180 or by contractual maintenance support provided by the user/owner.

e. The TMDE Support Coordinator will coordinate with the local Area TMDE Support Team (ATST) or Area Calibration Laboratory (ACL) to receive maintenance and service of TMDE-GP. In the event there is not an ATST or ACL available within the geographical location, coordination may be made with MMOD Tracy to provide maintenance and calibration services of TMDE-GP.

9-17. TMDE calibration documentation

a. All TMDE (GP & SP) will be included in the TMDE Management Information System (TEMIS) database managed and maintained by local ATST or ACL. This automated reporting system assists unit TMDE coordinators with TMDE calibration tracking and scheduling. The report includes the TMDE specifications, as well as, the date last calibrated and the date the next calibration is due.

b. It is the responsibility of the Unit TMDE coordinator to ensure that the results of any maintenance and calibration services performed by an alternate calibration capability are forwarded to the ATST or ACL for proper documentation to the TEMIS database.

Appendix A
References

A-1. Army Regulations

AR 25-30
The Army Integrated Publishing and Printing Program

AR 40-5
Preventive Medicine

AR 40-61
Medical Logistics Policies and Procedures

AR 190-51
Security of Unclassified (Sensitive and Non-sensitive) Army Property

AR 220-1
Unit Status Reporting

AR 310-25
Dictionary of United States Army Terms (Short Title: AD)

AR 385-10
Army Safety Program

AR 700-4
Logistics Assistance Program

AR 700-15
Packaging of Materiel

AR 700-68
Storage and Handling of Compressed Gases and Gas Liquids in Cylinders, and of Cylinders

AR 700-138
Army Logistics Readiness and Sustainability

AR 710-2
Supply Policy Below the Wholesale Level

AR 725-50
Requisitioning, Receipt, and Issue System

AR 735-5
Policies and Procedures for Property Accountability

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

AR 750-10
Army Modification Program

AR 750-43
Army Test, Measurement, and Diagnostic Equipment (TMDE) Program

A-2. Pamphlets

DA Pam 710-2-1
Using Unit Supply System (Manual Procedures)

DA Pam 710-2-2
Supply Support Activity Supply System: Manual Procedures

DA Pam 750-8
The Army Maintenance Management System (TAMMS)

A-3. Technical Bulletins

TB MED 1
Storage, Preservation, Packaging, Packing, Maintenance and Surveillance of Materiel -Medical Activities

TB MED 7
Maintenance Expenditure Limits for Medical Materiel

TB MED 521
Occupational and Environmental Health Management and Control of Diagnostic, Therapeutic, and Medical Research X-Ray Systems and Facilities

TB MED 523
Control of Hazards to Health from Microwave and Radio Frequency Radiation and Ultrasound

TB MED 524
Control of Hazards to Health from Laser Radiation

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

TB 43-180
Calibration and Repair Requirements for the Maintenance of Army Materiel

TB 750-25
Maintenance of Supplies and Equipment: Army Test, Measurement, and Diagnostic Equipment (TMDE) Calibration and Repair Support Program

A-4. Supply Bulletins

SB 8-75 Series
Medical Logistics Supply Bulletins

A-5. Referenced Forms

DA Form 2062
Hand Receipt/Annex Number

DA Form 2064
Document Register for Supply Actions

DA Form 2404
Equipment Inspection and Maintenance Worksheet

DA Form 2406
Materiel Condition Status Report

DA Form 2407
Maintenance Request

DA Form 2715
Unit Status Report

DA Form 3161
Request for Issue or Turn-In

DA Form 3318
Records of Demands - Title Insert

DA Form 5519-R
Tool Sign Out Log/Register

DA Form 5621-R
Leakage Current Measurement, General

DA Form 5622-R
Leakage Current Measurement, EKG

DA Form 5624-R
DC Defibrillator Inspection Record

DA Label 80
U.S. Army Calibrated Instrument

DA Label 175
Defibrillator Energy Output Certification

DD Form 314
Preventive Maintenance Schedule and Record

DD Form 1577
Unserviceable (Condemned) TAG – Materiel

DD Form 1577-2
Unserviceable (Reparable) Tag-Materiel

DD Form 2163
Medical Equipment Verification/Certification

DD Form 2164
X-ray Verification/Certification Worksheet

Appendix B
Medical Equipment Reporting Procedures

B-1. Purpose

a. This appendix summarizes policy and procedures for collecting and reporting the status of the physical condition of Army medical materiel IAW AR 700-138, Army Logistics Readiness and Sustainability.

b. The Materiel Condition Status Report (MCSR) provides commanders with information to analyze and predict equipment readiness and availability and the equipment status of their supported equipment.

c. Unit equipment readiness goals. The Army equipment readiness goal is 90 percent fully mission capable (FMC).

B-2. Reporting requirements

a. LINs listed in AR 700-138, appendix B have been designated mission-essential equipment and systems.

b. IAW AR 700-138, all Active Army and RC units operating equipment listed in its appendix B, will submit materiel condition status reports.

c. Commanders may use the DA Form 2406 for local use. Any items of equipment required for reporting through local commands that are not identified in AR 700-138, appendix B must be reported separately from the required DA Form 2406 entries.

B-3. Frequency of report

a. All Active Army units will make a monthly report on DA Form 2406 covering a 1-month period ending the 15th day of each month.

b. USAR and ARNGUS (including mobilization and training equipment sites (MATES) units will make a quarterly report on DA Form 2406 covering a 3-month period ending 15 January, 15 April, 15 July, and 15 October.

c. All equipment LINs authorized on the MTOE/TDA and/or on-hand on the last day of the report period and on the unit property book that are listed in appendix B will be reported on DA Form 2406.

d. If authorization documents are changed before modernization equipment is available for fielding, commanders will designate equipment on-hand as "in lieu of" the newly required equipment for materiel condition status reporting purpose. The "in lieu of" policy will apply only when the equipment is in lieu of modernization equipment. The "in lieu of" equipment should be listed in SB 700-20, appendix H, as an authorized substitute. If the item is not listed in SB 700-20, it is the unit commander's responsibility to initiate the process to incorporate the "in lieu of" item. In lieu of or substitute equipment will be reported on DA Form 2406, only if it is listed in AR 700-138, appendix B, or has been authorized by HQDA change message.

e. A substitute item is an item authorized for issue instead of or in place of an authorized standard item of like nature and quality. SB 700-20, appendix H, identifies items and procedures for making substitutions.

f. Items that are substitutes (SB 700-20, app H) or in lieu of appendix B items WILL NOT be reported if they are NOT listed in appendix B, or have NOT been authorized reportable by HQDA.

g. Equipment borrowed from another unit will not be reported by the using unit (see paragraph 2-6a, AR 700-138).

h. Equipment on loan is reported by the unit that has the equipment on its property book. When equipment is on loan, the borrowing unit keeps a duplicate DD Form 314 (or automated equivalent). The borrowing unit will give not mission capable supply (NMCS)/not mission capable maintenance (NMCM) data to the owning unit at the end of the report period. The duplicate DD Form 314 goes with the equipment when it is returned to its owner. Both units must ensure that the owner gets the duplicate DD Form 314 when the loan is completed. (See DA Pam 750-8 for DD Form 314 instructions.)

i. Assets at mobilization and training equipment sites (MATES), unit training equipment sites (UTES), or equipment concentration sites (ECS) are not loaned equipment. The MATES keeps the DD Form 314 for ARNG units. Only the owning USAR or ARNG unit will report this equipment.

j. Equipment on a DA Form 2407 (Maintenance Request) or DA FORM 5990-E (Maintenance Request) at a support unit/activity is reported NMC only if it has an NMC fault. It is counted FMC when the support unit/activity notifies the owning unit that the equipment has been repaired and is awaiting pick-up.

k. Equipment that is in a depot or at a depot level repair organization for repair or overhaul and return stays on the unit's property book. That equipment will be reported as NMC for support maintenance.

l. List equipment on the DA Form 2406 in LIN order.

m. When only one model is on-hand under a LIN, use one line in columns 9a through 9f to report it. If two or more models are on-hand for a LIN, use multiple lines. The first line (the authorized line) shows the totals for all models under a LIN. The model field is left blank. Then on separate lines beneath that LIN, show the information for each model. Columns 9a through 9e will show the total for all models authorized for that LIN. Leave the authorized column blank on the model lines (see figure 2-1).

n. For models listed in AR 700-138, appendix B, match the model number exactly. For example, more than one tank has an M1 model number. Each configuration has a slightly different number such as M1IP, M1A1, or M1A2.

o. Units (AA or property book level) that are operating under more than one MTOE/TDA will combine reportable equipment on a single DA Form 2406. Do not submit separate reports for MTOE equipment and TDA equipment under the same UIC and utilization code. If TDA equipment is carried under a UIC that ends in "99", a separate report is required. A separate report is required for each utilization code.

p. The EIC is a three-position equipment code for supply use. The code is put on DA Form 2407 and supply requests for items listed in appendix B. AR 710-2, DA Pam 710-2-1, DA Pam 710-2-2, and AR 725-50 explain when and how to use the codes for supply purposes.
q. Materiel Condition Status Report, DA Form 2406. The following briefly explains the entries required for completing DA Form 2406, Materiel Condition Status Report:

B-4. Medical company 2406 example

a. (Block 1) Period of report. When more than one day is covered, put the Julian date of the first day in the "FROM" space and the last day after "TO". The period of the monthly report is always 28-29-30-31 days. The period of the quarterly report submitted by USAR and ARNG units is always 90-91-92 days.
b. (Block 2) Date Prepared. Enter the Julian date the report is completed.
c. (Block 3) Utilization Code. Put in the Utilization Code from the list below. Use the code or codes for the parent unit making the report.

0--Active Components (except as otherwise listed).
4--Operational Readiness Float (ORF).
7--Army National Guard, except MATES.
8--Army National Guard (MATES).
A--Army Reserve units.
H--U.S. Army Intelligence and Security Command.
K--U.S. Army Training and Doctrine Command.
Q--Service schools.
W--National training centers.
Y--Army War Reserve Prepositioned Sets.

d. (Block 4a) Page number. Put in the page number in sequence.
e. (Block 4b) Number of pages. Put in the total number of the pages in the report. Do not put in this number until the report is done.
f. (Block 5) To: Enter the complete name and address (with APO code) of the parent unit.
g. (Block 6) From: Enter the complete name and address (with APO code) of the parent unit (no higher than battalion) making the report.
h. (Block 7) Unit Identification Code. Must contain the correct six character UIC of the submitting activity (the unit in block 6). This code always begins with a "W."
i. (Block 8) MTOE/TDA no. Should contain the numeric-alpha MTOE or TDA number.
j. Availability status (itemized). Includes columns 9a through 9e. Equipment goes in columns 9a through 9e in LIN order.
k. (Column 9a) Seq. No. Each line is numbered. If only one model is on-hand, a one line entry is needed. When more than one model of the same LIN is or was on-hand during the report period, make a line entry for each model. Use the same basic sequence number with a letter after 1, 1A, lB, etc; the same LIN will be used. Numeric entries must not exceed two digits; entries recorded as 1, 2, and 3 through 9 should be preceded with zeros (for example, 01, 02, 03). The numbers will start with 01 on the first line and will continue in numeric sequence. When alpha characters are added to numeric digits, the sequence must be numeric/alpha (for example, 01, 01A, 01B, 02, 03, 03A).
l. (Column 9b(1)) Noun. May contain an entry, not to exceed eight characters.
m. (Column 9b(2)) EOS code. For those items reported as a system. (Medical equipment has no systems.)
n. (Column 9b(3)) Model. Enter the model number. Leave blank if the line is an authorized line with separate models below it. Use the exact equipment model identification listed in appendix B. Leave blank if on-hand quantity is zero. Note. For models listed in appendix B, match the model numbers exactly.
o. (Column 9c) ECC-LIN. List the ECC and LIN. The ECC is written first, followed by the LIN (app B), but list the equipment in LIN order.
p. (Column 9d(1)) Authorized quantity. The number of items shown in column 9b(1) that are authorized on the unit MTOE/TDA. When more than one line shows models on-hand (numeric/alpha in column 9a), the authorization block for the "on-hand" line is blank. When an item is on-hand, but not authorized, enter a zero in this block.
q. (Column 9d(2)) On-hand quantity. Put in the number on-hand and on the property book as of the "TO" date in block 1. The day you actually got the equipment is considered a day on-hand. The day the equipment is dropped from the property book, it is no longer "on-hand", and it will not be recorded 'on-hand' that day. When an item is authorized, but not on-hand, enter a zero in this block.
Note: The total of the quantities on-hand in the "Issue lines" must equal the on-hand quantity in the related "authorized line" (for example, total of 2A, 2B, and 2C must equal the quantity entered in the on-hand column of line sequence number 2 (authorized line)).
r. (Column 9e(1)) Possible days. Enter the total number of equipment days the equipment was on-hand during the report period. A single item or system on-hand for one day is one equipment day. Only equipment that was on-hand on the last day of the report period is included. You can get the date the item arrived from the property book office. An entry in column 9e(1) must equal the entries in columns 9e(2), 9e(3)(a), and 9e(3)(b). If column 9d(2) on-hand-quantity is zero, enter zero in column 9e(1).
s. (Column 9e(2)) Available days. Enter the total number of days the equipment was FMC. (Available days equal the possible days minus non-available days.) FMC percent = Total available days divided by total possible days x100. The entry in this column must equal the entry in column 9e(1) minus the sum of the entries in columns 9e(3)(a) and 9e(3)(b). If column 9e(1) entry is zero, enter zero in column 9e(2).

t. Column 9e(3), Non-available days. Displays the number of day the equipment was down. The sum available days and non-available days must equal the possible days. If there are no entries in these columns, the entries in columns, Possible Days and Available Days must be equal.

u. (Column 9e(3)(a)) Organizational maintenance. Put in the total number of days the equipment was NMC at (organization) ORG level for supply (NMCS) and maintenance (NMCM) during the report period. This is taken from the DD Form 314.

v. (Column 9e(3)(b)) Support maintenance. Put in the total number of days the equipment was NMC at support level for supply (NMCS) and maintenance
(NMCM) during the report period. This number is taken from the DD Form 314.

w. (Column 9f(1) through 9f(5)). For field use only. These columns are used as a worksheet for the unit status report. Can be used for local management purposes or feeder data for DA Form 2715, Unit Status Report. To understand the header names, see AR 220-1. Data entered in these columns are not required to be forwarded to LOGSA.

x. Reverse side of DA Form 2406. The reverse side of DA Form 2406 (block 10) may be processed using the "R" card format as prescribed in table 2-6. These data are for local management purposes only and are not forwarded to LOGSA.

y. (Block 10) Non-available status (*Itemized*). Complete as needed locally.

z. (Block 11) Remarks. Use as needed to explain any entries on the form. For example, use this block to list: items turned in or issued during the report period, items short, substitute items, etc.

aa. (Block 12a) Signature. Commander or authenticating officer signs here.

ab. (Block 12b) Date. Enter the date the report is signed.

MATERIEL CONDITION STATUS REPORT
For use of this form, see AR 700-138; the proponent agency is ODCSLOG

Requirement Control Symbol
CSGLD-1042(R4)

1. PERIOD OF REPORT	2. DATE PREPARED	3. UTILIZATION CODE	4a. PAGE NO	4b. NO PAGES
FROM 0321 TO 0350	0351	0	1	2

5. TO *(Address including ZIP Code)*
Commander
MAIN SPT BN, LID

6. FROM *(Address including ZIP Code)*
Commander
MED CO, MSB, LID

7. UNIT IDENTIFICATION CODE
WBOFWV

8. TOE NO
08297L00000100

9. AVAILABILITY STATUS *(litemized)*

a SEQ NO.	b. NOMENCLATURE (1) NOUN	(2) EOS	(3) MODEL	c ECC LIN	d. DENSITY (1) AUTH QTY	(2) ON-HAND QTY	e. EQUIPMENT AVAILABILITY (1) POSSIBLE DAYS	(2) AVAILABLE DAYS	(3) NONAVAILABILITY DAYS (a) ORG S	(a) ORG M	(b) SPT S	(b) SPT M	f FOR FIELD USE ONLY (1) REQ QTY	(2) REQ DAYS	(3) FMC	(4) ER	(5) ERC
1	DEF ECG			OE D86072	3	3	90	82	4	4							
1a	DEF ECG		MRL90	OE D86072		1	30	30									
1b	DEF ECG		Lifepack 10	OE D86072		2	60	52	4	4							
2	EDG MACH		All Models	OR E17489	1	1	30	26		1	2	1					
3	OPER UT		2100	OF P19377	1	1	30	30									
4	PRC RD FLM		MM190	OD P63884	1	1	30	30									
5	REF SOL ST		All Models	OJ R64126	5	5	150	144		1		5					
6	STR SUR DR		FX1636	OM S39122	1	1	30	30									
7	XRY AP DTL		D3152	OQ X37050	1	1	30	30									

DA FORM 2406, APR 93 EDITION OF OCT 89 MAY BE USED USAPPC V4.00

Figure B-1. Sample of a completed DA Form 2406.

10. NONAVAILABILITY STATUS *(itemized)*

a. SEQ NO.	b. NOMENCLATURE (1) NOUN	b. NOMENCLATURE (2) MODEL	c REGISTRATION OR SERIAL NO.	d NON-AVAILABILITY REASON	e DATE NON-AVAILABLE	f. DATE ADMITTED TO SHOP (1) ORG	f. DATE ADMITTED TO SHOP (2) MAINTENANCE SUPPORT	g. SUPPORT SHOP JOB OR RON NO AND DODAAC	h. REMARKS NSN OR PART NO
1b	DEF ECG	Lifepack 10	1234567	B	0329	0329		03335102 W77EMS	Pacing Circuit physiocontrol22
2	EDG MACH	All Models	98765-4	D	0333	0333	0334	W88BMS 03330004	Motor Smoking
5	REF SOL ST	All Models	3-665544	D	0331	0331	0332	W88BMS 03320001	Freon Leak

11. REMARKS

12a. VERIFIED BY *(Signature)*

12b. DATE

* NOTE: Indicate reason for nonavailability as follows: **A** - *Modification;* **B** - *Parts;* **C** - *Malfunction;* **D** - *Support maintenance.*

USAPPC V4.00

REVERSE OF DA FORM 2406, APR 93

Figure B-2. Sample of a completed DA Form 2406–Continued.

Appendix C

Maintenance Standing Operating Procedures

C-1. Internal SOP

An internal SOP should address the following areas:

a. The receipt for items to be repaired, processing, repair, and disposition of the equipment, to include work order reconciliation procedures.
b. PMCS.
c. Medical equipment CVC services.
d. Inspection and condition coding of medical equipment.
e. Calibration of TMDE.
f. Medical equipment electrical safety.
g. Medical equipment battery maintenance program.
h. Shop safety to include ionizing and non-ionizing radiation hazards, use of power tools, etc.
i. Repair parts and tool accountability.
j. Quality control and assurance.
k. Recurring reports.
l. Support to satellites.
m. Lockout/tag out.
n. Procedures, responsibilities, and document work flow pertaining to automated reports, to include establishment and maintenance of a database.
o. Infection control (bi-annual review and approval).
p. HAZCOM.
q. Safe Medical Devices Act (SMDA) for reporting equipment incidents.

C-2. External SOP

External SOP should include:

a. How the equipment hand receipt holders acquire maintenance services.
b. Normal operating hours for receiving equipment for repair and picking up equipment which has been repaired.
c. Instructions for completing the work request.

Appendix D
Desk Reference Manuals

D-1. General

a. At a minimum, three desk reference manuals should be considered.
   (1) Repairer's Manual.
   (2) Repair Parts/Tool Room Manual.
   (3) Work Order / Automated Maintenance System Procedures.

b. Desk reference manuals require periodic updating to reflect procedural changes.

D-2. Suggested contents

To illustrate those items to consider for a desk reference manual, the following is a listing that could make up the desk reference manual for the MER:

a. Copy of the shop's SOP.
b. Copy of the local commander's maintenance directive.
c. A listing of wards and clinics:
   (1) Telephone numbers.
   (2) Scheduled services base dates.
   (3) Area maintenance priorities.
   (4) Names of NCOs.
d. An explanation of codes needed when performing a TI on a new item of medical equipment required to complete the local work sheets for AMEDDPAS.
e. Copies of appropriate chapters and appendixes of this bulletin.
f. Civilian procured repairer handbooks that include formulas, conversion factors and tables, electronic symbols, drill and tap sizes, medical terminology, etc.
g. Sample forms the repairer will be expected to complete.
h. A Julian date calendar.
i. Maintenance expenditure limit graph from TB MED 7.
j. A good index so the above items can easily be located by the repairer when needed.

Appendix E
Standard Army Management Information System

E-1. Standard Army Management Information System (STAMIS) for DA TOE medical equipment maintenance activities are:

a. ULLS-G – used for unit level maintenance administration and management.

b. SAMS-1 – used at the MEDLOG activity to roll-up supported organizations into some type of report to be utilized for analysis of the AO/TO.

c. SAMS-E - used for unit level maintenance administration and management, as well as at the MEDLOG activity to roll-up supported organizations. Roll up of supported organizations will enable analysis of the AO/TO maintenance performance and capability.

d. SAMS-2 – used at the MACOM level for reviewing medical equipment maintenance posture, requirements, and shortcomings within Department of the Army MTOE Medical organizations and organizations with medical equipment.

E-2. Maintenance management listings and reports.

a. Use the following automated reports from your ULLS for evaluating medical equipment maintenance posture within your organization.

(1) Monthly Maintenance Performance Report - SDI Report
(2) Scheduled Services Work Order Listing - SDI Report
(3) Scheduled Services Completion Report - SDI Report
(4) Equipment Non-Mission Capable (NMC) Report - SDI Report

b. Use the following automated reports from your SAMS for evaluating medical equipment maintenance posture within your AO/TO.

(1) Consolidated Monthly Maintenance Performance Report - SDI Report
(2) Consolidated Scheduled Services Workorders Listing - SDI Report
(3) Consolidated Scheduled Services Completion Report - SDI Report
(4) Consolidated Equipment Non-Mission Capable (NMC) Report - SDI Report

Appendix F
Safe Medical Devices Act

F-1. Purpose: To promote the safety of patients, visitors, and staff who, for whatever reason, come in contact with the medical facility's environment of care or medical equipment and to comply with Safe Medical Device Act of 1990.

F-2. Policy:

(a) Appropriate corrective action will be taken to protect the safety of all patients, visitors, and staff of the medical facility whenever information on a product related hazard or potential hazard is brought to the attention of the organization's staff.

(b) The Safe Medical Device Act of 1990 requires that medical device users report to the manufacturer and/or the F.D.A. incidents that reasonably suggest that there is a probability that a medical device has caused or contributed to the death of a patient, serious injury or illness.

(c) Serious illness or injury as defined by the Act is an illness or injury that is life threatening or that either results in permanent impairment of bodily function or permanent damage to a bodily structure or necessitates immediate medical or surgical intervention to preclude permanent impairment of a bodily function or permanent damage to a bodily structure.

(d) Medical devices include but are not limited to ventilators, monitors, dialyzers, and any other electronic equipment, thermometers, components, parts, accessories and related software.

(e) In accordance with Safe Medical Device Act of 1990, the Department of the Army has established appropriate methods for reporting these events. In cases involving medical devices where patients are injured or become seriously ill, a report must be filed within 10 working days to the manufacturer, the FDA if the manufacturer is unknown, and USAMMA.

F-3. Procedure for filing report:

a. When any device failure or user error has had an adverse outcome, the medical personnel who are aware of the incident will complete an incident report and forward it to the Risk Manager and Medical Maintenance within (24) hours. The investigation of the incident will include the following information:

(1) Patient's name
(2) Room and bed number
(3) Name of attending physician notified
(4) Product name
(5) Location of product
(6) Equipment identification number
(7) Serial number of product
(8) Model number
(9) Name of manufacturer, if known
(10) Brief description of incident

b. Immediately retain all packaging materials and disposable supplies.

c. Control settings, and any observed physical damage will be noted. Device will be impounded and shall be tagged, bagged and sequestered including identifying number and date. Device shall be logged into an impound log with all pertinent data recorded to show a "chain of evidence".

d. Investigation of incident shall be conducted to determine if a device failed or if there was a user error. This investigation shall be carried out by medical maintenance section.

e. Device failure investigation shall be carried out as appropriate before repair work is conducted.

f. All written communication submitted to the FDA, manufacturer, or USAMMA shall be reviewed by the facility Risk Manager prior to submittal. The Risk Manager will determine the appropriateness and that the submitted communication meets the requirements of the Safe Medical Device Act of 1990.

g. Any additional communications with the manufacturer or vendor shall be carefully and completely documented. Written acknowledgments will be requested for all verbal responses given by the manufacturer.

h. Copies of all written communications will be forwarded to the facility Safety Manager.

Appendix G
Battery Maintenance Program

G-1. Critical equipment battery replacement

a. It is essential to take a proactive approach to maintaining critical items of medical equipment. Defibrillators, patient monitors, and other lifesaving medical equipment must receive vigilant attention.

b. Battery (typically Nickel Cadmium (NiCad)) operated medical equipment may start malfunctioning at or around the 24-month point due to battery failure. To ensure that critical equipment items function when needed, consider instituting one of the following battery maintenance procedures.

(1)Remove batteries from the service and deep cycle semiannually using a medical battery conditioner and tester. Replace batteries every 36 months regardless of condition.

(2)Completely discharge the batteries semiannually by draining the battery through equipment operation and then fully recharge. Replace the batteries every 18 months regardless of condition.

G-2. Battery replacement management

a. The maintenance internal SOP should include one of the above procedures and a method used to identify the date of the last battery installation.

b. Consider annotating the battery replacement on the DD Label 2163, Equipment Calibration/ Verification/Certification Label.

Appendix H
Equipment Requiring Calibration/Verification/Certification

H-1. Calibration/Verification/Certification requirements

a. Properly functioning and calibrated medical equipment is critical to the correct diagnosis of patient illness and the administering of patient care.

b. Medical maintenance personnel should review the appropriate technical manuals and/or manufacturers' literature to determine calibration requirements and procedures for each item of medical equipment supported.

H-2. Equipment management

a. Equipment requiring calibration will be individually tracked and monitored. The items should be included in the automated medical maintenance automation system or tracked manually.

b. The following is a general list of medical equipment that requires periodic calibration.

Amalgamator
Analyzer, Blood Gas/pH/Pulmonary Function/Nitrous Oxide/Oxygen
Anesthesia Apparatus (all)
Angiographic Injector
Apnea Monitor
Balance, Electronic/Mechanical
Blood Cell Counter
Blood Gas Analyzer
Centrifuge (All)
Chromatography Equipment, Gas
Counter, Blood Cell
Defibrillator
Defibrillator/Monitor
Diathermy Unit
Electrocardiograph
Electrosurgical Apparatus
Fetal Heart Detector/Monitor
Hemodialysis Unit
Hood, Chemical/Fume/Laminar Air Flow/Microbiological
Hypo/Hyperthermia Unit
Incubator, Infant
Infusion Pump
Injector, Angiographic
Laser, Argon
Laser, Nd: YAG
Lithotripter, Ultrasonic
Monitor, Apnea/Fetal Heart/Physiologic/Pressure/Pulse/Respiration
Nitrous Oxide Analyzer
Oxygen Analyzer
pH Analyzer
Physiologic Monitor
Pulmonary Function Analyzer
Pulse Oximeter
Radiographic Units (all)
Spectrometer, Mass
Spectrophotometer
Spirometer
Stimulator, Nerve
Ultrasonic Unit, Diagnostic
Ultrasonic Unit, Therapeutic
Ventilator
Warmer, Blood
X-ray Apparatus (all)

Appendix I
Warranty/Contract Program

I-1. The objectives of the Army Warranty Program, as expressed within AR 700-129 are to—

a. Achieve and sustain a cost-effective warranty program for Army materiel.
b. Minimize user burden and promote user satisfaction.
c. Control warranty execution to assure maximum use and benefit from warranties.
d. Provide information for warranty administration, execution, and evaluation.
e. Achieve uniformity in managing and executing warranties.

I-2. Warranty coverage

Army warranties for centrally procured materiel should consider two types of coverage: individual item failure and systemic defect. Replacement assemblies may require both types of coverage.

a. Individual item failure coverage requiring individual warranty claim actions apply to MAC functions of maintenance or repair parts and special tool list (RPSTL) coded recovery functions that occur no lower than the field maintenance level for items and their subsidiary parts.

b. Systemic defect coverage provides protection to the lowest level of impact or expense and requires a contract remedy that may cover all contract deliverables.

I-3. Fielding of warranty items

a. Medical equipment fielded by USAMMA will be in accordance with appropriate materiel release, fielding, or transfer documents.
b. Warranty information and specific warranty requirements should be addressed in the MFP.
c. Warranty / contract issues or concerns should be addressed to USAMMA.

Appendix J
Medical Equipment Maintenance Evaluation and Assessment

J-1. Medical maintenance program responsibility
Unit commanders are responsible for the unit's medical equipment maintenance program. Programs that receive command emphasis typically flourish better than those which do not.

J-2. Evaluation and assessment
Commanders should periodically assess their unit's medical equipment maintenance program utilizing the checklist in Figure J-1.

Figure J-1. Commander's Medical Equipment Maintenance Assessment Checklist.

Maintenance POC:	Assessment		
Reviewer:	SAT	UNSAT	NA
1. References: AR 40-61, AR 700-138, AR 710-2, AR 750-1, AR 750-43, DA PAM 710-2-1, DA PAM 710-2-2, DA PAM 750-8, TB MED 7, TB MED 521, TB MED 750-2, TB 38-750-2, TB 43-180, SB 8-75 Series, SC 5180-8-A10, SC 5180-8-A14, NFPA 99, Manufacturers Literature			
2. Maintenance: Questions for Unit Commanders to evaluate the medical equipment maintenance procedures. Are TMs or operator and service manuals on hand for all medical equipment? AR 40-61 Is all MTOE medical equipment requiring PMCS listed in the ULLS computer? Is there a valid Equipment Maintenance and Inspection Worksheet (5988-E for ULLS) or DA 2404 on hand reflecting most recent maintenance service? Are scheduled maintenance services and calibrations being conducted IAW TMs and/or manufacturer's literature? Do all equipment requiring calibration services have a DD Form 2163 annotated with a valid date and affixed on the equipment item? AR 40-61 Are DA Forms 2407 (Maintenance Request) being maintained on non-operational equipment and turn-ins? TB MED 750-2, DA PAM 750-8 Does the defibrillator equipment have a DA Label 175 annotated with valid data and is there a current and completed DA Form 5624-R on file in the maintenance shop? TB MED 750-2 Are safety tests being conducted on all medical equipment that has been repaired and is it reflected on the DA Form 2407? AR 40-61, TB MED 750-2 Does unit have an Operator Maintenance Program? AR 750-1, TB MED 750-2 Is there a valid Equipment Maintenance and Inspection Worksheet DA Form 2404 (5988-E for ULLS), on hand reflecting the most recent operator PMCS? Are the results of the operator PMs being utilized and work orders submitted to Medical Maintenance within 3 working days? AR 750-1 What organization provides your next level of maintenance support?			
3. Maintenance Management: Does the maintenance section have an internal SOP? AR 750-1, TB MED 750-2 Does the section SOP cover all the individual subjects evaluated in this checklist? Are the SOP and its appendixes written in sufficient detail to enable new personnel to comply with the procedures? Has the SOP been updated within the last 18 months? TB MED 750-2			

Figure J-1. Commander's Medical Equipment Maintenance Assessment Checklist.

Maintenance POC:	Assessment		
Reviewer:	SAT	UNSAT	NA
Has the Commander published a maintenance directive delineating supervisor responsibility and is sufficient emphasis placed on equipment and operator maintenance per AR 750-1 and TB MED 750-2? Is the Customer Assistance Guide comprehensive enough to describe all customer services to include procedures for units to request assistance? Are DA Forms 2406 reviewed monthly to monitor readiness and actions taken to assist units when necessary? AR 220-1, AR 700-138			
4. TMDE: Questions to ask for proper use and maintenance of TMDE Is there an assigned TMDE coordinator in the maintenance section? TB MED 750-2 Is sufficient and modern TMDE available to ensure calibration and verification of medical equipment? AR 750-43 Does all TMDE have a DA Label 80 with current calibration dates? AR 750-43, TB 43-180 Is there a training program to ensure maintainers are familiar with the proper use of TMDE? TB MED 750-2 Are maintenance personnel familiar with the theater TMDE support structure? The point of contact for TMDE-SP calibration support is MMOD, Tracy (209) 832-4557, DSN 462			
5. Tool Control Have individual tool kits been sub-hand receipted to repair personnel? Is a shortage annex maintained in the toolboxes and on file? Are the tool kits inventoried on a semiannual basis? Have replacement tools been ordered for damaged or lost tools? Has a tool custodian been appointed in writing? AR 750-1; TB MED 750-2 Has the activity initiated and maintained DA Form 5519-R (Tool sign-in and out-register). TB MED 750-2			

Appendix K
Preventive Maintenance Inspection Checklists

K-1. Category A - all items. This checklist should be applied to determine the condition of all items.
a. The overall appearance and finish of the item will be up to organizational standards.
b. Interior and exterior of the item will be free of rust, corrosion, solutions, dirt, lint, and deposits.
c. Doors, drawers, panels, shelves, catches, latches, hinges, stops, door pulls, handles, knobs, and casters will be properly tightened or adjusted to operate smoothly.
d. Component holders, clips, and receptacles will be intact and properly adjusted.
e. Control knobs, mechanical locks, and levers will be securely attached to the driven element and properly indexed.
f. Nuts, bolts, screws, and other hardware will be tight and in good condition.
g. Operator's manual will be on hand in the organizational element utilizing the item.

K-2. Category B - hydraulic/mechanical. This checklist will be used as a guide to determine the condition of items which employ chains, gears, belts, bearings, levers, and/or hydraulic systems.
a. All gears will be free of excessive backlash.
b. All chains, gears, bearings, and bearing surfaces will be free of excessive wear and properly adjusted.
c. Axles, shafts, and levers will be free of excessive wear and play, and properly lubricated.
d. Belts, pulleys, and levers will be free of excessive wear and properly adjusted and aligned.
e. Hydraulic systems with their trips, locks, stops, and release mechanisms will be free of excessive wear and properly adjusted, fluid level will be proper and the system free of leaks.
f. Casters will be checked and lubricated with general purpose lubricant.

K-3. Category C - positive/negative pressure. This checklist will be applied to determine the condition of items which involve positive or negative pressures or the use of one or more medical gases, such as oxygen and nitrous oxide.
a. Where applicable, rubber parts, components, and fittings will exhibit original elasticity and shape. They will be free of cracks, splices, punctures, and faulty fittings. When equipment is used in a flammable location, conductivity will be verified in accordance with NFPA 99.
b. High pressure tubing will conform to the above and be free of leaks and frayed covering. All fittings and connectors will be in good condition and securely attached to hose ends.
c. All controls, regulators, flow meters, and flush valves will be properly adjusted to accurately regulate flow of gas. All temperature indicators will be checked to ensure accuracy.
d. Glass and plastic covers on meters, inspection ports, and containers will be free of cracks and chips. They will be clean and properly positioned for leak-free operation.
e. Safety and pop-off valves will be in proper operating condition.
f. Air evacuation systems will be capable of maintaining the desired vacuum within design limitations.
g. Grounding systems will be of the approved type and properly installed.

K-4. Category D - heating/cooling/mixing. This checklist will be applied to determine the condition of items which heat, cool, regulate, mix, pump, or circulate water and/or produce steam.
a. All water and steam chambers will be free of excessive rust, corrosion, and lime deposits.
b. All gasket material (such as rubber, cork, and composition type) will be free of breaks or wear which might result in an improper seal.
c. Door and lid closing mechanisms will operate freely and be adjusted to ensure a proper seal.
d. There will be no leaks (steam or water) in the plumbing, valves, valve packing, regulators, boiling chamber, tanks, or pumps.
e. All valves, regulators, controls, steam traps, and vacuum breakers will operate properly.
f. The heating system (electrical, fuel, or steam) will provide the proper temperature and/or pressure in the prescribed time under normal operation.
g. Low water cutoff and boiling point cutoff switches will function properly.

K-5. Category E - electrical/electronic. This checklist will be applied to determine the condition of items which employ electrical or electronic components.
a. Electrical connectors (jacks, receptacles, or plugs) will be of approved type, free of cracks or breaks, and properly attached to the line cord or cable. Mechanical indexing mechanisms to prevent improper alignment or mating of plugs and receptacles will be free from wear or damage.
b. Cables, cords, and internal wiring will be of an approved type and of proper wire size to safely carry the required current. In addition, all cables, cords, and internal wiring will be of sufficient length and free of unsafe or unsightly splices and of frayed, cracked, abraded, or brittle insulation.
c. Cables, clips, studs, and terminals will be free of dirt, rust, corrosion, and other deposits.
d. Switches, circuit breakers, relay points, and selectors will not be dirty, corroded, excessively worn, or pitted.
e. Grounding systems will be of an approved type and properly installed.
f. All electrical components (relays, transformers, capacitors, electron tubes and resistors) will operate without overheating.
g. Heating elements will produce and maintain the temperature rise required for proper operation.
h. Electrical meters will respond to the appropriate control and indicate properly.
i. Electrical components (such as connectors or switches) on explosion proof equipment will conform to the requirement of the NFPA 99.

j. Batteries will be properly charged and free of cracks, breaks, or leaks. Electrolyte of wet cell batteries will be at the proper level.
k. Electrical leakage currents shall be within acceptable limits IAW NFPA 99. Unless specified otherwise, frequency and procedures for testing leakage current shall be as prescribed by AR40-61, NFPA 99, and this bulletin.

K-6. Category F - electric motors. This checklist will be applied to determine the condition of items which employ electric motors.
a. The electric motor will operate under load without excessive variation, hunting (varying speed), or noise.
b. The electric motor will operate without excessive temperature rise when operated at the rated duty cycle and mechanical load.
c. The mechanical linkage between motor and load (belts, pulleys, chains, gears, and shafts) will be adjusted for proper drive and be free of excessive wear.
d. Oil and grease seals of rotating and reciprocating members will be in place and there will be no evidence of excessive leaks.
e. Brushes, brush rigs, and commentators will be clean and free of excessive wear. Brushes and brush rigs will be properly adjusted and free of excessive arcing during operation.
f. The bearings of the motor and mechanical load will be clean, free of excessive wear, and properly lubricated.

Appendix L
Sample Combat Support Hospital Internal Standing Operating Procedures

L-1. Structured maintenance support program
a. Unit commanders are responsible to establish and maintain structured medical maintenance support programs.
b. The program should by design enhance the unit's mission capability in accordance with the readiness objectives as defined by AR 700-138.

L-2. Commanders at all levels:
a. Provide leadership, technical supervision, and management control of materiel maintenance programs.
b. Established standing operating procedures for performing maintenance operations.
c. Emphasize the importance of safety and maintenance and ensure that subordinates are held accountable for the conduct of maintenance operations.

L-3. Standing operating procedures
a. Standing operating procedure should consist of two parts, an internal SOP to standardize internal shop operations and an external SOP (sometimes referred to as a customer assistance manual) addressing standard procedures for receiving medical maintenance support.
b. The following is a sample Combat Support Hospital Internal medical maintenance SOP.

HOSPITAL
MEDICAL MAINTENANCE
INTERNAL SOP

Section I. General

1-1. Purpose: This SOP establishes basic principles, policies and procedures to be used as a standard guideline for the efficient operation of the Hospital Medical Maintenance Section.

1-2. Scope: This SOP applies to all personnel assigned or attached to the hospital Medical Maintenance Section.

1-3. References:
a. AR 40-61
b. AR 750-1
c. TB 38-750-2
d. TB MED 750-2

1-4. Responsibilities:
a. Chief, Medical Maintenance Section will ensure that:
(1) Basic concepts, objectives, and policies are met for the maintenance of medical equipment.
(2) The maintenance of hospital medical equipment is effectively performed throughout its lifecycle.
(3) Maintenance programs for repair, preventive maintenance (PMCS) calibration/verification/certification (CVC), and electrical safety testing are implemented and performed consistent with available resources.
(4) Planning, guidance, and assistance are provided to other organizational elements which impact on the medical maintenance mission.
(5) Guidance is provided to the S-2/3 in the development of educational and training programs in maintenance for equipment operators and medical equipment repairers.
(6) Commander and staff are frequently updated on the status of medical equipment maintenance and associated programs.
(7) A master file copy of both operator and maintenance manuals has been established in the maintenance section for all equipment on hand.
(8) Assigned Medical Equipment Repairers are utilized for medical maintenance and not assigned additional duties which may adversely affect the maintenance of medical equipment.
b. NCOIC, Medical Maintenance Section works under the general supervision of the Branch OIC and will ensure that:
(1) Programmed scheduled/unscheduled workloads are assigned to individual repairers commensurate with their training and in accordance with this SOP.
(2) His or her counterparts and hospital staff are informed of any issues concerning medical equipment maintenance services.
(3) Knowledge and application of maintenance service procedures are in accordance with military and/or manufacturer's instructions.
(4) Required administrative records are maintained in accordance with applicable regulatory guidance.
(5) Soldiers are recognized for outstanding performance of duties. Conversely, disciplinary problems or additional training requirements should also be documented and brought to the attention of the appropriate level of command.

(6) Property accountability and security procedures are in place IAW regulations and directives governing security, accountability, and control of tools, TMDE, and other Army property.
(7) Safety procedures are strictly adhered to during maintenance operations.
c. Medical Equipment Repairers work under the general supervision of the Branch NCOIC and will ensure that:
(1) Documentation on work orders and associated maintenance forms is legible and in compliance with this SOP and other applicable directives.
(2) Safety procedures are strictly adhered to during maintenance operations.
(3) Preventive maintenance is performed in accordance with applicable technical manual or manufacturer's literature.
(4) Safety inspection/testing is performed in accordance with AR 40-61, TB MED 750-2, and NFPA 99.
(5) Personal responsibility is assumed for individual training and career development.
(6) Unsafe equipment is brought to the attention of user/operator personnel and their supervisory personnel.
(7) All maintenance related problems are communicated to their supervisors.

Section II.
Maintenance Policies

2-1. Scheduled Services Program

a. Scheduled maintenance is all actions performed in an attempt to retain an item in a specified condition by providing systematic inspection, detection, and prevention of incipient failures. Scheduled maintenance includes PM, CVC, and Electrical Safety Testing.
(1)PM - the care, servicing, inspection, detection, and correction of minor faults before these faults cause serious damage, failure, or injury. The procedures and the category of maintenance to perform PMCS are in the –10 and –20, equipment technical manuals, and lubrication orders.
(2)CL - the comparison of a medical system or medical device of unverified accuracy to a measurement system or device of known accuracy (which is directly traceable back to the National Institute of Standards and Technology (NIST)) to detect and correct if necessary, any deviations from required performance specifications of the medical system or medical device.
(3)ST - the preservation of an electrically safe environment for patients and staff through the evaluation and assessment of medical equipment to identify and correct electrical safety hazards that may exist in health care facilities.
b. Scheduled maintenance will be performed in accordance with AR 40-61, TB MED 750-2, and the equipment manufacturer's literature with regard to frequency of services.
c. All services will be documented on a DA Form 2404 using the format specified in TB 38-750-2 with the following exceptions:
(1) Column b - Responsibility for the performance of corrective action will be annotated as being either equipment operator (OM) or Medical Maintenance Section (MM).
(2) Column c - Nomenclature, serial number and MMCN number of each item serviced in that section.
(3) Column d - When corrective action is to be accomplished by the equipment operator, the corrective action required will be indicated (e.g. clean, replace, order etc.).
(4) Any deficiencies listed on the operator DA Form 2404 that require operator level replacement components, parts, or accessories must have the NSN and/or the manufacturer's part number for the items and the document number confirming the item was ordered, recorded in the corrective action column (column d).
d. During the performance of scheduled services, minor repairs beyond the capability of the operator will be performed by medical equipment repairer. Upon completion of these minor repairs, the medical equipment repairer performing the repairs will initial the corrected block on the operator DA Form 2404.
e. When equipment repairs are expected to exceed 10/15 minutes, the corrective action will be to submit a work order. (When the corrective action is to submit a work order, ensure the hand receipt holder or designated representative responsible for the equipment is aware of the status of their equipment).
f. Upon completion of scheduled services within each section, items that did not receive services will be identified along with the reason services were not performed. A memorandum identifying the items unavailable for services along with a copy of the medical maintenance DA Form 2404 will be provided to the hand receipt holder and the Commander. For equipment that did not receive services due to not being located, the memorandum will be forwarded to the Property Book Officer listing these items so that appropriate property accountability actions are taken. One copy of all medical maintenance documentation will be provided to the hand receipt holder. The hand receipt holder must sign the completed documentation acknowledging receipt and understanding of his or her responsibilities.
g. Medical Maintenance personnel performing scheduled services in each section will consult with equipment operators to ensure operators are familiar with the unit medical maintenance policies and procedures.

2-2. CVC Services
a. CVC services will be performed IAW applicable TM or manufacturers literature and any other applicable guidance.
b. Upon receipt of new equipment, the TM or manufacturers literature will be researched to determine if CVC services are required. When so indicated, the appropriate manual and automated records will be initiated and the equipment placed on the scheduled services program.
c. Upon completion of CVC services, the affixed DD Form 2163 will be annotated. See TB 38-750-2 for instructions. In addition to annotating the DD Form 2163, ensure the completion of CVC services performed are documented on the equipment's manual and automated maintenance history.
d. When performing CVC services for x-ray equipment, in addition to annotating the affixed DD Form 2163, a DA Form 2164 (X-ray Verification/ Certification Worksheet) must be completed IAW TB 38-750-2. A separate sheet of paper will be attached to the DD Form 2164 to indicate the manufacturer, model, serial number and date of calibration expiration of all items of TMDE used to perform the calibration. All documentation will be maintained on file pending completion of the next X-ray calibration.
e. Defibrillators will receive CVC services semiannually, using a defibrillator analyzer. A DA Form 5624R (DC Defibrillator Inspection Record) will be used to record the results of the calibration service. In addition, a DA Label 175 (Defibrillator Energy Output Certification Label) will be affixed to the unit. The DA Form 5624R will be maintained on file 6 months pending the next CVC service.
f. In reference to calibration of scales, TB 43-180 does not require calibration of scales other than those scales used at the local medical treatment facility (MEDDAC) that are designated as the official scales for weight determination. Upon request from the Hospital staff, a courtesy inspection of scales used for screening purposes within the unit may be performed, but a DD Form 2163 will not be affixed to the scales.

2-3. Electrical Safety
a. A continued effort will be made to provide an electrically safe environment within the hospital. Protecting the patients and staff from electrocution and electrical hazards is essential.
b. All medical equipment will receive an electrical safety test after repairs or modifications are performed. Completion results of all electrical safety tests will be documented on appropriate maintenance forms.
c. If equipment does not meet required limits, the following steps will be taken:
(1) DA Forms 5621-R (Leakage Current Measurements, General) or DA Form 5622-R (Leakage Current Measurements, EKG), as appropriate, will be prepared for the item or system. The forms will document defects, recommendations and actions taken. Refer to TB 38-750-2, Maintenance Management Procedures For Medical Equipment, for completion instructions and examples of the Leakage Current Measurements, General and Leakage Current Measurements, EKG forms.
(2) A work order must be initiated to correct the defect. Upon completion of the repair, a copy of the completed work order will be attached to the appropriate current leakage form and filed for a period of one year.

2-4. Unscheduled Services Program
These services include emergency and routine repair of medical equipment. These repairs may be performed either in shop or on site at equipment location. Other forms of unscheduled services are technical inspections and equipment installation or assembly. Unscheduled services should be submitted utilizing a work order from the requesting section.

2-5. Direct Support Maintenance
a. The local MEDCOM Installation Medical Supply Activity (IMSA) has responsibility for providing Direct Support level maintenance to TOE medical units as stated in AR 40-61. When the availability of maintenance support from the IMSA is resource constrained, contact USAMMA to coordinate maintenance support.
b. All efforts to accomplish medical maintenance missions at unit level will be exhausted prior to request for support. Examples of need for support are lack of personnel or TMDE.
c. All medical equipment submitted to direct support will be submitted on a work order with the receipt copy being maintained in Medical Maintenance along with original work order from equipment hand receipt holder.

Section III
Safety Program

3-1. Shop Safety
General shop safety rules will be practiced in the hospital medical maintenance section at all times. Important points of shop safety are:
a. Prevent electrical shock by identifying hazards and following safe repair procedures;
b. Follow safe handling procedures for medical equipment that may be contaminated;
c. Be familiar with fire protection rules, plans and evacuation routes;
d. Ensure there is proper ventilation for respiratory protection while performing any task where toxic materials, fumes, mists, or vapors are used or produced.
e. When working on x-ray equipment, ensure proper radiation safety procedures are followed at all times. Safety procedures for operation of x-ray equipment includes wearing of x-ray film badges, posting

of warning signs making others aware that an x-ray unit is in use, and ensuring proper shielding requirements from radiation source are met.

f. When using power equipment, proper eye and hearing protection devices must be worn.

g. All staff members must be familiar with proper operation and location of fire extinguishers and eye wash system located within the medical maintenance shop.

Section IV
Material Maintenance Management

4-1. General

a. Maintenance management is the process of establishing objectives to carry out maintenance responsibilities. Maintenance management consists of those continuing actions of planning, organizing, controlling and evaluating the use of manpower, funds, and facilities to accomplish missions and tasks.

b. A prime objective of the medical maintenance supervisor is to ensure optimal management and control of critical maintenance resources. Accomplishment of this objective is assisted by utilizing a management data collection system to monitor the performance of the medical maintenance section in relation to established performance standards.

c. The medical maintenance section will use the maintenance automation system (see TB MED 750-2, Appendix E) authorized to MTOE organization for management of medical equipment maintenance and repair parts within the Hospital.

4-2. Work Load Management

a. The NCOIC of medical maintenance must analyze requirements and direct resources toward the accomplishment of maintenance operations. The NCOIC must forecast requirements for PMCS and unscheduled services using information available from the authorized maintenance automation system outputs (see appendix E).

b. Workload control priorities are defined in AR 40-61 which states that scheduled services take precedence over all other services except emergency repairs. While in garrison, emergency repairs are those required to restore DA Form 2406 reportable medical equipment to a fully mission capable condition. When deployed, an emergency repair work order is any work order submitted on priority 01-03 equipment, which must be signed by the chief or NCOIC of the medical maintenance section.

4-3. Man-Hour Accounting

a. A man-hour accounting system will be used by the medical maintenance section to identify the use of duty hours for each direct labor person within the Medical Maintenance Section.

b. All direct labor personnel will be familiar with the following terms when completing individual time sheets:

(1) Reporting period. Each month consists of one reporting period. The reporting period is from the first day of the month to the last day of the month.

(2) Overtime. Overtime will be based upon a 40-hour week (8 hours per day for each duty day) within the report period. Man-hours expended in excess of this standard will be considered overtime.

(3) Assigned man-hours. This is the number of hours available based on the number of duty days multiplied by 8 hours per day during the report period.

(4) Available man-hours. These are man-hours available for production of direct or indirect labor.

(5) Direct labor. This is labor expended on equipment either performing scheduled or unscheduled services.

(6) Indirect labor. This is labor expended performing duty within the medical maintenance section that is not directly related to performing services on a piece of equipment.

(7) Duty absence. All time expended performing military training, inspections, parades, guard duty, offensive maneuvers, formations and time away from the section due to any other military requirements.

(8) Non-duty absence. These are man-hours spent during duty time such as official leave, sick call, passes and excused personal time to take care of personal business.

Section V
Maintenance Shop Stock/Tool Control Procedures

5-1. Repair Parts Management

a. Standard and nonstandard repair parts will be managed IAW the guidance provided in AR 40-61, AR 710-2, TB MED 750-2, and this SOP.

b. Shop stock (demand supported stock), mission essential, bench stock and minimum order repair parts are authorized IAW AR 40-61. The authorized maintenance automation system (see appendix E this publication) will be used when available to manage and account for repair parts.

5-2. Shop Stock

a. Selection of items for stockage will be based on three demands within a 180-day period. Once a repair part has met the criteria for initial stockage, at least one demand within a 180-day period must occur to retain it as a stockable item.

b. Computation of the requisitioning objective (RO) and reorder point will be IAW AR 40-61 and AR 710-2.

5-3. Mission Essential
The commander may authorize stockage of parts based solely on the premise that these items are deemed essential to support the mission. These repair parts will normally be associated with:
a. Lifesaving equipment.
b. Equipment for which the manufacturer no longer supply parts.
c. New equipment until demand data can be established.

5-4. Bench Stock
a. Bench stock is defined in AR 710-2. Bench stock will not include repair parts unique to an end item of equipment.
b. Bench stock will be managed IAW AR 710-2, and DA Pam 710-2-2.
c. Bench stock replenishment tags (DA Form 1300-4) are not required. The authorized maintenance automation system (see TB MED 750-2, Appendix E) generated bench stock listing provides all of the information required on the replenishment tag. The bench stock listing will be reviewed semi-annually by the maintenance officer.
d. Bench stock costs are not included in the cost of repair; however accounting for bench stock parts is required in order to provide an audit trail. Work orders will include all parts used, to include bench stock parts (except common hardware and bulk material such as nuts, bolts, etc.). Bench stock parts used will be identified on the work order. Work orders will indicate "n/c" meaning there is no charge.

5-5. Minimum Order
Shop stocks purchased as a result of minimum order requirements which are in excess of the stockage objective or not demand supported are authorized to be retained in shop stock and reduced through attrition. The DA Form 3318 for these items will be annotated to indicate that the item from the vendor is MO and the minimum dollar order (e.g., MO $100.00). Repair parts procurements requiring a minimum order should be ordered through the USAMMA. Under the auspicious of the AMEDD Centralized Repair Parts Program (ACRPP), USAMMA will incur all additional costs associated with minimum order requirements.
a. The Hospital has been designated as a Force Activity Designator (FAD) XXXX unit. The medical maintenance section can use one of three priorities when requisitioning parts. These priorities are 02, 05, and 12.
b. The maintenance officer and NCOIC are the only authorized personnel that can initial off on 02 and 05 repair part requisitions.
c. The individual certifying 02 and 05 requisitions will place their initials in column h of the document register (DA Form 2064) for each request submitted.

5-5. Request for Repair Parts
a. The work order may be used to request repair parts that are known to be stocked in shop supply. All requests for repair parts will be reviewed, approved and initialed by the NCOIC or the maintenance officer.
b. A DA Form 3161 will be used to order repair parts that are not stocked in shop supply. The DA Form 3161 will be attached to the work order and filed in the awaiting parts file once the repair part has been ordered.
c. All repair part requisitions will be ordered on a DA Form 2765-1 for standard repair parts or a DA Form 1348-6 for parts that are non-standard and must be local purchased. All class VIII-repair parts should be ordered through the hospital medical supply section. All class 9-repair parts should be ordered through the motor pool TAMMS/PLL clerk.
d. Once the repair part has been ordered, it must be logged on the document register with the applicable document number. The demand must also be annotated on the DA Form 3318 with the document number and entered into authorized maintenance automation system as a due-in (see the ULLS-G User Manual).

5-6. Tools Accountability
a. AR 735-5 states that all tools with a unit price greater than $5 are classified as durable property that must be controlled and responsibility assigned using a DA Form 2062.
b. Durable items that are components of sets, kits, or outfits will be controlled using hand receipt annexes or component lists. The senior maintenance person will sign for tool kits and individual tools from the property book officer and issue the tool or kit by sub-hand receipt to the individual repairperson.
c. Durable items that are not components of a set, kit, or outfit will be controlled using hand receipts and sub-hand receipts. These items may also be controlled using tool room procedures described below:
(1) Tools issued for one day or less will be issued using an internal log or temporary hand receipt.
(2) Tools issued for longer than one day but less than 30 days will be issued on a temporary hand receipt. Hand receipts (DA Form 3161) will be completed in duplicate. The original will be filed in the medical maintenance section and the copy will be given to the individual signing for the tool or tools. Once the item or items has been returned, both copies of the temporary hand receipt must be destroyed.

5-7. Inventory of Tools
a. All tools will be inventoried on a quarterly basis. Lost or damaged tools will be annotated on a DA Form 2062 shortage annex.
b. Tools that are lost due to negligence on the part of the responsible individual must be replaced by that individual either by direct replacement or a statement of charges.

Section VI
Shop Operations

6-1. Retention/Disposition of Medical Maintenance Records

a. Retention/Disposition of completed work order (Maintenance Request) will be kept on file for a period of one year following the close date. File in work order number sequence by close date.

b. AR 25-30, Chapter 3, is specific in that the creation of a form for a purpose for which a higher echelon form exists is prohibited. Accordingly, the hospital medical maintenance section will use existing forms (i.e., work order, DA Form 3161) for managing maintenance requests and repair parts rather than a variety of locally devised forms. Likewise, the use of commercially procured labels, stickers or forms to document performance of safety tests or CVC services is prohibited. Use only those forms listed in TB 38-750-2.

(1) Automated MMCN listing will be maintained for a period of 90 days with a current listing being produced and filed on a monthly basis.

(2) Automated Maintenance Performance Report will be maintained for a period of one year with a current report being reviewed and filed monthly.

6-2. Priorities

a. The complexity, density and the availability of maintenance resources require the establishment of priorities for the repair and/or performance of scheduled maintenance services. The priority system developed at the CSH Medical Maintenance Section requires strict adherence.

b. The significance of each area within the hospital to the overall delivery of medical care must be evaluated to determine each section's priority. The following is the list of hospital sections and their priority:

(1) Critical Care Areas:	
(a) OR 1/2/3	Priority 02
(b) ICU 1/2/3/4	Priority 02
(c) EMT	Priority 02
(2) Critical Support Areas:	
(a) CMS 1/2/3	Priority 05
(b) Labs Blood/General	Priority 05
(c) X-ray	Priority 05
(3) Other areas:	
(a) ICW 1-8	Priority 12
(b) MCW 1-10	Priority 12
(c) Clinics/Dental	Priority 12
(d) Pharmacy	Priority 12
(e) Misc. non patient care areas	Priority 24

c. The basic section priority will be assigned to all equipment maintenance requests received from that area with the exception of critical or lifesaving equipment. Any exception to this policy must be approved and initialed on the work order by the maintenance officer or NCOIC.

d. Selected priorities will be used for critical or lifesaving medical equipment. These pieces of equipment will receive a higher priority than the section priority. For example: A defibrillator in an ICW with a priority of 12 would be a priority 01 because it is a lifesaving critical piece of equipment.

e. In garrison, the highest priority will be 02. Priority 02 is reserved for DA Form 2406 reportable items in a non-mission capable status.

6-3. Scheduling and deferring maintenance

a. AR 40-61 stipulates that medical equipment maintenance scheduled services in field medical units will be completed annually. The exception to this being defibrillators, which should be tested semi-annually. The maintenance officer may increase other equipment items to a semi-annual schedule. During prolonged exercises or missions involving patient treatment, scheduled safety testing of electrically operated medical equipment designated for use in critical care areas will be performed on a semi-annual basis.

b. Due to the maintenance resources available and the configuration of DEPMEDS, a cyclic scheduled maintenance program is necessary. This means that 100% of the medical equipment in the hospital must be accomplished over a 12-month period. In order to accomplish this requirement, a certain number of sections or wards must be serviced each month. Determination as to which areas will be serviced during a particular month will be coordinated between the medical maintenance staff and Department of Nursing.

c. There will be times when a scheduled area will not receive services due to mission requirements or a shortage of maintenance personnel or resources. When scheduled maintenance is deferred, the action must be documented. The reason services were not performed will be annotated on the scheduled maintenance listing and initialed by the OIC or NCOIC of the Medical Maintenance Section. A copy of services not performed will be forwarded to the Chief Wardmaster who will coordinate with the medical maintenance NCOIC as to when the deferred services can be accomplished.

6-4. Equipment Management

a. Items of equipment requiring an individual historical record will be assigned an MMCN number. These items will be determined by maintenance managers based on item cost and type.

b. Items of non-technical equipment or equipment that does not require a maintenance history will be considered a group managed item. Group managed items will not have an individual MMCN number but a group managed MMCN number will be assigned to each area of the hospital to record scheduled and unscheduled services on group managed items within each area.

c. The performance of scheduled services will be recorded using the authorized maintenance automation system (see TB MED 750-2, Appendix E) generated scheduled service listing. Base dates for areas may be changed to adjust the workload or to have the services scheduled when desired. Priorities, scheduled service requirements and performance times must be reviewed periodically.

d. When an individual piece of equipment is transferred from one area to another, the scheduled service base dates must be changed to the base date of then new location. This action should be initiated upon notification from the property book officer or unit supply, that a piece of equipment has been moved.

e. Scheduled services performed that are not on the authorized maintenance automation system (see TB MED 750-2, Appendix E) scheduled service listing must be recorded using the unscheduled work order transactions as appropriate (i.e. PM, CL, ST).

f. Scheduled services accomplished as a portion of a repair will not be recorded as separate actions. All actions necessary to restore defective equipment to a fully mission capable status are considered part of the repair, to include electrical safety and any required calibration/verification. Total man-hours expended for all actions performed will be included in the repair total.

g. The NCOIC will ensure that copies of the latest authorized maintenance automation system (see TB MED 750-2, Appendix E) outputs applicable to maintenance management are on hand and available to all maintenance personnel. The equipment density listing should be manually updated as changes occur (i.e. additions, deletions, MMCN, serial number, model number, etc.).

h. The automated work order register will be reconciled at least monthly. All work orders listed on the register must be accounted for, those work orders on hand and not on the register must be entered into the system. Work orders on the register that are not located must be researched and the appropriate action taken.

i. When items of medical equipment due scheduled services cannot be located, a reasonable effort should be made to locate the item, but excessive time should not be spent locating the item. If the equipment operator/user is unable to locate the equipment, the required scheduled service will be closed out and identified as not being located.

j. The NCOIC must ensure that the scheduled services are completed in a timely manner and entered into the authorized maintenance automation system (see TB MED 750-2, Appendix E) data base.

6-5. Maintenance Request (work order)

a. All maintenance requests (work order) once processed in authorized maintenance automation system (see TB MED 750-2, Appendix E) , will be controlled by the NCOIC. The NCOIC will assign each work order to a technician in order of priority.

b. Maintenance requests will be filed in priority sequence by work order number and issued to a technician in the same order. Once a work order is assigned to a technician, the NCOIC will ensure the work is started in a timely manner.

c. Upon completion of repair the technician will return the work order to the NCOIC for review and close out on the work order register. The NCOIC or senior technician must inspect the completed work and initial in the inspected block of the Work order.

d. Once completed and processed, the work order will be placed in the awaiting pick up file. The equipment will be placed in the designated area for equipment pick up. The NCOIC will call the section NCOIC to inform them that the equipment is ready to be picked up.

e. Work orders that require parts to be ordered will be handled in the following manner:

(1) The work order with DA Form 3161 for required parts will be submitted to the NCOIC.

(2) The NCOIC will verify parts request and priority of requisition. The requisition will then be ordered through the appropriate class of supply and work order status updated on authorized maintenance automation system (see TB MED 750-2, Appendix E) to indicate that the work order is awaiting parts.

(3) Once completely processed, the work order and attached DA Form 3161 will be filed in the awaiting parts file in priority and work order sequence.

(4) Upon receipt of requested parts, the work order will be placed in the parts received file. The NCOIC will issue the parts and work order to the technician who ordered the parts.

(5) Once the parts are installed and the work order has been completed, the work order will be given to the NCOIC for processing. The NCOIC will ensure that the work order is closed out in authorized maintenance automation system (see TB MED 750-2, Appendix E) and all costs posted to the maintenance history for the repaired item. The work order will be placed in the awaiting pick up file and the owner will be notified. The equipment will be placed in the designated awaiting pick up area.

6-6. Modification and Alteration of Medical Equipment

a. Modification and alteration of medical equipment will only be performed when directed by USAMMA.

b. Suggested modifications should be forwarded directly to USAMMA and will not be implemented until the suggestion has been approved.

6-7. Test, Measurement, and Diagnostic Equipment (TMDE)

a. The NCOIC or designated representative in the medical maintenance section will ensure that TMDE used in the repair and calibration of medical equipment is calibrated at the proper interval.

b. Calibration requirements for TMDE are listed in TB 43-180. The unit TMDE coordinator will notify the section when an item is due for calibration. The item will be submitted on AMXTM Form 34A to the local TMDE Support Center.
c. Medical specialty TMDE that is not supported by the local TMDE Support Center must be sent to the DEPMEDS TMDE Support Lab at Tracy Depot. These items include patient simulators, defibrillator analyzers, electrical safety analyzers, electrosurgical analyzers and any other medical TMDE that cannot be calibrated locally.
d. TMDE that is submitted for calibration or repair must be clean and complete with all accessories and cables etc. that are required to perform calibration of the equipment. TMs or manufacturers literature will also be submitted with each item and documented on the Form 34A as being turned in with the equipment along with any accessories.
e. TMDE that does not require calibration must have a DA Label 80 attached with the letters “CNR” stamped on the label identifying them as TMDE that does not require calibration.

6-8. Maintenance of Support Equipment
a. Maintenance of support equipment is essential to the readiness of the Medical Maintenance Section. The primary items of equipment are the medical maintenance ISO shelter and the Environmental Control Unit (ECU).
b. Maintenance on the ISO shelter will be performed on a monthly basis. A monthly DA Form 2404 will be completed and PMCS performed IAW the technical manual. The DA Form 2404 will indicate all deficiencies noted with part numbers and document numbers listed for parts that are needed.
c. Operator Maintenance of the ECU will be performed on a weekly basis. A weekly DA Form 2404 will be completed IAW the technical manual and will list all needed repair parts and document numbers that are needed. The DA Form 2404 will be submitted to the motor pool upon completion of the weekly PMCS. Repair part status will be requested and updated on a weekly basis. Assistance will be provided to the utilities section when the equipment is due for scheduled services.
d. A copy of each DA Form 2404 will be filed in the medical maintenance section for all support equipment. An individual file will be maintained for each item.
e. For man-hour accounting purposes, time will be carried as productive indirect time.

Section VII
Technical Inspections (TI) on Medical Equipment

7-1 Types of Technical Inspections
a. TI for Issue. This is an inspection of newly procured equipment prior to issue. Equipment will be inspected for:
(1) Appearance (external damage).
(2) Completeness (accessories, manuals, etc.).
(3) Internal condition (damage, leaks, broken parts, etc.).
(4) Proper performance.
b. Part of the TI for issue is to complete all manual and automated maintenance records on maintenance significant items. Non-technical or non-maintenance significant medical equipment must also receive a technical inspection, but do not require maintenance records.
c. Information as to the recipient or hand receipt holder for the equipment must be provided by unit supply or the PBO. The equipment hand receipt holder and the location must be provided prior to the equipment leaving the shop. This is necessary to ensure maintenance records accurately reflect equipment location and proper base date to receive scheduled services.
d. TI for turn in. This is an inspection of medical equipment, maintenance significant or non-maintenance significant that is excess.
e. The TI for turn in work order must come from the PBO. If the equipment is maintenance significant item with an assigned MMCN number, all maintenance records must be closed out as part of the TI.
f. All equipment that receives a TI for turn in must be tagged with a DD Form 1577 (Material Condition Code Tag) prior to being returned to the PBO.

7-2. Condition Coding of Medical Equipment
a. Upon performing a technical inspection for turn in on a piece of medical equipment, a supply condition code must be determined. The following supply condition codes will be used when condition coding medical equipment:
(1) Code "A" Serviceable medical equipment with over 6 months remaining life expectancy.
(2) Code "B" Serviceable medical equipment which has reached or exceeded its life expectancy.
(3) Code "F" Unserviceable, economically repairable medical equipment.
(4) Code "H" Unserviceable, uneconomically repairable medical equipment which does not meet the repair criteria; i.e. exceeding the Maintenance Expenditure Limit (MEL).
b. To assist in assignment of condition codes, a Maintenance Expenditure Limit graph is located in TB MED 7.
c. Condition coding is not required by the technician for repair services. However, if in the process of the inspection and evaluation of the equipment, it is determined that repair costs will exceed the MEL, then a supply condition code "H" will be assigned. When this situation occurs, the following actions are required:
(1) The technician will annotate on a work order the following:
(a) Estimated parts and parts cost to return the equipment to a serviceable condition.

(b) Estimated man-hours to complete the repair.
(c) A supply condition code.

(2) The senior maintenance manager will:
(a) Verify and authenticate the condition code assigned by the technician by placing his or her signature on the work order.
(b) Notify the hand receipt holder by memorandum.
(c) Attach a copy of the maintenance history and work order to the memorandum.
(d) Filed a copy of the memorandum in a suspense file pending decision on the waiver.

(3) The hand receipt holder will:
(a) Consult with the maintenance NCOIC or OIC and unit supply/PBO.
(b) Prepare an endorsement if a waiver is desired to the hospital commander and provide the necessary justification, i.e. equipment is essential to the unit readiness or mission.
(c) Return the memorandum to medical maintenance if the equipment is not to be repaired indicating such. Upon receipt of the memorandum, the equipment will be returned to the hand receipt holder. The hand receipt holder will then notify unit supply or the PBO.
(d) Prepare an endorsement if a waiver is desired to the hospital commander and provide the necessary justification, i.e. equipment is essential to the unit readiness or mission.

(4) The PBO will:
(a) Prepare turn in documents when disposal action is required.
(b) Arrange for pick-up and transportation of equipment to DRMO.
(c) Make appropriate adjustments to the hand receipt and property book.

(5) The commander will endorse the memorandum back thru the hand receipt holder to medical maintenance indicating approval or disapproval.

(6) Upon receipt of an approved waiver, the medical maintenance section will complete the repairs necessary and attach the approved waiver to the work order.

(7) The medical maintenance OIC must sign all work orders for condition coded equipment for turn-in.

-signed-
Chief, Medical Maintenance

Appendix M
Sample Combat Support Hospital External Standing Operating Procedures

M-1. Structured maintenance support program
a. Unit commanders are responsible to establish and maintain structured medical maintenance support programs.
b. The program should by design enhance the unit's mission capability in accordance with the readiness objectives as defined by AR 700-138.

M-2. Commanders at all levels:
a. Provide leadership, technical supervision, and management control of materiel maintenance programs.
b. Established standing operating procedures for performing maintenance operations.
c. Emphasize the importance of safety and maintenance and ensure that subordinates are held accountable for the conduct of maintenance operations.

M-3. Standing operating procedures
a. Standing operating procedure should consist of two parts, an internal SOP to standardize internal shop operations and an external SOP (sometimes referred to as a customer assistance manual) addressing standard procedures for the customer to receive medical maintenance support.
b. The following is a sample Combat Support Hospital medical maintenance external SOP.

COMBAT SUPPORT HOSPITAL
MEDICAL MAINTENANCE BRANCH
CUSTOMER ASSISTANCE MANUAL (External SOP)

1. Purpose. This SOP supplements the instructions contained in AR 40-61, AR 750-1 and TB MED 750-2 detailing procedures to be followed in completing equipment maintenance and prescribes disposition. It further provides guidance to clinical staff in proper operator level preventive maintenance, scheduled services, and established general maintenance policies and responsibilities.

2. Scope. The procedures outlined herein are applicable to all personnel assigned or attached to the Combat Support Hospital.

3. Responsibilities. The Medical Maintenance Branch is responsible for the installation, repair, and preventive maintenance and calibration procedures necessary to ensure proper functioning of all medical and dental equipment used in the Combat Support Hospital.

4. Manual Review. All personnel will review this Customer Assistance SOP within 30 working days after reporting for duty and annually thereafter. Upon completion of this review, individuals will print their name, date and initial the cover sheet designated for this purpose.

5. Detailed Information. Instruction on the various policies, are contained in the enclosed example memorandums.

6. Point of contact for the manual is the undersigned at (123) 456-7890.

Super Warrant Officer
CW2, Medical Service
Chief, Medical Maintenance Branch

1. Purpose
To provide medical equipment management guidance to clinical staff within the organization and non-organizational medical elements requiring maintenance support or assistance from the Combat Support Hospital.

2. Scope
These procedures are applicable to all sections or activities requesting maintenance service from the CSH Medical Maintenance Branch.

3. Mission
To ensure all medical equipment belonging to the Combat Support Hospital is maintained in a fully mission capable status. The Medical Maintenance Branch will provide unit level medical equipment maintenance services for all sections within the organization. The following table depicts the different Medical Materiel and Medical Equipment Sets associated with an MRI configured Corps level Combat Support Hospital.

08945A COMBAT SUPPORT HOSPITAL CORPS (MRI)

08960A 84 Bed Company

08547AA Early Entry Hosp

PAR	LIN	ERC	SET	SET TITLE	QTY
305	M23673	B	249	MES CHEM AGENT/2000	2
305	M25865	B	258	MES CHEM PATIENT/2000	1
305	M72084	A	M523	MMS MED MNT 84 BED CO	1
306	M73050	P	M308	MMS TRIEMT PREOPDEP/M	1
307	M08417	P	M302	MMS CENTRAL MAT SER/M	1
307	M13428	A	M542	MMS CMS SP AUG 84 BED	1
307	M72936	P	M301	MMS OP ROOM DEPMEDS/M	1
310	M09576	P	M309	MMS POST-OP ICU DEP/M	2
312	M08599	A	M310	MMS INTMDCARE WDDEP/M	1
313	M73254	A	M506	MMS PHARMACY 84 BED	1
314	M73482	A	M503	MMS LAB (GEN) 84 BED	1
314	M73732	A	M504	MMS LAB (LIQ BLD) 84B	1
315	M73175	A	M334	MMS XRAY LOWCAP DEP/M	1
315	M86675	P	M305	MMS XRAY DEPMED/M	1

08547AB 40 BED AUGMENTATION

PAR	LIN	ERC	SET	SET TITLE	QTY
317	M14517	A	M583	MMS MED SUP: 84 BED	1
318	M72868	A	M314	MMS ORTHO CAST CLINIC	1
318	M72423	A	M513	MMS MEDICAL SVC CLINIC: 84 BED	1
318	M31824	A	M316	MMS OB-GYN CLINIC	1
319	M08599	A	M310	MMS INTERMEDIATE CARE WARD	2

08948AB 164 Bed Company

PAR	LIN	ERC	UAC	NOMENCLATURE	QTY
204	M25865	B	258	MES CHEM AGENTS PATIENT DECON	2
204	M23673	B	249	MES CHEM AGENT PATIENT TRTMNT	3
204	M72152	A	M725	MMS MED MAINT; 164 BED	1
204	M14585	A	M783	MMS MED SUP; 164 BED	1
205	M73050	P	M308	MMS TRIAGE/EMERGENCY/PRE-OP	1
206	M72936	P	M301	MMS OR	2
206	M08417	P	M302	MMS CMS	2
206	M32074	A	M417	MMS ORTHO SURG AUG	1
206	M08951	A	M742	MMS CMS AUG: 164 BED	1
208	M72050	A	M312	MMS PT/OT	1
208	M31824	A	M316	MMS OB-GYN	1
208	M72868	A	M314	MMS ORTHO CAST	1
208	M72355	A	M713	MMS MED SVC; 164 BED	1
209	D43882	A	M374	DENTL MTL SET DENTAL X-RAY	1
209	D65926	A	M370	DENTL MTL SET GEN DENT	1
209	D43836	A	M476	DENTAL MTL SET DENTAL HYG	1
211	M09576	P	M309	MMS POST-OP/ICU WARD	2
212	M08599	A	M310	MMS INTERMED CARE WARD	7
213	M73186	A	M706	MMS PHARMACY: 164 BED	1
214	M13275	A	M703	MMS LAB (GENERAL): 164 BED	1
214	M08849	A	M704	MMS LAB (LIQ BLD BNK): 164 BED	1
215	M73175	A	M334	MMS X-RAY LOW CAP PORT	1
215	M72300	P	M307	MMS X-RAY	1

4. References
   a. AR 40-61 — Medical Logistics Policies and Procedures
   b. AR 220-1 — Unit Status Reporting
   c. AR 700-138 — Army Logistics Readiness and Sustainability
   d. AR 710-2 — Inventory Management Supply Policy Below the Wholesale Level
   e. AR 725-50 — Requisitioning, Receipt, and Issue System
   f. AR 750-1 — Army Materiel Maintenance Policy and Retail Maintenance Operations
   g. DA PAM 710-2-1 — Using Unit Supply Systems (Manual Procedures)
   h. TB 38-750-2 — Maintenance Management Procedures for Medical Equipment (Forms)
   i. TB MED 750-2 — Medical Maintenance for MTOE Units

5. Location and points of contact.
   a. Medical Maintenance is located in BLDG 1234, Productivity Lane, Fort Getitdone, NY.
   b. Points of Contact
      (1) OIC: CW2 Super Warrant, warrants@garrison.army.mil, (123) 456-7890
      (2) NCOIC: SSG Tough Stuff, stufft@garrison.army.mil, (123) 456-6789
      (3) 68A, MER Technician: SPC Fred G. All
      (4) 68A, MER Technician: SPC Jane D. Snuffy
      (5) 68A, MER Technician: SPC Joe P. Brain
   c. Maintenance Shop Telephone Numbers
      Commercial (123) 456-7890/6789; DSN: 444; FAX: 5678

6. Hours of operation.
Garrison hours for medical equipment maintenance are:

Monday	0900-1700
Tuesday	0900-1700
Wednesday	0900-1700
Thursday	1300-1700
Friday	0900-1700

7. Available equipment services.
   a. Technical Inspections (TI) for issue of new equipment
   b. Scheduled Services for Medical Equipment
   c. Remedial Maintenance and Repairs for Medical Equipment
   d. Technical Inspections (TI) for turn-in of old equipment
   e. Special Services (SS)
      (1) Training on Set-up and Use of Medical Equipment
      (2) Staff Assistance Visits (SAVs)
      (3) Waiver of Maintenance Expenditure Limit (MEL)

8. Responsibilities of Unit Commanders, Sub-Hand Receipt Holders, and Clinical Staff.
   a. Delegation of Authority Cards (Signature Cards): Unit commanders must provide a copy of their Assumption of Command orders to the Medical Maintenance Branch. Unit Commanders must ensure that all sub-hand receipt holders of medical equipment provide a completed DA Form 1687, Notice of Delegation of Authority or (Signature Card). The Delegation of Authority card establishes authorized chain of custody for equipment submitted to and retrieved from the branch.
   b. User Level Maintenance (DA Form 2404 or 5988E or Automated Form):
      (1) Section NCO(s), clinical staff, and equipment operators are an integral part of the maintenance process. Operator maintenance is the keystone to an effective medical equipment maintenance program and is essential for keeping all clinical equipment in peak operating condition. Unit commanders must place sufficient emphasis and allocate adequate time for unit personnel to perform user level maintenance for medical equipment. Commanders must ensure that medical equipment maintenance is included in the unit's training schedule. Section NCO(s) and Clinical Staff must ensure proper maintenance is performed on a regular basis. Use DA Form 2404 or DA Form 5988E to record medical equipment deficiencies identified during operator/user level maintenance.
      (2) Medical equipment operators must perform routine inspections to ensure that equipment is ready for use and reliable for its intended mission. Operator maintenance includes:
         (a) Cleaning exterior surfaces and accessories;
         (b) Accountability of operator manuals;
         (c) Confirming accessories and supplies required for equipment operation are available and functioning;
         (d) Inspecting, oiling or lubricating moving parts;
         (e) Replacing blown light bulbs and minor accessories;
         (f) Replacing worn rubber tubing or broken bottles;
         (g) Seeking help from the medical maintenance branch for medical equipment problems that exceed user level maintenance authority.

Note: *While directing operator maintenance, supervisors and staff need to beware of the clinic handyman (every clinic has one!). Only trained medical equipment repairers are authorized to perform repairs that involve taking the equipment apart.*

      (3) Operator/user replaceable parts. The operator's manual or technical manual normally clarifies operator's maintenance tasks. Generally, components, accessories, and parts that are easily accessible and don't require tools, test equipment or complex technical skills should be taken care of by the operator.
   c. Training: It is the senior persons' responsibility to ensure that all equipment operators are trained on the use of all equipment in their section. Each ward master and/or section supervisor must always be cognizant of the following:
      (1) Availability of operator's manuals and TM(s) for reference. If an operator's manual is missing, contact the equipment manufacturer to order the appropriate manual. If there are any questions or concerns about the proper version or issue of the manual, contact medical maintenance for assistance.
      (2) Are operators trained to use the equipment? Ensure all operators are familiar with all equipment they may be required to use during patient care. The section NCO, clinical staff expert, or most experienced member of the section should train them as soon as possible. The Medical Maintenance Branch is available to assist with training on the proper operation of medical equipment items; this however does not include the clinical or diagnostic application of the equipment. Please provide a written request for equipment training well in advance so that medical maintenance staff (68As) may program training time into the training schedule and prepare to provide you with quality training.
   d. Equipment storage and use: Equipment must be stored in a manner that prolongs its life and allows for safe retrieval, use, and/or shipment of all components or accessories at any given time. It is essential that when medical equipment is needed to save a soldier's life that all required components, accessories, and consumables are readily available. If your area has more than one make and model of the same equipment, keep the accessories separated and labeled. Using the wrong parts or accessories can result in equipment damage and/or patient injury. It is the clinic's or section's responsibility to ensure that the correct types and quantities of supplies are readily available. *Please consult the Organization*

Medical Supply Activity or Company Supply NCO for initial supply and re-supply procedures. (This is covered in the unit's Command Supply Discipline Program)

e. Life cycle management: The Medical Maintenance Branch will continue to support medical equipment as long as the means to repair the equipment are available. Periodically, medical equipment manufacturers discontinue product lines and eventually the availability of repair parts and accessories from the manufacturer cease to exist. If your medical equipment can't be repaired by our branch and we are unable to coordinate maintenance support through either DS/GS maintenance or USAMMA's depot level maintenance activities, it may be necessary to condition code (Code "H") your equipment and recommend replacement. Should this happen, the unit commander and hand receipt holder will be notified by memorandum of the branch's recommendations. *Once a condition Code "H" is given to equipment, it is up to the hand receipt holder, unit commander, and BN S-4 to arrange for replacing the equipment with a new one.*

f. Remember: When medical equipment requires repair, make sure a maintenance request is initiated and broken equipment is taken to the medical maintenance branch in a timely manner. We can't repair something if we don't know it's broken.

9. Organization maintenance procedures overview.

a. TI for equipment Issue - New equipment requiring a TI for issue must have a maintenance request as well as a completed DA Form 3161, IAW DA PAM 710-2-1. The DA Form 3161 will let maintenance staff know which official hand receipt holder and to which section the equipment belongs allowing for inclusion of the item in the scheduled maintenance program.

b. Scheduled Services

(1) As the title depicts, scheduled services will be managed and performed on a scheduled basis. The purpose of routinely scheduling maintenance services is to preclude equipment failures that may be costly, both in resources and at the expense of the patient. Scheduled maintenance will be performed during the month it is scheduled. Table 9-1, scheduled services schedule by month lists the areas to be serviced by month. The Annual Scheduled Services Summary Report is published and reviewed with unit commanders for inclusion in the training schedule.

(2) Preventive Maintenance Checks and Services (PMCS) will be performed IAW equipment TM(s) or manufacturer literature. Scheduled Services include the following types of inspections:

(a) Preventive Maintenance Checks and Services, (PM)

(b) Electrical Safety Test, (ST)

(c) Calibrations or Calibration Verification and Certification (CVC)

(3) The medical maintenance branch will notify unit commanders and section supervisors of upcoming scheduled maintenance requirements during maintenance meetings one month prior to the month their services are scheduled. If after the 1st week, availability of the equipment is not determined or provided for scheduled services by the hand receipt holder or designated representative, a memorandum with a list of all equipment not available for service will be sent to the appropriate hand receipt holder(s) and the appropriate company commander, notifying the responsible parties that services are due and that the equipment is considered misplaced or not located if it's not made available.

(4) Hand receipt holders are suspensed by the 15th of the month services are due to make the equipment available to the medical maintenance personnel. Every effort should be made to comply. A written explanation must be provided to the Chief, Medical Maintenance Branch if there are extenuating circumstances for which the suspense cannot be met. After the suspense period, the company commander, BN S4 and CSH Executive Officer will be informed so that appropriate administrative actions may be initiated IAW AR 735-5. At this point the hand receipt holder has had 45 days fair notification to determine the equipments location and make the equipment available for scheduled services. Records will be appropriately documented to annotate historical patterns of failure to comply and inconsistencies in property maintenance and accountability. The action code "NL" will be documented to the maintenance history for not located equipment.

(5) When scheduled services are completed the department/section staff will be provided copies of documentation identifying the extent of services performed and the status of their equipment. A copy of all documentation will be retained on file in the Medical Maintenance Branch.

(6) In accordance with the FORSCOM Hospital Optimization Standardization Program (HOSP) the 164 Bed Company, TOE 08948AB, of the Combat Support Hospital has been located to Sierra Army Depot for storage until required to be deployed. Maintenance of the 164 Bed Co will be conducted on an annual basis during the month designated by FORSCOM.

c. Unscheduled Service or Repairs, (RE)

(1) Equipment requiring remedial repair will be reported to the medical maintenance branch as soon as the equipment is determined to be in the state of disrepair.

(2) The clinical staff is responsible for ensuring equipment is cleaned and disinfected before submitting a maintenance request for repair or service. Equipment not meeting cleanliness standards may not be accepted.

(3) Unscheduled work requests will be assigned a work order number and the receipt copy of the work order will be returned to the section NCO or delegated representative. The receipt copy of the work order is the property accountability document for portable equipment brought to the medical maintenance shop and must be surrendered when the equipment is picked up. If the receipt copy is lost, a memorandum from the hand receipt holder or delegated representative is required prior to picking up the equipment.

08960A 84 Bed Company					
08547AA Early Entry Hosp					
LIN	**SET**	**SET TITLE**	**MONTH**	**MONTH2**	**POC**
M23673	249	MES CHEM AGENT/2000	Jan		SSG Sarin
M23673	249	MES CHEM AGENT/2000	Jan		SSG Mustard
M25865	258	MES CHEM PATIENT/2000	Jan		SSG Compound
M73050	M308	MMS TRIEMT PREOPDEP/M	Apr		SSG Prepare
M08417	M302	MMS CENTRAL MAT SER/M	Oct		SSG Sterile
M13428	M542	MMS CMS SP AUG 84 BED	Oct		SSG Sanitary
M72936	M301	MMS OP ROOM DEPMEDS/M	Feb	Aug	SSG Cutter
M09576	M309	MMS POST-OP ICU DEP/M	Mar	Sep	SSG Healer
M09576	M309	MMS POST-OP ICU DEP/M	May	Nov	SSG Helping
M08599	M310	MMS INTMDCARE WDDEP/M	Jun		SSG Hurtone
M73254	M506	MMS PHARMACY 84 BED	Oct		SSG Quaalude
M73482	M503	MMS LAB (GEN) 84 BED	Jun		SSG Protein
M73732	M504	MMS LAB (LIQ BLD) 84B	Jun		SSG Hemophilic
M73175	M334	MMS XRAY LOWCAP DEP/M	Apr	Oct	SSG Roentgen
M86675	M305	MMS XRAY DEPMED/M	Apr	Oct	SSG Emission
08547AB 40 BED AUGMENTATION					
LIN	**SET**	**SET TITLE**	**MONTH**	**MONTH2**	**POC**
M14517	M583	MMS MED SUP: 84 BED	Oct		SSG Procure
M72868	M314	MMS ORTHO CAST CLINIC	Jul		SSG Bone
M72423	M513	MMS MEDICAL SVC CLINIC: 84 BED	Jul		SSG Bender
M31824	M316	MMS OB-GYN CLINIC	Jan		SSG Childs
M08599	M310	MMS INTERMEDIATE CARE WARD	Jan		SSG Heart
M08599	M310	MMS INTERMEDIATE CARE WARD	Jul		SSG Raitt

Table 9-1. Scheduled Services Schedule By Month

(4) When the maintenance service is completed, a copy of the work order will be provided documenting the extent of services performed and the status of the equipment. Retain this in your section's files for 1 year.

d. TIs for equipment turn-in. Medical equipment that is excess, being replaced, or determined to be no longer required must be technically inspected by medical maintenance personnel to determine the proper condition code prior to being turned in through the supply system. In order to properly evaluate the serviceability and condition of the equipment, all components and accessories (i.e. kits, cables, transducers, battery packs, manufacturer's literature, etc.) needed to operate the equipment are will be required to be included when submitted to maintenance.

e. Special Services (SS)

(1) TI for Re-issue or Lateral Transfer

(2) Waiver of Maintenance Expenditure Limit (MEL)

(3) Staff Assistance Visits SAV(s)

f. Equipment Evacuated for Sustainment (DS/GS) Support. Unserviceable but economically reparable equipment beyond our capabilities may need to be evacuated to the next higher level of maintenance. The U.S. Army Medical Materiel and Research Command has four depot level operations that also function as regional medical equipment maintenance management cells. When support coordination is necessary, maintenance will contact the regional manager associated with our support region to determine the best available support. Dental hand pieces, microscopes, x-ray tubes and high tension cables will automatically be sent to the appropriate Maintenance Operation Division (MOD) for repair and return. Un-economically reparable equipment will be condition coded IAW AR 725-50.

g. Staff Assistance Visits. The medical maintenance branch is available to provide SAV upon the sections request. It is in the best interest of the organization to ensure leadership personnel are familiar with maintenance policies and procedures. Please notify the medical maintenance branch so the appropriate time and resources may be scheduled.

10. Medical standby equipment program (MEDSTEP).

a. To assist in preserving the availability of critical medical equipment, the AMEDD has established a Medical Standby Equipment Program. The program involves positioning end items, components, assemblies, and sub-assemblies with deployed Sustainment (DS/GS) maintenance organizations (typically MEDLOGs) to support theater operations.

b. When the medical maintenance supervisor determines repair of a critical equipment item requires extensive time or resources, the medical maintenance branch, on a case-by-case bases, may coordinate to obtain MEDSTEP assets from the supporting Sustainment (DS/GS) medical maintenance organization. MEDSTEP is ordinarily DXed to reduce transportation requirements.

c. MEDSTEP should only be DXed for repairable medical equipment. MEDSTEP will not typically be provided for uneconomically repairable equipment, nor will it be provided to modernize a unit.

d. The unit's medical maintenance and/or logistics representative will contact the Sustainment (DS/GS) organization or depot support to confirm availability of MEDSTEP. MEDSTEP is a "supply" item for the support activities and remains on the stock record account until required by a supported unit. Once MEDSTEP is DXed, the unit must provide the DA FORM 3161 to the PBO for a serial number change. Your PBO will do the Administrative Adjustment Report (AAR) to document changes to property records and your hand receipt. Retain the DA FORM 3161 and AAR in your HR folder.

DEPARTMENT OF THE ARMY
HEADQUARTERS, COMBAT SUPPORT HOSPITAL
FORT ANYWHERE, FLORIDA 12345

REPLY TO
ATTENTION OF

S: 1 October 2004

MCMR-MMM-MM 17 September 2005

MEMORANDUM THRU Commander, Medical Company

FOR NCOIC, Operating Room C (03)

SUBJECT: Notification of Scheduled Services for October 2005

1. Reference. TB MED 750-2, dated April 2005, para 6-3j, AR 40-61, dated 28 January 2005.

2. Medical equipment belonging to **Operating Room** is scheduled for services during the month of October 2004. The enclosed list of equipment requires service to verify accuracy of operation. Coordinate with the organization's Medical Maintenance Branch NCOIC by the suspense to have the equipment scheduled for services. Please plan time in your unit's training calendar for equipment services to be accomplished.

3. Prior to medical maintenance personnel attempting to perform organization level service, please ensure the following user/operator level tasks are accomplished.

a) **Accountability**. Ensure the serial numbers for each item matches the number on the enclosed list. All accessories that are required to operate the equipment must accompany the equipment. Coordinate with medical maintenance personnel to ensure each item is made available for scheduled services.

b) **Operator Maintenance**. Perform general cleaning, function checks and operator maintenance for each item, documenting deficiencies in the section's workbook of DA Form 2404(s). Initiate a work request for equipment that requires repairs. Note any missing or broken accessories that will hinder proper equipment function.

4. The Medical Maintenance Branch personnel are available to assist with training of clinical staff on equipment set-up and capabilities if needed. Please coordinate training requirements in advance with the Chief, Medical Maintenance Branch so that training may be properly planned and executed.

5. Maintain this correspondence in the section supervisor's file. POC is the undersigned at 456-7890.

EXAMPLE
Scheduled Service
Notification

Medical Maintenance Officer/NCO
Rank, BS
Position, Medical Maintenance Branch

Encl

CF:
Commander, MED CO

DEPARTMENT OF THE ARMY
HEADQUARTERS, COMBAT SUPPORT HOSPITAL
FORT ANYWHERE, FLORIDA 12345

REPLY TO
ATTENTION OF

S: 1 September 2005

MCMR-MMM-MM 16 August 2005

MEMORANDUM THRU Commander, Medical Company

FOR Hand Receipt Holder for

SUBJECT: Record of Condition Code and Disposition Instructions for Medical Equipment

1. References. AR 725-50 dated 15 Nov 95 and DOD 4160.21-M Defense Disposal Manual

2. Purpose. To provide a written record of supply condition code of medical equipment and provide appropriate disposition instructions for Unit Commander, Hand Receipt Holder, and Unit Supply NCO.

3. The Medical Maintenance Branch has determined that the following medical equipment is no longer repairable and must receive a Supply Condition Code "H" designation.

LIN: M79195, NSN: 6515014235877, Nomenclature: Vital Signs Monitor
Model: 106EL, Serial Number: TB07375, Repair Cost: $6,300.00, Replacement Cost: $8,687.65

4. The listed equipment must be removed from the hand receipt holder's records in ULLS-S4 and turned-in to DRMO by the Unit Supply NCO. Turn-in to DRMO must take place within 120 days from the date on this memo.

5. The Medical Supply Activity must order a brand new item to replace the item that is turned-in. Once received, the new item must be place on the hand receipt by the Unit Supply NCO, and a technical inspection for issue must be completed prior to pick-up by the section NCO for replacement.

6. Point of contact is the undersigned at 456-7890.

EXAMPLE
Supply Condition Code "H"

Medical Maintenance Officer
Rank, Medical Service
Position, Medical Maintenance Branch

CF:
S-4, Medical Logistics Officer
Company Commander, MED CO

DEPARTMENT OF THE ARMY
HEADQUARTERS, COMBAT SUPPORT HOSPITAL
FORT ANYWHERE, FLORIDA 12345

REPLY TO
ATTENTION OF

S: 1 October 2005

MCMR-MMM-MM 19 August 2005

MEMORANDUM THRU Commander, Medical Company

FOR Medical Company Platoon Sergeants

SUBJECT: Delegation of Authority Cards (DA Form 1687)

1. References. AR 710-2-1 dated 31 Oct 1997, AR 40-61 dated 28 January 2005.

2. Purpose. To provide guidance for accountability and chain of custody for non-expendable medical equipment that is delivered to and picked up from the Medical Maintenance Branch for services.

3. The Medical Maintenance Branch must have an updated delegation of authority card on file for each primary hand receipt holder of non-expendable medical equipment. The delegation of authority cards will clearly identify who is sub-hand receipted medical equipment and responsible for coordinating equipment services for each clinical section within the hospital. This responsibility is normally delegated to section supervisors and will be indicated on each DA Form 1687.

4. Regulation requires that if a hand receipt holder or sub-hand receipt holder will be away from the unit more than 30 consecutive days, a change in hand receipt holder responsibility should take place. Whenever there is a change in the primary or sub-hand receipt holder, delegation of authority cards will be updated so that the Medical Maintenance Branch can coordinate services with the appropriate points of contact.

5. Each section must provide a DA Form 1687 to the Medical Maintenance Branch by the above suspense date.

EXAMPLE
Delegation of Authority

Medical Maintenance Officer
Rank, BS
Medical Maintenance Branch

CF:
CDR
XO

DEPARTMENT OF THE ARMY
HEADQUARTERS, COMBAT SUPPORT HOSPITAL
FORT ANYWHERE, FLORIDA 12345

REPLY TO
ATTENTION OF

MCMR-CSH-CDR 8 December 2006

MEMORANDUM FOR ALL CSH Personnel

SUBJECT: Medical Equipment Maintenance Program Commander's Directive

1. Purpose. To inform leaders and staff within my command of my expectations as it pertains to medical equipment readiness and the importance of ensuring that the right medical equipment is available for patient care at the right place at the right time. It is critical that all medical equipment affiliated with this medical treatment facility be maintained in a fully mission capable (FMC) status.

2. Goal. To implement an effective unit level medical equipment maintenance program that includes all medical equipment associated with this organization's healthcare mission.

3. An effective unit maintenance program includes three key elements; operator maintenance, scheduled PMCS, and remedial maintenance.

a. Operator maintenance is the cornerstone to an effective unit level maintenance program, hence the most critical element. Section leaders/supervisors will:

(1) Ensure all equipment operators/users are trained and familiar with all medical equipment with which they may come in contact while performing patient care.

(2) Ensure all medical equipment within their charge is accounted for and routinely inspected for operability to include verifying cleanliness, availability of all components and accessories, and proper storage conditions.

b. All medical equipment utilized by this CSH will be included in the medical maintenance scheduled services program. The senior medical equipment repairer will:

(1) Ensure all maintenance significant medical equipment is documented in the Standard Army Management Information System and has a maintenance historical record.

(2) Maintain schedules determining when the hospital's medical equipment is scheduled to be serviced by section/hand-receipt.

(3) Coordinate the performance of scheduled maintenance services IAW established maintenance schedules. Deviations from established PMCS schedules will be documented and reviewed at the monthly training briefing.

(4) Document performance of services and apprise the Executive Officer and the Commander of shortfalls and significant equipment accountability and maintenance issues.

c. All personnel will maintain a constant awareness of equipment status and ensure that any and all medical equipment utilized for patient care is appropriately serviced and functioning correctly. Any equipment that is not functioning correctly will immediately be reported to the medical maintenance branch. Medical maintenance will make every effort to effect repairs in a timely and efficient manner.

4. The point of contact is the CSM, XO or the undersigned at 456-7890.

/- Original Signed by Hospital Commander -/
HOSPITAL COMMANDER
COL, MC
Commanding

EXAMPLE
Commander's Maintenance Directive

Appendix N
Medical Standby Equipment Program

N-1. Purpose. To assist in preserving the availability of critical medical equipment, the AMEDD has established a Medical Standby Equipment Program (MEDSTEP). The program provides the capability of positioning end items, components, assemblies, and sub-assemblies with deployed sustainment maintenance organizations (typically MEDLOGs) to support theater operations.

N-2. Responsibility. The USAMMA, as the material developer, determines initial MEDSTEP assets required to support initial theater operations. Until contingency operations dictate otherwise, it is USAMMA's responsibility to maintain and account for MEDSTEP assets on the stock record account. Upon determination that a sustainment maintenance capability will be established in the AO/TO, MEDSTEP assets will be loaned to the deploying MEDLOG organizations with a sustainment medical equipment maintenance mission.

a. MEDLOG organizations loaned equipment to support the AO/TO will manage and account for the MEDSTEP assets. MEDSTEP assets will:

(1) Be maintained and accounted for on the MEDLOG activity's stock record account.

(2) Be included in the automated maintenance database as maintenance significant for scheduling and monitoring of required services.

(3) Be provided to the gaining organization on an exchange basis. *The premise of loaning MEDSTEP to forward deployed organizations only to be exchanged again at a later time while in combat is not only impractical but obtuse.*

(4) Defective medical equipment received from medical organizations as a result of an exchange will be repaired and returned to the stock record account.

(5) Initiate a DA Form 3318 (Records of Demands - Title Insert) for each MEDSTEP asset. Annotate all work request numbers in the user column of the DA Form 3318. This data will authenticate justification and required quantities for prolonged and future operations.

(6) Not typically be used to fill equipment shortages, replace uneconomically repairable items, expand operational missions, or satisfy temporary loan requirements. The AO/TO senior medical commander or MLMC commander may authorize exceptions under emergency or unique conditions.

b. Medical organizations requiring MEDSTEP assets will:

(1) Notify the supporting MEDLOG or MLMC of urgent situation equipment requirements;

(2) Exchange with supporting MEDLOG activity economically repairable medical equipment incapable of being repaired at the unit level;

(3) Account for received equipment on the activity's property book. Once MEDSTEP is DXed, the unit must provide the DA Form 3161 to the PBO for a serial number change. The PBO will perform the Administrative Adjustment Report (AAR) to document changes to property records.

c. Upon determination that a sustainment medical maintenance support capability is no longer necessary in the AO/TO, all MEDSTEP assets will be returned to USAMRMC. Contact USAMMA to determine the appropriate location for the MEDSTEP assets to be returned.

Appendix O
Army Prepositioned Stocks

O-1. Purpose. The department of the Army has equipment assets, configured IAW specified standard requirements codes (SRC), pre-positioned in key locations throughout the world to support emergency deployment operations.

O-2. Responsibility. Medical APS equipment, although belonging to Army Materiel Command (AMC), is managed by USAMMA and maintained on an annual basis. APS ranges from entire Combat Support Hospitals to medical companies and teams.

a. The APS medical equipment, when handed off from the USAMMA Medical Logistics Support Team (MLST) to the receiving medical organization, will be in a 100% fully mission capable status.

b. The medical organization that receives APS medical equipment will ensure the equipment received is appropriately accounted for and maintained while the equipment is in their control.

c. Upon completion of contingency operations, APS equipment should be returned to USAMMA only after verification that it is 100% FMC. It is imperative that APS is maintained and ready for the next deploying medical organization.

Glossary
Section I. Abbreviations

AMEDD	Army Medical Department
AR	Army Regulations
BS	Bench Stock
BSL	Bench Stock Level
CFR	Code of Federal Regulations
CONUS	Continental United States
COR	Contracting Officer Representative
CP	Control Period
CSDP	Command Supply Discipline Program
CT	Computed Tomography
CTA	Common Table of Allowance
CVC	Calibration/Verification/Certification
DA	Department of the Army
DMSB	Defense Medical Standardization Board
DOD	Department of Defense
DOL	Director of Logistics
DPSC	Defense Personnel Support Center
DRMO	Defense Reutilization and Marketing Office
DS	Direct Support
EC	Environment of Care
ECRI	Emergency Care Research Institute
EO	Equipment Operator
EPA	Environmental Protection Agency
ER	Emergency Room
FDA	Food and Drug Administration
FM	Field Manual
FY	Fiscal Year
GS	General Support
HAZCOM	Hazard Communications
HQ	Headquarters
IAW	In Accordance With
ICU	Intensive Care Unit
IMO	Information Management Office
IMSA	Installation Medical Supply Activity
MACOM	Major Command
MEDCEN	Medical Center
MEDCOM	Medical Command
MEDDAC	Medical Department Activity
MEDSTEP	Medical Standby Equipment Program
MEL	Maintenance Expenditure Limit
MER	Medical Equipment Repairer
MERP	Mission Essential Repair Parts
MMPR	Monthly Maintenance Performance Report
MO	Minimum Order
MOS	Military Occupational Specialty
MOU	Memorandum of Understanding
MTF	Medical Treatment Facility
NCDRH	National Center for Devices and Radiological Health
NCO	Noncommissioned Officer
NIST	National Institute of Standards and Technology
NFPA	National Fire Protection Association
NICAD	Nickel Cadmium
NIIN	National Item Identification Number
NMP	National Maintenance Point
NSN	National Stock Number
OEM	Original Equipment Manufacturer
OR	Operating Room
OSHA	Occupational Safety and Health Act
OST	Order and Ship Time
PAM	Pamphlet

PBO	Property Book Officer
PLL	Prescribed Load List
PMCS	Preventive Maintenance Checks and Services
PMO	Property Management Office
RCC	Recoverability Code
REG	Regulation
RMC	Regional Medical Command
RO	Requisitioning Objective
ROP	Reorder Point
RPPF	Radiation Protection Program File
SB	Supply Bulletin
SL	Stock Level
SMDA	Safe Medical Devices Act
SOP	Standing Operating Procedure
SOW	Statement of Work
SSA	Supply Support Activity
STAMIS	Standard Army Management Information System
TAMMS	The Army Maintenance Management System
TB	Technical Bulletin
TDA	Table of Distribution and Allowance
TDY	Temporary Duty
TI	Technical Inspection
TM	Technical Manual
TMDE	Test, Measurement, and Diagnostic Equipment
UPS	Uninterruptible Power System
USACHPPM	United States Army Center for Health Promotion and Preventive Medicine
USAMMA	United States Army Medical Materiel Agency
WO	Warrant Officer

Section II. TERMS

Accessories	Accessories are items which enhance or provide additional capabilities to an end item. An accessory may be expendable, durable, or nonexpendable. Whereas a component is a functional element of a set or system, an accessory is considered to be a supplementary item. A transducer for an ultrasound scanner is a component of that end item. Additional transducers, which provide additional capabilities, are considered to be accessories to the end item.
Calibration/verification/ certification	The verification of the calibration of an item of equipment compared to the original manufacturer’s specification using calibrated TMDE. Physical calibration is not accomplished unless the verification step indicates the system is within tolerances. The final step to every verification and/or calibration is to certify compliance by affixing a completed DD Form 2163, Medical Equipment Verification/Certification.
Equipment maintainer	Personnel trained in the repair of medical equipment. Assigned Army personnel are in MOSs 670A, 68A, and appropriate civilian repairer/engineer series.
Equipment operator	The person responsible for operating an item of medical equipment and providing before, during, and after operator maintenance. These services may consist of dusting, washing, cleaning, checking for loose or missing hardware, checking for frayed cables, and replacing operator replacement items and accessories.

Isolated input/isolated patient lead	A patient lead having a high resistance to ground or to either conductor of the equipment's power cord. If the patient lead is connected between ground or to either conductor of the power cord, the result would be current flow below a hazardous limit in the lead. Ideally the isolation would result in infinite impedance between the patient lead and ground or the power cord conductors, with no current flow when the patient lead is connected to either. On ECG's, the isolation is commonly made using an isolation transformation at a point on the apparatus where the patient cable enters the chassis but prior to making connection to any of the equipment's electrical circuits.
Maintenance supervisor	The individual assigned to the medical maintenance branch who works for the senior maintenance manager and is responsible for the day-to-day maintenance operations.
Non-technical equipment	Equipment that is usually mechanical, electromechanical, or electrical requiring only basic skills to maintain; not normally incorporating any solid state components or printed circuit boards. This equipment will not compromise or jeopardize a patient's health or well being.
Operator replacement item	Those items and accessories that do not require installation/repair by a MER. Items and accessories (hand pieces, transducers, etc.) that can be replaced by users/operators are not classified as repair parts, but user replacement items. User replacement items do not require extensive disassembly of the item, critical alignment or adjustment after replacement, or tools. Users/operators should not attempt repairs beyond those authorized as part of operating technique.
Patient vicinity	The space, in which patients are normally cared for, with surfaces likely to be contacted by the patient or an attendant who can touch the patient. Within a patient room, the patient vicinity is considered to be 6 ft beyond the perimeter of the bed and extending vertically to 7.5 feet above the floor.
Preventive maintenance checks and services	A program of systematic care, servicing, and inspecting of equipment to maintain it in a standard serviceable condition and to detect and correct minor faults before they develop into major defects.
Repair parts	AR 40-61, AR 750-1, and this bulletin assign the responsibility of maintenance and repair of medical equipment to qualified MERs. AR 310-25 defines a repair part as any part, subassembly, assembly, or component required for installation in the maintenance or repair of an end item.
Senior maintenance manager	The individual assigned to the medical maintenance branch with overall responsibility and authority for managing the medical maintenance operations for the MTF. Also may be referred to as the Maintenance Manager. In the case of this individual's absence, the person filling the position of NCO would assume responsibility.
Surveillance	A visual inspection of the equipment or its sealed storage container to determine if there is a need to perform a more in-depth operation test or technical inspection.
Technical equipment	Equipment usually requiring an increased knowledge of electronics as compared to the skill level required to maintain non-technical equipment. It is usually electronic, incorporating printed circuit boards.

GLOSSARY

> Acronyms are listed on pages GL-1 through GL-8
>Terms/Definitions are listed on pages GL-9 through GL-11

Acronyms:

Abbreviation	Definition
AAALAC	American Association for Accreditation of Laboratory Animal Care
AAC	Acquisition Advice Code
ACSIE&FM	Assistant Chief of Staff for Installations Environment and Facility Management Environment and Facility Management
ACSLOG	Assistant Chief of Staff for Logistics
ACSRM	Assistant Chief of Staff for Resource Management
ACTEDS	Army Civilian Training, Education and Development System
ADAL	Addition or Alteration
AFR	Air Force Regulation
AIT	Automatic Identification Technology
AKO	Army Knowledge Online
AMC	Army Materiel Command
AMC/SG	Air Mobility Command/Surgeon General
AMDF	Army Master Data File
AMEDD	Army Medical Department
AMEDDC&S	Army Medical Department Center and School
AMEDDPAS	Army Medical Department Property Accounting System
APS	Army Pre-Position Stocks
AR	Army Regulation
ARC	Accounting Requirements Code
ARNG	Army National Guard
ARSAMS	Army Reserve Supply and Maintenance System
ASARDA	Assistant Secretary of the Army for Research, Development and Acquisition
ASD/HA	Assistant Secretary of Defense for Health Affairs
ASHE	American Society of Healthcare Engineers
ASL	Authorized Stockage List
AT/FP	Anti-Terrorism / Force Protection
AWR	Air-Worthiness Release
BPA	Blanket Purchase Agreement
BSC	Balanced Score Card
BSL3	Bio-Safety Level 3 Facility
C, ES	Chief, Environmental Services
CAD	Computer-Aided Design/Drawing
CADD	Computer-Aided Drafting and Design
CAIM	Customer Area Inventory Management
CAP	Council of American Pathologists (CAP)
CAPS-W	Commercial Accounting and Payment System Worldwide
CARS	Custom Army Reporting System

Abbreviation	Definition
CATCODE	Category Code
CBRN	Chemical Biological Radiological and Nuclear
CDR	Commander
CEEP	Capital Expense Equipment Program
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CIF	Central Issue Facility
CIIC	Controlled Inventory Item Code
CLRP	Command Logistics Review Program
CLRT	Command Logistics Review Team
CLS	Combat Lifesaver
CMMS	Computerized Maintenance Management System
COCOM	Combatant Command(er)
CONUS	Continental United States
COR	Contracting Officer's Representative
CSH	Combat Support Hospital
CTA	Common Table of Allowances
DA	Department of the Army
DA PAM	Department of the Army Pamphlet
DAAS	Defense Automatic Addressing System
DAB	Division and Below
DAPA	Distribution and Pricing Agreement
DBBS	Defense Blood Bank System
DBPA	Decentralized Blanket Purchase Agreements
DCAM	DMLSS Customer Assistance Module
DCDD	Directorate of Combat and Doctrine Development
DCM	DMLSS Communications manager
DEA	Drug Enforcement Administration
DENCOM	Dental Command
DFAS	Defense Finance and Accounting Service
DFAS-IN	Defense Finance and Accounting Service - Indianapolis Center
DFAS-SA	Defense Finance and Accounting Service - San Antonio
DHP	Defense Health Program
DIC	Document Identifier Code
DIN-PACS	Digital Imaging Network–Picture Archiving Communications System
DISC	Defense Industrial Supply Center
DLA	Defense Logistics Agency
DLAM	Defense Logistics Agency Manual
DLAR	Defense Logistics Agency Regulation
DLIS	Defense Logistics Information System
DMFO	Defense Medical Facilities Office
DMLSS	Defense Medical Logistics Standard Support
DMMC	Division Materiel Management Center
DMOC	Division Medical Operations Center
DMSB	Defense Medical Standardization Board

Abbreviation	Definition
DMSO	Division Medical Supply Office
DoD	Department of Defense
DODAAC	Department of Defense Activity Address Code
DoDI	DoD Instruction
DOL	Directorate of Logistics
DOS	Days of Supply
DPW	Director of Public Works
DRMO	Defense Reutilization and Marketing Office
DS	Division Surgeon
DSCP	Defense Supply Center Philadelphia
DSN	Defense Switching Network
DVA	Department of Veterans Affairs
DWCF	Defense Working Capital Fund
EAC	Echelons Above Corps
ECAT	Electronic Catalog
ECIP	Energy Conservation Investment Program
ECN	Equipment Control Number
ECP	Exposure Control Plan
ED	Emergency Division
EEMP	Excess Equipment Management Program
EMCS	Energy Monitoring and Control System
EOQ	Economic Order Quantity
EOR	Element of Resources
EPA	Environmental Protection Agency
EPR	Environmental Program Requirements
EPR-M	Environmental Program Requirements - USAMEDCOM
ERP	Enterprise Resource Planning
ES	Environmental Services
ESL	Estimated Storage Life
ESO	Environmental Science Officer
ESOC	Emergency Supply Operations Center
ESPC	Energy Savings Performance Contract
ETM	Equipment and Technology Management
F&AO	Finance and Accounting Office
FAAST	Facility Assistance and Assessment Support Team
FAR	Federal Acquisition Regulation
FCI	Facility Condition Index
FDA	Food and Drug Administration
FEDLOG	Federal Logistics Record
FEDSTRIP	Federal Standard Requisitioning and Issue Procedures
FIA	Financial Inventory Accounting
FLCM	Facility Life Cycle Management
FM	Facilities Management, or, Field Manual (when followed by a number)
FM-ACE	Facility Management Applied and Continuing Education course

Abbreviation	Definition
FMB	Facility Management Branch
FMV	Fair Market Value
FORSCOM	United States Army Forces Command
FSC	Federal Supply Catalog / Federal Supply Class
FSM	Facility Sustainment Model
FSMC	Forward Support Medical Company
FSS	Federal Supply Schedules
FST	Forward Surgical Team
FTP	File Transfer Protocol
FY	Fiscal Year
GCSS-A	Global Combat Support System-Army
GSA	General Services Administration
HA	Health Affairs
HAZMAT	Hazardous Materiel
HCA	Health Care Activity
HFPA	Health Facility Planning Agency
HQIFS	Headquarters Integrated Facilities System
IAW	In Accordance With
IFS-M	Integrated Facilities System Mini/Micro
IM	Inventory Management
IM/IT	Information Management/ and Information Technology
IM/ITS	Information Management and Information Technology Systems
IMA	Installation Management Activity
IMMSS	Integrated Modular Medical Support System
IMPAC	International Merchant Purchase Authorization Card
IMSA	Installation Medical Supply Activity
IPD	Issue Priority Designator
IS	Information Systems
ISP	Installation Support Package
ISR	Installation Status Report Installation Status Report
ISSA	Inter-Service Support Agreements
ITO	Installation Transportation Office
JCAHO	Join Commission on Accreditation of Healthcare Organizations
JMAR	Joint Medical Asset Repository
LAN	Local Area Network
LIN	Line Item Number
LMC	Linen Management Committee
LO	Land Operations
LSU	Life Safety Upgrade
MACOM	Major Command (United States Army)

Abbreviation	Definition
MC4	Medical Communications for Combat Casualty Care
MCA	Military Construction, Army
MCDM	Medical Chemical Biological Radiological and Nuclear (CBRN) Defense Materiel
MCN	Management Control Number
MCO	Marine Corps Order
MCSC	Materiel Category Structure Code
MEDCASE	Medical Care Support Equipment
MEDCAT	Medical Catalog
MEDCEN	Medical Center
MEDCOM	U.S. Army Medical Command
MEDDAC	Medical Department Activity
MEDLOG	Medical Logistics
MEDLOG Bn	Medical Logistics Battalions
MEDSILS	Medical Services Information Logistics Systems
MEDSUP	Medical Supply
MEET	Mission Essential Equipment Training
MEIS	Military Environmental Information Source
MES	Medical Equipment Sets
MFT	Materiel Fielding Team
MHS	Military Health System
MIDI	Military Item Disposition Instructions
MILCON	Military Construction
MILSBILLS	Military Standard Billing System
MILSTRIP	Military Standard Requisitioning and Issue Procedures
MIREP	Medical Instrument Recycling Program
MLMC	Medical Logistics Management Center
MLST	Medical Logistics Support Team
MMBP	Military Medical Benefits Property
MMI	Medical Materiel Information
MMQC	Medical Materiel Quality Control
MMS	Medical Materiel Sets
MNT	Maintenance
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MOV	Materiel Obligation Validation
MR/MC	Major Repairs/Minor Construction
MRMC	Medical Research and Materiel Command
MRO	Materiel Release Order
MSC	Major Subordinate Commands
MSDS	Materiel Safety Data Sheets
MSE	Mobile Subscriber Equipment
MSMC	Main Support Medical Company
MSO	Medical Supply Officer
MSPC	Medical Space Planning Criteria
MST	Medical Support Team
MTDA	Modified Table of Distribution and Allowances

Abbreviation	Definition
MTF	Medical Treatment Facility
MTOE	Modified Table of Organization and Equipment
NATO	North Atlantic Treaty Organization
NAVMEDCOMINST	Naval Medical Command Instruction
NAVSUPINST	Navy Supply Instruction
NDC	National Drug Codes
NFPA	National Fire Protection Association
NGB	National Guard Bureau
NICP	National Inventory Control Point
NOSTRA	Naval Ophthalmic Support and Training Activity
NSN	National Stock Number
O&M	Operations & Maintenance
OAP	Organizational Assistance Program
OCIE	Organizational Clothing and Individual Equipment
OCONUS	Outside Continental United States
OFAB	Optical Fabrication Advisory Board
OFE	Optical Fabrication Enterprise
OFL	Optical Fabrication Laboratories
OIP	Organizational Inspection Program
OMA	Operations and Maintenance, Army
OMB	Operations Management Bulletin
OMD	Operations and Maintenance, Defense
OPA	Other Procurement, Army
OPD	Other Procurement, Defense
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety & Health Administration
OST	Order and Shipping Time
OTSG	Office of the Surgeon General
PAD	Patient Administration Division
PARC	Principle Assistant Responsible for Contracting
PBO	Property Book Officer
PBT	Pyridostigmine Bromide Tablets
PBUSE	Property Book Unit Supply Enhancement
PC	Personal Computer
PFD	Program for Design
Plexus-D	PMI Tracking System
PM	Preventive Maintenance
PMBS	Precious Metals Bearing Scrap
PMC	Precious Metals Coordinator
PMed	Preventive Medicine
PMI	Patient Movement Items
PMM	Precious Metals Monitor
PMR	Patient Movement Request

Abbreviation	Definition
PMRP	Precious Metals Recovery Program
POU	Point of Use
PPP	Power Projection Platform
PR	Purchase Request
PRA	Property Record Administrative Adjustment
PRV	Plant Replacement Value
PRweb	Purchase Request Web
PSP	Power Support Platform
PT&I	Predictive Testing and Inspection
PV	Prime Vendor
QA	Quality Assurance
QC	Quality Control
RC	Reserve Component
RCHD	Reserve Component Hospital Decrement
RCM	Reliability Centered Maintenance
RDTE	Research Development Test and Evaluation
RIA	Regional Incentive Agreements
RIC	Routing Identifier Code
RMC	Regional Medical Command
RMW	Regulated Medical Waste
RO	Requisition Objective
SAMS-1	Standard Army Maintenance System Level 1
SAMS-2	Standard Army Maintenance System Level 2
SAP	Systems Applications and Products
SAV	Staff Assistance Visit
SB	Supply Bulletin
SC	Supply Catalog
SCM	Supply Chain Management
SCR	System Change Request
SECNAVINST	Secretary of the Navy Instruction
SF	Standard Form
SIMLM	Single Integrated Medical Logistics Manager
SKO	Sets, Kits, and Outfits
SLEP	Shelf Life Extension Program
SMDA	Safe Medical Devices Act
SME	Subject Matter Expert
SOS	Source of Supply
SRM	Sustainment, Restoration, and Modernization
SRP	Soldier Readiness Processing
SRTS	Spectacle Request Transmission System
SSA	Supply Support Activity
TAC	Transportation Account Code

Abbreviation	Definition
TAMMIS	Theater Army Medical Management Information System
TAMMIS-MEDSUP	Theater Army Medical Management Information System Medical Supply
TB MED	Technical Bulletin, Medical
TCAM	TAMMIS Customer Assistance Module
TDA	Table of Distribution and Allowances
TEWLS	Theater Enterprise Wide Logistics System
TI	Technical Inspection
TM	Technical Manual
TMDE	Test, Measurement, and Diagnostic Equipment
TMIP	Theater Medical Information Program
TMU	Table Maintenance Utility
TO&E	Table of Organization and Equipment
TRO	TriCare Regional Office
TSG	The Surgeon General
UA	Unit Assemblage
UAL	Unit Assembly Listing
UBL	Unit Basic Load
UDP	Unit Deployment Packages
UDR	Universal Data Repository
UIC	Unit Identification Code
ULLS-G	Unit Level Logistics System Ground
ULLS-S4	Unit Level Logistics System – S4
UMC	Unspecified Minor Construction
UMCS	Utility Monitoring and Control System
USACHPPM	U.S. Army Center for Health Promotion and Preventive Medicine
USAHFPA	U.S. Army Health Facility Planning Agency
USAMEDCOM	U.S. Army Medical Command
USAMITC	U.S. Army Medical Information Technology Center
USAMMA	United States Army Medical Materiel Agency
USAMMCE	United States Army Medical Materiel Center Europe
USAMMDA	United States Army Medical Materiel Development Activity
USAR	United States Army Reserve
USARC	United States Army Reserve Command
USAREUR	United States Army Europe
USARPAC	United States Army Pacific
USPFO	United States Property and Fiscal Officer
VETCOM	Veterinary Command
VFA	Vanderweil Facility Advisors
WAWF	Wide Area Work Flow
WAWF-RA	Wide Area Work Flow-Receipts and Acceptance
WRAMC	Walter Reed Army Medical Center
WRM	War Reserve Materiel

Terms:

Term	Definition
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. (*AR 40-61, AR 710-2, AR 735-5, DA PAM 710-2-1, DA PAM 710-2-2*)
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: a. Formal – Stock record accounting for supplies being held for issue from time of receipt until, issued, shipped or dropped from accountability. (A*R 40-61, AR 710-2, AR 735-5, DA PAM 710-2-1, DA PAM 710-2-2*). b. Property Book – Accounting for nonexpendable organization property upon receipt and until subsequently turned-in, used (consumed) for authorized purposes, or dropped from accountability. (*AR 40-61, AR 710-2, AR 735-5, DA PAM 710-2-1, DA PAM 710-2-2*).
Army Master Data File (AMDF)	An official source of supply management data used in medical logistics. The U.S. Army Materiel Command publishes it monthly.
Army Medical Command	An organization that has command over one or more MEDCENs, MEDDACs, or medical research activities. Includes U.S. Army Medical Command, U.S. Army Medical Research and Materiel Command, and 18th Medical Command.
Bulk (liquid) gases	A fixed, central system consisting of a main storage tank that pipes oxygen, ethylene oxide, or other gasses to patient care areas.
Capital expense equipment program	Equipment having a unit price less than current OPD threshold.
Command Surgeons	Senior Medical Corps officer who is part of the Division/Corps/Theater/MACOM special staff. Keeps the commander informed regarding medical aspects of operations.
Durable item	An item of Army property coded with an ARC of “D” in the AMDF or DoD Medical Catalog. Durable items do not require property book accountability. Durable items are identified with an ARC “D” in the AMDF or UDR. Commercial and fabricated items similar to items coded “D” in the AMDF or UDR are considered durable items.

Term	Definition
Expendable	An item that is consumed or loses its identity in use. Expendable items are identified with an ARC of X in the AMDF or UDR
Gas analysis	A measurement of the percentage of the gas in a sample by volume using a battery-operated, portable, hand-held instrument.
Health Care Activity (HCA)	All TOE and TDA facilities that provide medical care and support. Includes hospitals, clinics, dental activities, veterinary activities, combat stress, preventive medicine, logistics, and evacuation.
Installation medical supply activity (IMSA)	In CONUS, the SSA for medical materiel for an installation or geographic area. In OCONUS, it is normally the primary SSA for medical materiel for a designated geographic area.
Leased Equipment	Leased equipment requires legal agreement and accountability. Files should 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 (MSC)	MSCs under USAMEDCOM; includes RMCs, CHPPM, VETCOM, DENCOM, AMEDDC&S, and USAMRMC.
Management level	An acceptable range of performance expressed with upper and lower control limits. Performance that is not within the acceptable range warrants management review.
Management objective	The point of measured performance that is generally attainable under normal operating conditions.
Medical Care Support Equipment (MEDCASE)	That equipment authorized for acquisition through OPD and MED MILCON funding programs that is required in AMEDD TDA fixed health care activities.

Term	Definition
Medical materiel	Medical materiel includes nonexpendable, durable, and expendable supplies used in HCAs, medical research and laboratory facilities and other medical related institutions and units in the AMEDD.
Military Medical Benefits Property (MMBP)	Consists of equipment loaned from a treatment facility to authorized personnel when needed for the treatment of injury or disease.
Performance measures	A selected indicator that is used as a barometer or gauge to compare actual performance against a management objective or the parameters of a management level.
Regulated Medical Items	Materiel identified in the AMDF or FEDLOG or UDR with an AAC A. Examples would be MES, patient-movement items, and ASIOE.
Regulated Medical Waste	Includes liquid or semi-liquid blood or other potentially infections 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 flood or other potentially infectious materials.
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). Does not necessarily require suspension of the item.

2006 CUMULATIVE INDEX FOR THE SB 8-75 SERIES

SUBJECT	SB 8-75-	Page
A		
A2S - AMEDD Small Shelter	S4	8-1
AAC - Acquisition Advice Code	S4	6-1
AAC "W" and "J" Relationships	S5	12-1
Abaxis Clinical Chemistry Analyzer, Model Piccolo, NSN 6630-01-415-1593	S2	1-1
Acceptance Testing	S5	10-6
Acquisition Advice Code (AAC) 'W' and 'J' Relationships	S1	4-1
Acquisition Advice Codes and Unit Funded Requisitions	S7	5-10
Activity/RMC/MSC Commander Review and Approval	MEDCASE	4-2
Additional Information for Contacting USAMMA (at the end of each chapter)	S7	
Additional Product Information – CBRN and MCDM	S7	5-4
Administrative and Information Management Introduction	MEDCASE	13-1
Alaris Infusion Pump, Model 2863B, NSN 6515-01-452-0625	S2	1-1
Alaris Infusion Pump, Model MEDSYSTEM III, NSN 6515-01-452-0625	S2	1-2
Alaris Infusion Pump Service Bulletins	S2	1-2
Alternate Acquisition Activity Introduction	MEDCASE	8-1
AMEDD Fielding Policy	S4	1-1
Analyzer, Gas, Anesthetic, 6630-01-487-6987	S6	3-1
Anesthesia Apparatus, 6515-01-457-1840	S6	2-1
APPMO Responsibilities	S5	10-1
Approval of MEDCASE/SuperCEEP Requirements Introduction	MEDCASE	4-1
APS and SC VIII APS Locations	S7	3-1
APS Program Background	S7	3-1
APS Storage Sites	S7	8-2
AR ACEL – Army Reserve Acceleration Program	S4	4-2
ARNG Federal Supply Class 6505 Materiel	S10	4-1
ARNG Requisitioning Instructions	S10	5-1
ARNG Unit Inspection Checklists:	S10	6-1
Pharmaceuticals and Injection Devices	S10	6-3
Management of Medical Assemblages	S10	6-7
Medical Equipment Maintenance	S10	6-9
Army Medical Logistics (MEDLOG) Overview	S1	2-1
Army National Guard (ARNG) Responsibilities	S10	All
Army Prepositioned Stock (APS) Program	S7	3-1
Army Prepositioned Stock (APS) and Unit Deployment Package (UPD) Automated Systems	S7	8-1
Army Transformation/Medical Logistics Support "Army At War"/AMEDD Modularity/ PPBE/Army Reserve Force Generation	S1	2-1
Army War Reserve Deployment System (AWRDS)	S7	8-1
Arthroscopic System, 6515-01-431-9631	S6	2-1
Asset Visibility	S7	8-2
Assignment of a BLIC	MEDCASE	3-4
Assignment of a MEDCASE/SuperCEEP ACN	MEDCASE	3-3
Authorized Recipients of Controlled Substances DODAAC Requisitioners (Table 4-1)	S1	4-3
Auto Sequences, Fluke Biomedical/DNI Test Equipment	S6	3-1
Available Operator and Maintenance Literature	S2	1-2

SUBJECT — SB 8-75- — Page

Availability of the USAMMA CD-ROM ---------- S1 ----------1-3
Award and Acceptance ---------- MEDCASE ------- 12-4

B

Background – APS and UPD ---------- S7 ----------8-1
Background on DOD/FDA Shelf Life Extension Program (SLEP) ---------- S7 ----------9-1
Base Level Commercial Equipment (BCE) ---------- MEDCASE ------- 13-5
Basic Procedures for Local Purchase ---------- MEDCASE ---------7-4
Basic Requisitioning Procedures ---------- MEDCASE ---------6-1

Battery Support System, 6625-01-192-9460 ---------- S6 ----------2-1
Belmont Blood Fluid Warmer, Model FMS 2000, NSN 6515-01-479-4269 ---------- S2 ----------1-2
Book Set Components Listing in NSN Order ---------- S9 -- Appendix B
Business Process Improvements for Military Radiology ---------- S5 ----------4-2

C

Calibrator – Analyzer (VT-Plus), 6515-01-491-6615 ---------- S6 ----------3-1
CD ROM, Availability of the USAMMA CD ---------- S1 ----------1-3
Centrally Managed Program – Supply Class VIII ---------- S1 ----------3-1
Centrally Managed Systems ---------- MEDCASE ------- 13-4
Central Requirements ---------- MEDCASE ------- 3-12

CICA ---------- MEDCASE ------- 14-2
Class VIII Contingency Materiel Programs - Introduction ---------- S7 ----------1-1
Clinical Approach and Business Process Reengineering ---------- S5 ----------5-6
Combat Support Equipment Assessment (CSEA) ---------- S1 ----------3-1
Communication/Automation Data Processing Equipment Acquisition ---------- MEDCASE ------- 13-3

Competition in Contracting Requirements Introduction ---------- MEDCASE ------- 14-1
Computed Radiography, 6525-01-504-5002 ---------- S6 ----------2-1
Concentrator, Oxygen, 6515-01-434-4629 ---------- S6 ----------2-2
Consumable/Support Items for Medical Equipment Unique to a Set are
Identified in Section IV in the Published UA Listings ---------- S5 --------- 11-6
Consumables Handbook ---------- S4 ----------7-1

Container Inspection ---------- S4 --------- 13-1
Content and Numbering System for the SB 8-75 Series ---------- S1 ----------1-2
Controlled Substance Authorized Recipients Listings (Table 4-1) ---------- S1 ----------4-3
Controlled Substances – NSNs ---------- S5 --------- 12-1
CSC Inspections ---------- S4 --------- 12-1
Cumulative SB 8-75 Series Index for 2006 ---------- SB-11 --------- IN-1

D

DA SB 8-75 Series Overview ---------- S1 ----------1-1
Damage Inspection After Movement ---------- S4 --------- 13-1
Defense Medical Logistics Standard Support (DMLSS) System ---------- S7 ----------8-3
Defense Logistics Agency (DLA) Customer Support Assistance Representatives -------- S1 ----------4-1
Defense Reutilization Management Office (DRMO) ---------- S6 ----------1-4

SUBJECT — SB 8-75- — Page

Defibrillator, Monitor Recorder, 6516-01-515-4197 ---------- S6 ----------2-3
Dental Operating Unit, Field, 6520-01-493-3759 (AKA "DEFTOS") ---------- S6 ----------2-3
DEPMEDS DISE/PDISE Systems ---------- S4 --------- 15-3
Deputy Commander for Operations (MCMR-MMO) ---------- S1 ----------2-6
Deputy Commander for Support (MCMR-MMA) ---------- S1 ----------2-9

Derivative DODACC and UIC ---------- S4 ----------3-1
Destruction of MCDM ---------- S7 ----------5-9
Development of MEDCASE/SuperCEEP Requirements Introduction ---------- MEDCASE ---------3-1
Deviations ---------- MEDCASE ---------1-3
DH1 Project – Deployable Force Package (DFP) ---------- S7 ----------5-1

DHS Project – Initial Potency & Dated (P&D) MCDM for the Medical Equipment Set,
Chemical Agent Patient Treatment (LIN M23673) ---------- S7 ----------5-5
Diagnostic Imaging and Radiation Therapy Requirements ---------- MEDCASE ------- 12-1
Diagnostic Imaging and Radiation Therapy Requirements Introduction ---------- MEDCASE ------- 12-1
Diagnostic Imaging and Radiation Therapy Requirements Scope ---------- MEDCASE ------- 12-1
Digital Imaging and the Digital Imaging Communication in Medicine
Standard Introduction ---------- S5 ----------8-1

Digital Technology ---------- S5 ----------4-3
DISE – Distribution Illumination Systems Electrical ---------- S4 --------- 15-1
Disposition of Replaced TEMPER ---------- S4 ----------8-3
DMLSS System ---------- MEDCASE ---------3-6
DOD/FDA Shelf Life Extension Program (SLEP) ---------- S7 ----------9-1

Dolly Set, M-1022A1 Current Status ---------- S4 --------- 14-1
Draft Copy of *TB MED 750*-1 ---------- SB-11 ---------- C-1
Drug Enforcement Administration (DEA) Biennial Controlled Substance Inventory ----- S1 ----------4-2

E

Electrosurgical Apparatus, 6515-01-309-6647 ---------- S6 ----------2-4
Environmental Services Management In Healthcare Organizations ---------- SB-11 ----------7-1
Equipment Contracting for the Laboratory ---------- S5 ----------7-1
Equipment Replacement ---------- MEDCASE -------- 2-5
Equipment Replacement Report ---------- MEDCASE ------- 16-1

Equipment Replacement Reports General ---------- MEDCASE ------- 16-1
Equipment Replacement Reports Introduction ---------- MEDCASE ------- 16-1
Emergency Operations Center (EOC), The Medical Logistics Support Team (MLST),
and The USAMMA Forward Logistics Support Element (USAMMA FWD) ---------- S7 ----------7-1
Errata Sheet for SB 8-75-S7 ---------- SB-11 ----------i
Excess Medical Materiel ---------- S1 ----------4-4

Excess Medical Materiel ---------- S4 ----------2-1
Execution and Acquisition Source ---------- MEDCASE ------- 12-2
Execution of BLIC "MB" Requirements ---------- MEDCASE ---------5-2
Execution of MEDCASE/SuperCEEP Requirements Introduction ---------- MEDCASE ---------5-1
Expiration of Unfunded MEDCASE/SuperCEEP Requirements ---------- MEDCASE ---------4-3

External N_2O Regulator Verification ---------- S6 ---------- H-1
External O_2 Regulator Verification ---------- S6 ---------- G-1
External Standard Operating Procedures, Medical Maintenance Operations Division
Hill AFB, UT ---------- S6 ---------- A-1

SUBJECT — SB 8-75- — Page

External Standard Operating Procedures, Medical Maintenance Operations Division
Tobyhanna, PA ---------- S6 ---------- B-1
External Standard Operating Procedures, Medical Maintenance Operations Division
Tracy, CA ---------- S6 ---------- C-1
Extended Installation ---------- MEDCASE ------- 12-3

F

Facility Life-Cycle Management ---------- SB-11 ----------8-1
FDA/DOD Shelf Life Extension Program Testing Criteria ---------- S7 ----------9-1
Federal Supply Class (FSC) 6505 Materiel for ARNG ----------S10 ----------4-1
FED LOG on CD ---------- S5 --------- 12-2
Financial Management ---------- MEDCASE ---------2-6

Fleet Management System (FLMS) ---------- S7 ----------8-3
Force Projection Directorate (MCMR-MMO-P) ---------- S1 ----------2-7
Force Sustainment Directorate (MCMR-MMO-S) ---------- S1 ----------2-8
Foreword For SB 8-75-S7 ---------- S7 ----------i
Funding MEDCASE/SuperCEEP Requirements ---------- MEDCASE ---------5-1

Funds and Funding Policy for Site Preparation ---------- S5 ----------3-2
Funds Management at the Station ---------- MEDCASE ---------5-2

G

General Information ---------- S5 ----------1-1
General Information (RCHD) ---------- S7 ---------- 6-2
General Medical Materiel Information ---------- S1 ----------4-1
Generator, Oxygen, Medical, POGS, 6530-01-533-4481 ---------- S6 ----------2-4
Glossary for:
SB 8-75-MEDCASE ---------- MEDCASE ------- GL-1
SB 8-75-S1 ---------- S1 --------- GL-1
SB 8-75-S3 ---------- S3 --------- GL-1
SB 8-75-S4 ---------- S4 --------- GL-1
SB 8-75-S5 ---------- S5 --------- GL-1
SB 8-75-S7 ---------- S7 --------- GL-1
SB 8-75-11 ---------- SB-11 --------- GL-1

Goals of Digital Radiology ---------- S5 ----------4-2
Goals of Military Radiology ---------- S5 ----------4-1
Ground Rod Set ---------- S4 ----------9-2

H

Hand Receipts ---------- S4 ----------3-2
HOSP – Hospital Optimization Standardization Program ---------- S4 ----------4-1

I

Identification of Key Elements to be Monitored ---------- S5 ----------9-4
Identification of Requirements ---------- MEDCASE ---------3-2

SUBJECT — SB 8-75- — Page

Information Assurance ---------- S5 -------- 10-10
Information Mission Area (IMA) Software and Hardware ---------- MEDCASE ------- 13-2
Information Regarding the SB 8-75 Series ---------- S1 ---------- 1-1
Initial Issue Medical, Chemical, Biological, Radiological, and Nuclear Defense Materiel (MCDM) ---------- S7 ---------- 5-1
Initiation of BLIC "NF" and BLIC "MB" Requirements ---------- MEDCASE ------- 3-11

Inscribing Equipment ---------- S6 ---------- 1-3
Installation During Site Preparation ---------- S5 ---------- 3-3
Instructions for Obtaining Supply Catalogs and Supply Bulletins ---------- S5 --------- 11-2
Instructions for Recording DIN-PACS Medical Systems on Activity Property Books for Sites Using DMLSS ---------- SB-11 ---------- B-1
Integrated Logistics Support ---------- S1 ---------- 3-2

International Logistics Office (ILO) and Foreign Military Sales (FMS) ---------- S7 -------- 10-1
Introduction to Processing of Urgent and Emergency MEDCASE/SuperCEEP Requirements ---------- MEDCASE ---------- 9-1
Introduction to SB 8-75-11 ---------- SB-11 ---------- 1-1
Introduction to SB 8-75-S9 ---------- S9 ---------- i-1
Invasive Monitoring of mA for the Philips BV 300 C-Arm ---------- S2 ---------- 1-3

ISO Door Locking Device ---------- S4 --------- 11-1
ISO Scissor Jacks ---------- S4 --------- 10-1
ISO Toolbox Inventory ---------- S4 ---------- 9-1

J

Justification for Other-Than-Full-and-Open Competition ---------- MEDCASE ------- 14-3
Justification of Requirements ---------- MEDCASE --------- 3-5

L

Labeling Requirements and Guidance ---------- S7 ---------- 9-4
Laboratory Automation ---------- S5 ---------- 7-3
Leased Equipment ---------- MEDCASE --------- 5-4
Lifepak 10 Defibrillator/Monitor, NSN 6515-01-453-4003 ---------- S2 ---------- 1-3
Light, Field Surgical, 6530-01-343-2033 ---------- S6 ---------- 2-5

LOA Management ---------- MEDCASE --------- 7-2
Loan or Lease of Medical Materiel ---------- S1 ---------- 4-5
Local Area Network (LAN) and Wide Area Network (WAN) ---------- MEDCASE ------- 13-3
Local Purchase and Letters of Authority (LOA) Introduction ---------- MEDCASE --------- 7-1
LOGCAT Codes ---------- MEDCASE ------- 11-2

Logistics Assistance Program ---------- S4 ---------- 5-1
Logistics Assistance Program (LAP) ---------- S1 ---------- 3-3
Logistics Support Elements ---------- S5 ---------- 6-1

M

Maintenance Allocation Chart (MAC) ---------- S8 ---------- 1-4
Maintenance Divisions' Addresses ---------- S6 ---------- 1-2
Maintenance Operations Division (MOD) Chief Personnel ---------- S6 ---------- 1-1

(Continued) 2006 CUMULATIVE INDEX

SUBJECT	SB 8-75-	Page
Major Medical Assemblages/SC Number Cross Reference Listing	S5	11-2
Management and Accountability of Initial Issue DFP MCDM	S7	5-3
Management and Accountability for Initial Issue Potency & Dated (P&D) MCDM for the Medical Equipment Set, Chemical Agent Patient Treatment (LIN M23673)	S7	5-6
Management of Requisitions	MEDCASE	6-5
Managing Technology in the Military Laboratory Introduction	S5	7-1
Materiel Acquisition Directorate (MCMR-MMO-A)	S1	2-6
Materiel Acquisition Directorate Realignment	S5	1-2
MEDCASE and SuperCEEP General Information Introduction	MEDCASE	1-1
MEDCASE and SuperCEEP General Information Responsibilities	MEDCASE	1-1
MEDCASE Introduction	S5	2-1
MEDCASE/SuperCEEP Action Codes	MEDCASE	4-3
MEDCASE/SuperCEEP Eligibility of Costs Other Than Unit Price	MEDCASE	15-2
MEDCASE/SuperCEEP Process	S5	2-1
MEDCASE/SuperCEEP Program Eligibility	MEDCASE	2-1
MEDCASE/SuperCEEP Program Policies Introduction	MEDCASE	2-1
MEDCASE/SuperCEEP Programs	S5	2-1
Medical Equipment/Instrument Illustrated Catalog on CD	S5	11-2
Medical Book Sets for TOE Units in LIN Order	S9	Appendix A
Medical Equipment Maintenance	SB-11	6-1
Medical Equipment Management	SB-11	5-1
Medical Equipment Service Literature Support	S6	1-3
Medical Equipment Support	S6	1-1
Medical Logistics Management Internship Program	S1	3-3
Medical Logistics Support Team (MLST)	S1	3-4
Medical Logistics Systems	SB-11	2-1
Medical Maintenance Operations In MTOE Units, *TB Med 750-2*	S6	1-4
Medical MILCON Projects (BLIC “NF” and “MB” Requirements) Introduction	MEDCASE	11-1
Medical Maintenance (Policy, Procedures, Repairers, Logs, Etc.)	S10	3-1
Medical Maintenance Operations Division Personnel	S2	1-3
Medical Materiel Management	SB-11	3-1
Medical Materiel Quality Control (MMQC) and Medical Materiel Information (MMI) Messages	S1	4-6
Medical Materiel Readiness	SB-11	9-1
Medical Services Information Logistics System (MEDSILS)	S5	12-3
Meter X-Ray Calibration, 6525-01-502-0504	S6	3-2
Methods of Describing MEDCASE/SuperCEEP Requirements	MEDCASE	14-2
MILCON Project Requirements Management (BLIC “NF” and “MB”)	MEDCASE	3-9
Military Item Disposal Instructions (MIDI)/Military Environmental Information Source (MEIS)	S5	12-3
Military Laboratory Benchmark Indicators	S5	7-2
Military Radiology Functional Economic Analysis Introduction	S5	4-1
MIPR Requests	MEDCASE	8-1
MLST Organizational Structure (Diagram)	S7	7-3
Monitor, Vital Signs, 6515-01-423-5796, 6515-01-423-5872, 6515-01-432-2707, and 6515-01-432-2711	S6	2-5

SUBJECT — SB 8-75- — Page

Monitor, Vital Signs, 6515-01-432-2707 and 6515-01-432-2711 ---------- S6 ----------2-6
Monitor, Vital Signs, 6515-01-432-2711 ---------- S6 ----------2-6
MRI Conversion Overview ---------- S4 ----------4-1
MTF-Generated MEDCASE Program Requirement ---------- S5 ----------2-3
MTF or RMC Initiation of Requirements ---------- MEDCASE ---------3-2
Multimeter, Radiographic, PMX-III, 6525-01-387-0212 ---------- S6 ----------3-3

N

Noncompetitive Acquisition ---------- MEDCASE ---------2-7

O

Object is Improved Access to Radiology ---------- S5 ----------8-3
Objectives for MEDCASE/SuperCEEP Program Submissions ---------- MEDCASE ---------3-7
Obtaining the Consumables Handbook ---------- S4 ----------7-2
On-Line Capability to Request NSN Assignment ---------- S5 --------- 11-3
Operating Table Components ---------- S6 ---------- K-1

Operator Level PMCS ---------- S8 ---------- 1-1
Optical Fabrication ---------- SB-11 --------- 11-1
Optical Microscope, 6650-00-973-6945 ---------- S6 ----------2-7
Overview of a Medical MILCON Project ---------- MEDCASE ------- 11-1
Overview of Requisition Processing ---------- MEDCASE ---------6-2

Overview of SB 8-75-11, *AR 40-61* Revisions ---------- SB-11 ---------- ii
Overview of the Local Procurement Process ---------- MEDCASE ---------7-1
Overview of the MIPR Process ---------- MEDCASE ---------8-1
Overview of SB 8-75-S5 ---------- S5 ----------1-3

P

PACS and Teleradiology Systems Introduction ---------- S5 --------- 10-1
PDISE – Power Distribution Illumination Systems Electrical ---------- S4 --------- 15-1
Physical Examination Stations – ARNG ---------- S10 ----------2-1
Planning and Assessments ---------- S5 --------- 10-3
Preventive Maintenance Checks and Services (PMCS) ---------- S8 ---------- 1-1

Price Estimates ---------- MEDCASE ------- 15-1
Procedures for Management of Medical Assemblages ---------- SB-11 --------- 10-1
Processing of Urgent and Emergency MEDCASE/SuperCEEP Requirements
Introduction ---------- MEDCASE ---------9-1
Procurement Strategies ---------- S7 ---------- 4-2
Program Composition for RCHD ---------- S7 ---------- 6-1
Programming and Funding ---------- S5 --------- 10-2

Project Approval and Funding Procedures ---------- S5 ----------3-4
Property Accountability ---------- MEDCASE ---------2-6
Property Accountability and Maintenance Management of DIN-PACS ---------- S5 --------- 10-9
Pump, Infusion, 6515-01-486-4310 ---------- S6 ----------2-8
Pump, Infusion, 6515-01-452-0625 and 6515-01-486-4310 ---------- S6 ----------2-7

SUBJECT — SB 8-75- — Page

Pump, Infusion, 6515-01-486-4310, Display Problems ---------- S6 ---------- I-1
Pump, Intravenous Infusion, 6515-01-498-2252 ---------- S6 ---------- 2-9
Purpose and Applicability of SB 8-75-S5 ---------- S5 ---------- 1-3
Purpose and Applicability of SB 8-75-MEDCASE ---------- MEDCASE ---------- 1-1

Q

Quality Control Information ---------- SB-11 ---------- 4-1

R

Radiology Performance Measures and Targets ---------- S5 ---------- 4-3
Receipt Processing ---------- MEDCASE --- 5-3, 6-5
Recommending Changes to the WebMRE System ---------- MEDCASE ------- 10-2
Recision of SB 8-75 Issues ---------- S1 ---------- 1-2
Recommended Service Object Pairs from the DICOM Standard ---------- S5 ---------- 8-2

Recommending Improvements and Reporting Errors for Medical Sets,
Kits, and Outfits ---------- S5 ---------- 11-4
References and Resources ---------- MEDCASE ------- 11-3
Refrigerator, Blood, 4110-01-506-0895 ---------- S6 ---------- 2-9
Refrigerator, Blood, 4110-01-506-0895 PMCS Procedures ---------- S6 ---------- J-1
Relabeling of MCDM ---------- S7 ---------- 5-8

Release Authority (Deployments) ---------- S7 ---------- 4-3
Release Authority (Humanitarian Relief Only) ---------- S7 ---------- 4-3
Release Procedures for All Initial Issue MCDM ---------- S7 ---------- 5-6
Repairer Level PMCS ---------- S8 ---------- 1-3
Reserve Component Hospital Decrement (RCHRD) ---------- S7 ---------- 6-1

Relocatable Buildings ---------- MEDCASE ------- 15-1
Reporting Discrepancies ---------- MEDCASE ------- 15-5
Reports of Suspended or Destroyed Items ---------- S1 ---------- 4-6
Required Service Object Pairs from the DICOM Standard ---------- S5 ---------- 8-1
Requirements Determination ---------- S7 ---------- 2-1

Requirements for Operations and Equipment ---------- S5 ---------- 5-6
Reserve Component Medical Materiel Management Information ---------- S1 ---------- 4-7
Responsibilities During the Project ---------- MEDCASE ------- 11-4

S

Sample Data Collection Assistance Visit Policy ---------- S5 ---------- 9-3
Sample Data Collection Guideline and Sample Sectors ---------- S5 ---------- 9-1
Sample Data Collection Program (with Figure 4-1) ---------- S1 ---------- 4-7
Sample Data Collection Program Introduction ---------- S5 ---------- 9-1
Sample Data Collection Program Management Policy ---------- S5 ---------- 9-1

Sample Data Collection Quality Control Process and Data Verification Policy ---------- S5 ---------- 9-4
Sample Standard Operating Procedure for TOE Organizations
(Combat Support Hospital) ---------- S6 ---------- E-1
SB 700-20 LINs ---------- S5 ---------- 12-4
Scissor Jacks Placement ---------- S4 ---------- 10-2

(Continued) 2006 CUMULATIVE INDEX - DA SB 8-75-11

SUBJECT	SB 8-75-	Page
SC VIII APS Assets	S7	3-2
Shipment of MEDCASE/SuperCEEP Items	MEDCASE	6-4
Similar Asset/Estimated FMV Worksheet	SB-11	A-1
Site Preparation Requirements Introduction	S5	3-1
Site/Regional Project Team Activities—Assessments and Implementations	S5	10-4
SLEP Process	S7	9-2
Special Eligibility Criteria	MEDCASE	2-2
Special MEDCASE/SuperCEEP Program Considerations Introduction	MEDCASE	15-1
Special Procedures	MEDCASE	12-5
Special Purpose Test, Measurement, and Diagnostic Equipment (TMDE-SP) Tables	S6	F-1
Special Requirements for Submission and Approval (Routine)	MEDCASE	12-2
Split Property Books	S4	3-1
Sterilizer, Steam, 6530-01-431-6564 and 6530-01-442-8720	S6	2-9
Storage And Shipping Containers	S6	1-3
Storage Requirements	S7	5-8
Submission of Requirements	MEDCASE	3-7
Supply Class VIII Sustainment Requirements Process	S7	A-1
Support For Class VIII Medical Materiel	S1	2-1
Support Strategy	S5	6-1
Supportability Analysis Introduction	S5	6-1
Sustainment	S5	10-8
Sustainment Fieldings	S4	1-4

T

Table, Operating, Field, 6530-01-321-5592	S6	2-10
Table, Operating, Hospital (Field), 6530-01-353-9883	S6	2-11
TAMMIS Enterprise-Wide Logistics System (TEWLS)	S1	3-5
TARA Cycle Review	S5	5-8
TARA Process	S5	5-2
TARA Schedule	S5	5-5
TB-MED 750-1, Draft Copy	SB-11	C-1
TDA Approval and Type Classification Exemption	MEDCASE	17-3
Team Approach for TARA	S5	5-4
Technology Assessment and Requirements Analysis Program Introduction	S5	5-1
Technology Assessment and Requirements Analysis (TARA)	S1	3-6
Technology Assessment and Requirements Analysis (TARA) Confidentiality	MEDCASE	17-3
Technology Assessment and Requirements Analysis (TARA) Coordination	MEDCASE	17-1
Technology Assessment and Requirements Analysis (TARA) Integration	MEDCASE	17-3
Technology Assessment and Requirements Analysis (TARA) Introduction	MEDCASE	17-1
Technology Assessment and Requirements Analysis (TARA) Methodology	MEDCASE	17-1
Technology Assessment and Requirements Analysis (TARA) Mission	MEDCASE	17-1
Technology Assessment and Requirements Analysis (TARA) Program Review	MEDCASE	17-3
Telecommunications Equipment	MEDCASE	13-4
Teleradiology Functionality	S5	10-9
Testing Criteria (SLEP)	S7	9-1
Test, Measurement, And Diagnostic Equipment (TMDE) Authorizations	S6	1-4

(Continued) 2006 CUMULATIVE INDEX

SUBJECT	SB 8-75-	Page
The Army Centrally Managed Medical Potency and Dated (P&D) Materiel Program	S7	4-1
The USAMMA CD ROM Is Available	S1	1-3
The USAMMA Forward Logistics Support Element (USAMMA FWD)	S7	7-4
The USAMMA Medical Logistics Support Team (MLST)	S7	7-1
The U.S. Army Medical Materiel Agency (USAMMA)	S1	2-3
The U.S. Army Medical Materiel Agency Centralized Class VIII, Repair Parts Program	S2	1-5
TMDE Program Manager Address Change	S2	1-5
Tool Kit, Medical Equipment Maintenance and Repair: Repairman's, NSN 5180-00-611-7923, LIN W45334	S2	1-5
Transmittal Request for New DOD Form DD 2282	S4	12-2
Turnkey Acquisition	MEDCASE	13-4
Types of A2S	S4	8-2
Types of MIPRs	MEDCASE	8-1

U

ULLS-G	S7	8-3
Unit Assemblage Listings (UALs) – Bill of Materiel	S1	4-8
Universal Data Repository	S5	12-4
Updating of Unit Assemblages	S5	11-1
USAMMA MEDCASE/SuperCEEP Manager POC	S5	2-3
USAMMA TMDE Calibration Support	S2	1-6
USAMMA's Logistics Assistance Program	S6	1-4
USAMMA's Logistics Assistance Program, Medical Maintenance Support	S6	D-1
USAMMA's Medical Maintenance Operations Division On-line	S2	1-6
Use of HEPA Filter With IMPACT 754 Ventilator	S6	L-1

V

Vaccines	S1	3-7
Vendor Selection	S5	10-5
Ventilator, 6530-01-464-0267	S6	2-11
Ventilator, Impact Model 754, NSN 6530-01-464-0267	S2	1-6

W

'W' and 'J' Relationships	S4	6-1
Warranties	MEDCASE	15-4
War Reserve Requirements	S7	2-1
Web-Accessible UA Products	S4	11-4
Web MEDCASE Requirements and Execution (WebMRE) System Introduction	MEDCASE	10-1
WebMRE Access Form	MEDCASE	10-1
WebMRE/Theater Enterprise Wide Logistics System (TEWLS)	MEDCASE	10-1
Website Information On DOD/FDA Shelf Life Extension Program (SLEP)	S7	9-5
Wholesale Supply Source Actions	MEDCASE	6-3
Wholesale Supply System (Requisitions) Introduction	MEDCASE	6-1

SUBJECT SB 8-75- Page

X

X-Ray Apparatus, Dental, Handheld, 6525-01-425-5216 ---------- S6 --------- 2-12
X-Ray Apparatus, Radiographic, Med, 6525-01-384-9296 ---------- S6 --------- 2-12
X-Ray App Rad/Fluor, C-Arm, 6525-01-452-0956---------- S6 --------- 2-12

By Order of the Secretary of the Army:

PETER J. SCHOOMAKER
General, United States Army
Chief of Staff

Official:

JOYCE E. MORROW
Administrative Assistant to the
Secretary of the Army

Distribution:

To be distributed in accordance with initial distribution number (IDN) 340016, requirements for the SB 8-75 Series.

PIN: 018136-000