Army Regulation 40–61

Medical Services

Medical Logistics Policies and Procedures

Headquarters
Department of the Army
Washington, DC
25 January 1995

Unclassified

SUMMARY of CHANGE

AR 40–61
Medical Logistics Policies and Procedures

This revision--

- Makes the U.S. Army Medical Materiel Agency (USAMMA) the proponent agency for the SB 8-75 series (para 1-4d).
- Updates the role of Defense Personnel Support Center (DPSC) in medical materiel management (para 2-3a).
- Adds requirements for the transfer of medical materiel between Department of Defense (DOD) Military Departments (para 2-4).
- Updates the role of the Defense Medical Standardization Board (DMSB) in the standardization of medical items (para 2-7).
- Implements policy for quality assurance of bulk liquid oxygen (para 2-15).
- Deletes the requirement to prepare either a DA Form 444 (Inventory Adjustment Report) or a memorandum to account for suspension or reinstatement of materiel (para 2-16).
- Clarifies the management of shelf life items (para 2-20a).
- Updates the reference for disposal codes of drugs and reagents (para 2-24a).
- Adds a requirement for a contractor disposing of hazardous medical waste to submit a certificate of destruction (para 2-24b(2)(a)).
- Revises the purpose of the Logistics Assistance Program (LAP) (para 2-25).
- Updates the section on identification of nonstandard medical materiel (paras 2-29 through 2-31).
- Allows flexibility within the installation medical supply activity (IMSA) by the use of commercial inventory services (para 3-8).
- Recognizes prime vendor distribution contracts as an alternative to stockage(para 3-9b).
- Updates information on AAC D and H items (para 3-14a).
- Allows local purchase authority by the service item control center (para 3-24n).
- Revises policy on management of excess medical materiel (paras 3-42 through 3-46).
- Explains the disposal procedures for spent fixer solution(3-49c).
- Adds procedures for the management of hazardous wastes (para 3-50).

- Determines the management of silver alloys (para 3-54c).
- Establishes guidelines for the bulk storage of ethyl alcohol (para 3-56a(4)).
- Requires that a record of all controlled substances be maintained on DA Form 1296 (Stock Accounting Record) (para 3-56b(1)).
- Assigns rank requirements for inventory officers (para 3-57a).
- Rescinds the requirement to submit the Local Purchase of Medical Materiel Report (RCS MED-230) (chap 3).
- Adds the substitution policy for medical items (para 4-4).
- Changes and defines budget line item codes (para 4-7a).
- Increases medical command (MEDCOM) responsibility in determining funding for the Medical Care Support Equipment (MEDCASE) Program (para 4-9b(3)).
- Makes the Office of The Surgeon General (OTSG) approval authority for field operating agency requirements with a unit cost of over $25,000(para 4-10e).
- Expands application of Army Medical Department Property Accounting System (AMEDDPAS) version 9.5 (para 4-19f(1)).
- Changes automated hand receipt procedures in AMEDDPAS (para 4-19j).
- Adds new policy on resupply sets (para 5-4b).
- Identifies accounting procedures for the SC 6545-8-CL-HR series (para 5-6a(2)(a)).
- Removes the requirement for table of organization and equipment(TOE) units with Theater Army Medical Management Information System (TAMMIS) to fill out a DA Form 1296 and DA Form 4996-R (Quality Control Card) when accounting for expendable and durable items (para 5-6a(2)(c)).
- Adds the requirement to use readiness computation procedures to determine the status of medical assemblages for readiness reporting purposes(para 5-14).
- Rescinds requirements of the Supplemental Medical Materiel Program(chap 5).
- Rescinds the requirement to submit the PWRMS-MF Status Report (RCS MED-167) (chap 5).
- Adds guidance on medical materiel sets (chap 5, sec III).
- Adds information on applicable maintenance management systems(para 6-2k).
- Adds testing standards for line isolation monitors in accordance with National Fire Protection Association (NFPA) Standard 99 (para 6-5c).
- Revises guidance on calibration, verification, and certification(CVC) services (para 6-6).
- Sets the demand requirement for shop stock (para 6-23f(1)).
- Adds a new chapter 9 on Army Reserve Programs (materiel stocks).

- Defines a program to centrally fund Medical Materiel through the Medical Materiel Program for Defense against Nuclear, Biological, and Chemical Agents (para 9-7).

- Adds a new appendix E on equipment on hand (EOH) readiness computation procedures.

Headquarters
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Washington, DC
25 January 1995

***Army Regulation 40–61**

Effective 22 February 1995

Medical Services

Medical Logistics Policies and Procedures

By Order of the Secretary of the Army:

GORDON R. SULLIVAN
General, United States Army
Chief of Staff

Official:

MILTON H. HAMILTON
Administrative Assistant to the Secretary of the Army

History. This printing publishes a revision of this publication. This publication has been reorganized to make it compatible with the Army electronic publishing database. No content has been changed.

Summary. This regulation on medical logistics policies and procedures has been revised to update Department of Army policies, procedures, and programs for managing medical materiel and for logistics support. It provides guidance in addition to that found in basic logistics directions for accomplishing functions peculiar to medical logistics management.

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

Proponent and exception authority. The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions to this regulation that are consistent with controlling law and regulation. Proponents may delegate the approval authority, in writing, to a division chief under their supervision within the proponent agency who holds the grade of colonel or the civilian equivalent.

Army management control process. This regulation contains management control provisions, but does not identify key management controls that must be evaluated.

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from HQDA(DASG–LO), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Interim changes. Interim changes to this regulation are not official unless they are authenticated by the Administrative Assistant to the Secretary of the Army. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

Suggested Improvements. Users of this publication are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (DASG–LO), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Distribution. Distribution of this publication is made in accordance with the requirements on DA Form 12–09–E, block number 2062, intended for command levels A, B, C, D, and E for the Active Army and command level B for the Army National Guard and the U.S. Army Reserve.

Contents (Listed by paragraph and page number)

* This regulation supersedes AR 40–61, 30 April 1986. It rescinds RCS MED–167 and RCS MED–230.

Unclassified

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RESERVED

Chapter 1
Introduction

1–1. Purpose
This regulation prescribes Army policies, procedures, and responsibilities for managing medical materiel and for logistics support.

1–2. References
Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms
Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. Responsibilities
a. The Surgeon General (TSG). TSG, as the Army manager for medical logistics, will—

(1) Develop all aspects of organization, administration, and staff supervision of activities that manage medical materiel.

(2) Develop and manage all medical materiel management systems and the medical materiel acquisition process, programs, and program data Army-wide. This includes—

(a) Exercising responsibility for the overall management of medical assemblages for the Army.

(b) Approving the composition of major medical assemblages.

(c) Budgeting for the initial issue of medical assemblages and for all procurement appropriation (PA) funded medical equipment, regardless of whether it is initial issue or replacement.

(3) Exercising overall responsibility for medical materiel mobilization programs.

(4) Establishing medical logistics procedures within the framework of the Army logistics system.

(5) Ensuring the continuous operation of the Army Medical Department's (AMEDD's) quality assurance system. This system includes the quality control of medical materiel.

(6) Providing advice and assistance to Headquarters, Department of the Army (HQDA) agencies, major Army commands (MACOMs), and Army activities on medical logistics matters.

(7) Monitoring the effectiveness of medical supply support Army-wide, from Defense Logistics Agency (DLA) support centers to using activities.

(8) Coordinating with other Services, the Defense Personnel Support Center (DPSC), and the Defense Medical Standardization Board (DMSB) in the development and use of medical materiel.

(9) Managing worldwide medical materiel logistics assistance to Army activities (see AR 700–4) and to non-U.S. forces as approved under the Army Security Assistance Program.

(10) Acting as executive agent for AMEDD Army reserve (AR)/operational project (OP) program segments. (See chap 9.)

b. Commander, U.S. Army Medical Command(USAMEDCOM). The commander, under the supervision of the Chief of Staff, U.S. Army, and TSG, ensures that subordinate installations, medical centers (MEDCENs), and medical department activities (MEDDACs) manage medical materiel in accordance with this regulation.

c. Commander, U.S. Army Medical Research and Materiel Command (USAMRMC). The commander, under the jurisdiction of TSG, researches, develops, and modifies medical materiel for use by field medical units. (See AR 70–1.)

d. Commander, U.S. Army Medical Materiel Agency(USAMMA).

(1) USAMMA is the logistician (see para 2–26), provider, and service item control center (SICC) for medical materiel, as well as the proponent agency and publisher of the Supply Bulletin (SB) 8–75 series.

(2) USAMMA is the Army Secondary Inventory Control Activity for medical materiel and provides continuous support to develop and maintain the Federal Catalog System and Army cataloging operations.USAMMA—

(a) Performs all functions related to developing and using cataloging tools.

(b) Maintains the Army medical logistics data in the Federal Logistics Information System (FLIS) and the Army Central Logistics Data Bank.

(c) Ensures activity interest is recorded in the FLIS and the Army Master Data File (AMDF) on appropriate national stock numbers (NSNs) required to support the AMEDD mission.

(3) Under the control of TSG, USAMMA performs functions to improve and assist in the development, management, and execution of medical supply support. (See paras 5–2 and 7–2.)

(4) USAMMA is the central quality assurance coordinating activity for medical materiel for the Army. USAMMA will ensure the acquisition, maintenance, dissemination, and followup of medical materiel quality assurance data and actions, Army-wide.

(5) To accomplish its mission, USAMMA is authorized direct contact with activities of DLA, Army commands, command surgeons, Army health care facilities, and other activities within the Department of Defense(DOD) in matters related to the management of medical materiel and maintenance functions.

(6) USAMMA provides management for AR Programs.(See chap 9.)

e. Commanders of Army medical commands (MEDCOMs) and command surgeons. These commanders and surgeons are responsible for the implementation, coordination, and technical direction of Army medical logistics and materiel programs (see para 2–26), evaluation of their effectiveness, and initiation of corrective action. They are also responsible for recovery and disposal programs. (See paras 3–49 and 3–50.)

f. Commanders of U.S. Army MEDDACs and MEDCENs. Commanders of MEDDACs and MEDCENs are responsible for total medical logistics materiel management within the activity and support to authorized units within assigned geographic areas. They provide supply and maintenance support, technical assistance, and guidance to organizational elements of the MEDDACs, MEDCENs, dental activities (DENTACs), regional dental activities, and other units authorized support.

g. Heads of installation medical supply activities(IMSAs). IMSAs and other medical units are responsible for requirements computation, storage, quality control, distribution of supplies and equipment, formal accountability, budgeting, financial inventory accounting (FIA), and other functions necessary for the effective management of medical materiel.

h. Heads of table of organization and equipment (TOE)units and separate medical activities not authorized stock record accounts. Heads of these units and activities are responsible for the management of medical materiel authorized or on hand in accordance with this regulation.

i. Unit commanders. These commanders are responsible for the accountability, control, safeguard, and maintenance of medical materiel. Command visibility, with emphasis and interest in medical logistics will be maintained, since this area directly affects all aspects of the medical mission.

1–5. Automation application
The policies established in this regulation apply to manual and automated medical logistics operations. Proponents of automated systems being developed for fielding will comply with these policies. Activities operating under an approved automated supply system will use the automated procedures and capabilities of the automated system to satisfy the policies prescribed in this regulation.

1–6. Recordkeeping requirements
This regulation requires the creation, maintenance, and use of specific records, which are listed in table 1–1. (See AR 25–400–2 for file numbers (FNs), descriptions, and dispositions.)

Table 1–1
Recordkeeping requirements

File number: 40–61a **Description:** Alcohol and narcotic controls
File number: 40–61b **Description:** Medical materiel adoption
File number: 40–61c **Description:** Quality assurance of medical materiel
File number: 40–61d **Description:** Logistics assistance
File number: 40–61e **Description:** Medical supply support
File number: 40–61f **Description:** Equipment management
File number: 40–61g **Description:** Medical sets, kits, outfits
File number: 40–61h **Description:** Medical mobilization programs
File number: File number: 40–61i **Description:** Medical equipment maintenance
File number: File number: 40–61j **Description:** Medical logistic service
File number: 40–61k **Description:** Hazardous medical materiel/waste disposal

1–7. Deviations
Deviations from the policies and procedures within this regulation are not authorized without prior approval of TSG. Requests for deviation will be submitted with complete justification through command channels to HQDA(DASG–LO), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Chapter 2
The Army Medical Materiel Management System

Section I
Medical Materiel Management Guidance

2–1. Policy and procedural guidance
This chapter provides policy and procedural guidance for the management of medical materiel. This guidance augments policy and procedures specified in AR 710–2, DA PAM 710–2–1, and DA PAM 710–2–2.

2–2. Special considerations of medical materiel
The medical materiel category possesses certain characteristics that set it apart from other commodities. These factors place unique requirements on Army managers of medical materiel.

a. The medical materiel management system must be immediately and completely responsive to the health care requirements of the Army community. The ultimate purpose of this system is the effectiveness of the Army, which is affected by the health of the soldier. It is not enough that the medical support system be adequate to meet most needs of the Army.The ability to predict a specific requirement demands responsive supply support. Support must be responsive to differences in professional training and to specialty requirements. The system must be capable of rapidly adapting to large increases in patient load and to widely varying environments with a minimum adverse effect on efficiency. Close rapport between the medical logistician and the health care provider is essential for the maintenance of the health of Army personnel and the Army's retention of its trained professionals.

b. Medical materiel is highly technical and requires extensive capability to research, develop, field, evaluate, repair, and establish Army medical materiel requirements. The Federal Government exercises stringent control over medical products. The Army continuously interfaces with other agencies at the professional level on materiel matters.Medical materiel management significantly impacts on the efficacy of medical materiel within the Army by integrating public health policy and technical guidance from a variety of sources into a highly specialized medical logistics system. The need for a unique medical management system is, therefore, recognized throughout DOD.

c. The health care activity is the primary user of medical materiel within the Army. These activities are field medical units in direct support of combat forces and fixed facilities (MEDDAC, MEDCEN, DENTAC, or Area Dental Laboratory). The MEDDAC and MEDCEN are unique in the Army in that their many elements are not separate units. Its medical supply element is a functional part of the medical activity.

d. To maintain high standards of medical support, medical materiel management provides for exceptions to regulations in the AR 700 series. The intent is to follow AR 700–series regulations to the maximum extent possible; however, where conflicts exist, the provisions of this regulation will take precedence for medical logistics and medical materiel management.

2–3. DOD and Army roles in medical materiel management
a. The DPSC, the wholesale commodity manager for medical materiel under DLA, is responsible for the central management and acquisition of medical materiel for the DOD. Its primary responsibilities include cataloging, purchasing, issuing, management of excess, financial accounting, contract monitoring, and disposal of medical materiel. Centralized management offers the opportunity to obtain materiel with more favorable pricing using an established ordering and support system.Accordingly, Army health care commanders are authorized to deviate from the central system and procure items locally when items are needed immediately to save lives or prevent suffering, when no comparable item is available in the system, when the item is identified as local purchase in the AMDF, or when the local commander and/or contracting officer determines that local purchase is in the best interest of the Government in terms of quality, timeliness, and cost.

b. The DMSB is a joint activity of DOD subject to professional policy provided through the Assistant Secretary of Defense(Health Affairs). TSG appoints one AMEDD general officer to serve as the Army member of the DMSB. The DMSB is the primary activity responsible for the effective management of the clinical and technical aspects of medical materiel and the deployable medical systems (DEPMEDS). This includes the standardization or deletion of items in the wholesale supply system. The Board evaluates the need for the item, determines the essential characteristics of the item, and performs other related coordination and investigative functions. The DMSB directs the development of DEPMEDS, ensuring that they are standardized to the maximum extent consistent with the distinct missions of the military Services. The complete mission and functions of the DMSB are prescribed in AR 10–64/OPNAVINST 6700.2/AFR 160–29/MCO 5420.18A, chapter 4.

c. Army responsibilities for medical materiel are summarized in chapter 1 of this regulation.

2–4. Transfer of medical materiel between DOD Military Departments
a. DOD Directive (DODD) 6015.5, 23 Jun 87, authorizes the joint use and/or transfer of medical materiel (supplies and equipment) among the military departments without reimbursement, when appropriate and feasible.

b. Joint medical logistics support is appropriate in the following instances:

(1) To realign medical logistics support for the operation of Joint Military Medical Command (JMMC) and other similar joint medical organizations.

(2) To realign medical logistics support for the operation of single logistics manager systems within joint and specified commands.

(3) To realign medical logistics support in pursuing formal and informal joint Service sharing programs. These may include, but are not limited to, programs identified in operating arrangements, Memorandums of Understanding, Memorandums of Agreement (MOA), and Inter-Service Support Agreements (ISSAs). These actions may be appropriate for medical treatment facilities (MTFs) not under the direction and/or control of a JMMC or similar joint medical organization.

c. When appropriate, materiel accountability transfers will be directly coordinated between the DOD military departments without prior excess reporting within the losing Service or through the Defense Reutilization and Marketing Office (DRMO).

d. Activities desiring to transfer materiel with another Service will identify the materiel and forward a request through their MEDCOM to HQDA (DASG–LO), 5109 Leesburg Pike, Falls Church, VA 22041–3258, for review and approval.

2–5. Interface of medical materiel procedures under the International Standardization Agreement

The American, British, Australian, and Canadian Forces have agreed to accept each Nation's medical materiel procedures so that they interface within their national supply systems. The need for cross-supply may occur whenever multinational forces are present in a theater of operation.

a. Use of cross-supply procedures can occur in some or all of the following areas:

(1) Requisitioning from depots.

(2) Return of materiel to depots.

(3) Acknowledgement of issue and receipt.

(4) Receipt dues-out procedures.

(5) Serviceability classification.

(6) Repair and maintenance (within the medical supply system's facilities).

b. A medical logistics liaison will be established within the theater of operations medical materiel management system to assist in establishing this interface, to develop specific cross-supply procedures, and to provide other logistics assistance as required.

c. This procedure implements American-British-Canadian-Australian Quadripartite Standardization Agreement 291 (QSTAG–291).

Section II
Medical Materiel Adoption

2–6. Medical materiel acquisition

The medical materiel acquisition process is outlined in AR 40–60. This process specifies military medical materiel fielding requirements for TOE units.

2–7. Standardization

a. Individual medical items are standardized by the DMSB based on recommendations from the military Services, including AMEDD personnel and activities, presentations by manufacturers and suppliers, management reports, and cataloging data from the DPSC. The focus is changing within the medical materiel management system, as based upon DOD intent to make greater use of automation systems, electronic commerce technologies, and American National Standard Institute agreements, to standardize only those items considered essential for readiness and sustainment missions (i.e., Deployment-Day (D-Day) Significant items). Greater use is to be made of item identification methodologies, such as medical item identification numbers(MIINs), that accommodate the essential need for item identification yet do not require or need full standardization consideration and effort.

b. Standardization of medical systems that are deployable involves the systematic development of DEPMEDS, on a line-by-line basis, to ensure that components are standardized to the maximum extent possible. Deviations are documented and based only on the distinct missions or logistical and support restrictions of the military Services. An MTF equipped with DEPMEDS is capable of being located in a desired or required area of operation during a contingency, war, or national emergency.

c. Recommendations for standardization of biologicals, drugs, and pharmaceuticals should be submitted through the local pharmacy and therapeutics (P&T) committee as specified by AR 40–2.

d. Units, activities, and personnel of the Army may submit recommendations for new or improved medical supplies and equipment. Recommendations, with justifications, should be submitted by letter to the Commandant, AMEDD Center and School (AMEDDC&S), ATTN:HSHA–FC, Fort Sam Houston, TX 78234–6100, for TOE materiel; and to HQDA (DASG–LO), 5109 Leesburg Pike, Falls Church, VA 22041–3258, for nontype classified medical materiel. As a minimum, the following information will be furnished:

(1) Complete description of the item, to include National Drug Code (NDC) or National Health-Related Item Code when applicable.

(2) Sketches, drawings, or photographs if available.

(3) Statement of need or intended use.

(4) Essential characteristics or capabilities.

(5) Urgency of requirement.

(6) Manufacturer's name, address, literature, catalog number, and price data.

(7) Federal supply contract number if available.

(8) Benefits to be derived in terms of improved health care, efficiency, and economy.

(9) TOE and table of distribution and allowances(TDA) units which might use the item.

(10) Other information as appropriate (for example, domestic or foreign origin, packaging, unit of issue, and shelf life information).

2–8. D-Day Significant items

a. Based on input from the military Services, the DMSB will maintain a list of D-Day Significant items. These items constitute the minimal requirement, adequate but austere, for the general medical and surgical care of casualties should D-Day occur. All items designated as D-Day Significant will be assigned an NSN. See paragraphs 3–11 and 8–20*e*(6) of this regulation for additional guidance.

b. Authorized items within medical sets, kits, and outfits (SKOs) will be established based on the D-Day Significant item list to the maximum practical extent.

Section III
Materiel Demonstration, Examination, and Evaluation

2–9. Commercial materiel testing

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

b. This section does not apply to the following:

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

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

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

(4) Drugs, biologicals, reagents, medicated cosmetics, and toiletries. (See AR 40–2.)

c. Written agreements between the Government and the vendor are mandatory for examinations/evaluations and are strongly recommended for demonstrations. The supporting contracting office should execute these written agreements. See paragraph 2–11*b*(3) for minimum elements to be included in the agreement.

2–10. Program components

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

(1) Maintain a repository of medical or medical-related product information according to this section.

(2) Manage approved materiel evaluations requested by activities.

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

(1) Provide copies of materiel examination results to USAMEDDBD.

(2) Comply with approved evaluation plans for materiel evaluations and provide results to USAMEDDBD.

2–11. Procedures for demonstrations, examinations, and evaluations

a. Materiel demonstrations. Demonstrations consist of the exhibit, use, or application of an item by the vendor. They do not involve action by Army personnel beyond observing the operation or use of the product by the vendor.

(1) Commanders of Army MEDDACs or DENTACs may approve demonstrations.

(2) No endorsements or statement of results or opinions will be provided the vendor.

(3) All expenses incident to the demonstration will be borne by the vendor. This includes costs of transporting the product and its installation and operation.

(4) A demonstration does not change the Federal Acquisition Regulation (FAR) or DOD FAR Supplement (DFARS) requirements governing follow-on contracting actions. Close coordination with the supporting contracting office is necessary to avoid contracting violations or claims.

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

(1) Commanders of Army MEDDACs or DENTACs may approve examinations when a demonstration is not expected to be adequate for determining the desirability of the item for future use.

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

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

(a) Items will be delivered, installed, operated, and removed at no cost to the Government.

(b) The Government will not be responsible for the loss, damage, or destruction of materiel while in its possession.

(c) Expenses for the return of materiel to the vendor after examination will be borne by the vendor.

(d) Special maintenance or operator training prior to the examination will be provided by the vendor at no cost to the Government.

(e) The activity and individuals examining the item assume no obligation to furnish an oral or written report to the vendor on the results of the examination.

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

(g) The vendor will not make reference to the examination for advertising or other promotional purposes unless the information has been published or presented through recognized professional media or its release has been specifically approved by TSG.

(4) When an examination item is delivered, the property management officer will establish temporary informal property accountability for nonexpendable items. This property will be issued on a hand receipt to the principal investigator. The hand receipt and accounting records will be cleared on return of the materiel to the vendor following the examination. These property records will be maintained with the property book as prescribed by AR 25–400–2.

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

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

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

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

(1) Commanders of MEDDACs and DENTACs will submit evaluation requests through Commander, USAMEDCOM,(MCHA–P), to USAMEDDBD in accordance with MACOM/MEDCOM procedures. Format guidance for requests is provided in appendix B.

(2) On receipt of the request, USAMEDDBD will prepare a Resume Sheet for presentation to the USAMEDCOM Test Schedule and Review Committee.

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

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

(5) USAMEDDBD will prepare the evaluation report.

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

d. Aeromedical suitability determinations. Aeromedical evacuation (AE) suitability determinations are made after specialized tests and/or evaluations are conducted. Their purpose is to ensure an effective and safe interface between the machine, patient, crew, and aircraft.

(1) AE suitability determinations are no longer handled by the USAMEDDBD. This function is handled by the Combat Developer at the AMEDDC&S. Requests should state whether the equipment is for—

(a) Wartime.

(b) Peacetime movement of military or military dependents.

(c) Peacetime movement of civilians.

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

Section IV
Quality Assurance of Medical Materiel

2–12. Functional areas

a. AMEDD commands and activities will use all available sources of information to perform the functions below. Medical logistics activities and pharmacy activities will—

(1) Act as a source of quality control information by conducting a constant surveillance program of medical materiel in storage or use.

(2) React to quality control information by ensuring that all sequentially numbered USAMMA quality control messages and the SB 8–75 series are received, registered, and observed.

(3) Provide quality control information to medical receiving, storage, shipping, and maintenance elements and to supported medical activities and units that consume medical materiel.

(4) Suspend, report, extend potency period (to include remarking), and destroy or dispose of medical materiel as indicated or directed.

b. The chief of the logistics division will coordinate with health care activity risk managers to ensure that medical materiel quality control (MMQC) procedures are included in the MEDDAC, MEDCEN, or DENTAC Quality Assurance Program as required by AR 40–68, chapter 3. The chief of the logistics division will also advise the risk manager of all potential compensable medical materiel problems.

c. Upon submission of a medical materiel complaint, logistics managers and clinicians will make every effort to preserve evidence in all cases.

2–13. Sources of quality control information

The following sources of quality control information will be used by all AMEDD activities involved in medical materiel management:

a. USAMMA quality control messages.

(1) *General guidance.* USAMMA MMQC messages contain information of system-wide interest. This includes suspension of medical materiel, extension of storage time periods (potency expiration dates), disposition instructions, and other significant quality control information.

(2) *Procedures.* Supply accounts at the IMSA 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, nomenclature action required, and remarks. If a message is missing, initiate a tracer action through message routing channels or obtain a copy directly from Commander, USAMMA, ATTN:SGMMA–O, Fort Detrick, Frederick, MD 21702–5001. Activities with an automated quality control module in their inventory management system; for example, The Theater Army Medical Management Information System (TAMMIS), are not required to maintain a manual register. MMQC messages will be retained on file for at least the current calendar year and the prior calendar year according to AR 25–400–2.

(3) *Transmission.* USAMMA MMQC messages are transceived, worldwide, to units and activities of the Active Army, U.S. Army Reserve (USAR), and State adjutants general.

(4) *Address indicator group (AIG).* The current composition of each AIG under which messages are dispatched is published annually in November. Requests for AIG additions, deletions, or modifications will be submitted to the address in (2) above.

(5) *Army National Guard (ARNG) actions.* Upon receipt, State adjutants general will distribute copies of all MMQC messages to division medical supply offices; medical logistics (MEDLOG)battalions; and ARNG training sites operating troop medical clinics (TMCs).Additionally, State adjutants general will immediately distribute all MMQC messages concerning Type I medical materiel complaints and the Food and Drug Administration (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.

(6) *Overseas actions.* MEDLOG battalions outside the continental United States (OCONUS) designated as the supply support activity (SSA) within a command or area of operations (AO) may create their own quality control message series which must incorporate the USAMMA MMQC messages as well as locally published quality control messages.OCONUS activities supported by the MEDLOG battalions publishing these messages will maintain a record of these messages in numerical sequence.

b. SB 8–75 series. These supply bulletins are distributed through normal Army pinpoint distribution channels and provide other essential medical logistical information such as new information and general guidance on medical logistics topics.

c. Consolidated Defective Medical Materiel List(CDMML). The CDMML is published annually in the SB 8–75 series (SB 8–75–S5). It is cumulative for the period 1 January 1983 through 30 March 93. The CDMML is a reference for medical supply personnel identified by lot number and manufacturer. It is used to determine whether a particular item is defective and whether disposition instructions were issued.

d. TB 740–10/DLAM 4155.5/AFR 67–43, appendix M. This publication contains storage quality control procedures and serviceability standards applicable at all levels of materiel management. Questions related to information contained in the publication may be directed to Commander, USAMMA, ATTN: SGMMA–O, Fort Detrick, Frederick, MD 21702–5001.

e. AMDF, Federal Logistics Data on Compact Disc(FEDLOG), and the DOD Medical Catalog, Volumes II and III. The AMDF, FEDLOG, and DOD Medical Catalog are the official sources of supply management data (for example, shelf life codes (SLCs)). They have precedence over conflicting data published in other Army publications and TB 740–10/DLAM 4155.5/AFR 67–43, appendix M, unless otherwise stated in USAMMA MMQC messages. Interim changes made by these messages will be reflected in the AMDF, FEDLOG, and the DOD Medical Catalog as soon as possible.

2–14. Quality control at the installation level

a. IMSA or MEDLOG battalion SSA quality control functions. The IMSA or MEDLOG battalion SSA is the focal point on the installation for dissemination and collection of medical materiel quality control information. The IMSA or MEDLOG battalion SSA provides quality control information (such as reports of materiel defects) to the wholesale system based on surveillance findings and reports from supported units. It also reacts to and disseminates information furnished by USAMMA and other sources. As the focal point for quality control information, the IMSA or MEDLOG battalion SSA—

(1) Establishes and operates medical materiel surveillance programs.

(2) Ensures proper dissemination of USAMMA MMQC messages and information to supported units.

(3) Prepares reports or takes other actions as required by this section.

(4) Establishes procedures to ensure that materiel is marked to reflect current quality control information.

(5) Ensures that materiel is stored in such a manner as to prevent its deterioration.

(6) Provides logistics assistance to supported units for quality control matters.

b. Other Quality Control Programs (QCPs) for medical materiel. MEDLOG battalions not operating as formal SSAs and other medical supply operations will maintain a QCP for their medical materiel stocks. These activities will respond to requests from the wholesale system for quality control information by conducting appropriate research or surveillance and providing information through their supporting IMSA to the wholesale system. These activities will receive MMQC messages and information from the IMSA for internal use and distribution to supported activities.

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. (See para 3–37*e* for further guidance.)

(1) Emergency or battery-powered temperature alarm systems will be used on refrigerator storage units at the IMSA. Alarms will be monitored on a 24-hour basis. Items requiring refrigeration will be stored and shipped at temperatures between 35 and 46 degrees Fahrenheit (2 degrees C and 8 degrees C) and frozen items at temperatures below 32 degrees Fahrenheit(0 degrees C). IMSAs, MEDLOG battalions, and other medical supply operations will comply with any special instructions on the item or shipping label or in the Federal Supply Catalog.

(2) X-ray film will be stored on edge in a vertical position, when possible, since pressure tends to fog the film.

(3) Dry-cell batteries will be removed from instruments prior to storage.

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

d. Storage quality control records. IMSAs will maintain supplemental records for all expiration dated materiel. MEDLOG battalions and other medical supply operations will maintain quality

control records according to command or command surgeon guidance. As a minimum, quality control records will reflect the manufacturer, lot number, and current expiration date. DA Form 4996–R (Quality Control Card) or automated records (for example, TAMMIS quality control module) will be used.DA Form 4996–R will be reproduced locally on 8- by 5-inch card stock. A copy for reproduction is located at the back of this regulation. Use quality control records to—

(1) Ensure rotation of stocks.

(2) Prepare reports of items which cannot be used prior to expiration.

(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.

(1) The new expiration date will be stenciled on the outside of bulk stocks. The original expiration or manufacturer's date will be lined through, but not blotted out, so that the original information is retained. When space does not permit stenciling, labels may be placed on the exterior pack. These labels should not cover the lined-through original manufacturer's date. Stencils and labels will contain space for the authorizing official's signature and will read: EXP DATE EXTENDED TO (new date). WARNING: CONTENTS MUST BE RE-MARKED WHEN PACK IS OPENED.

(2) When issues are made in original pack quantities, the recipient of such issue will, when the original pack is opened, mark the new expiration date on each unit of issue.

(3) Upon receipt of notice of a new expiration date, each unit of issue and intermediate package in loose issue will be re-marked with the new date.

2–15. Quality assurance of bulk liquid oxygen

a. Policy, responsibilities, and procedures on the receipt and administration of bulk liquid oxygen used for medical purposes are established in accordance with DODD 6055.10.

b. Definitions for terms used in this paragraph are explained below:

(1) *Anesthetist.* Used to identify anesthesiologists, other physician anesthetists, nurse anesthetists, or dentist anesthetists.

(2) *Liquid oxygen.* In a fixed central oxygen system, liquid oxygen from a main storage tank is the source of the gaseous oxygen that is piped to patient care areas.

(3) *Oxygen analysis.* Provides a measurement of the percentage of oxygen in a gas sample. A battery-operated, portable, hand-held instrument is the currently available technology of measuring the percent of oxygen.

c. The MTF or dental treatment facility (DTF)commander will ensure that—

(1) The concentration and amount of bulk liquid oxygen is confirmed and documented at the time of delivery to an MTF or DTF.

(2) Anesthesia and analgesia equipment is tested for proper functioning before its use on any patient.

d. The chief of the logistics division at each MTF or DTF or in support to an MTF or DTF will implement procedures to—

(1) Ensure that bulk liquid oxygen storage container has an outlet that allows access for testing the purity of the oxygen.

(2) Establish written procedures specifying the steps for receipt and storage of bulk oxygen at each MTF and DTF with liquid oxygen storage capability. The MTF or DTF commander shall designate in writing those individuals who are responsible for the receipt of liquid oxygen and for documenting the concentration of the liquid oxygen. Only individuals who have been designated in writing and have received training in the use of the oxygen analyzer shall monitor bulk liquid oxygen deliveries.

(3) Establish appropriate training in the use of the oxygen analyzer for personnel monitoring bulk liquid oxygen deliveries.

(4) Whenever there is a delivery of bulk liquid oxygen, document the results of the oxygen analysis and the name of the individual accepting delivery and retain on file for 2 years from the date of the receipt and testing.

(5) Specify in writing what actions are to be taken and who must be notified if at the time of delivery the oxygen contains less than 95.0 percent, by volume of oxygen, test device accuracy considered.

(6) Deal with an oxygen system emergency and to minimize patient risk, establish a written plan describing the medical gas alarms and the actions to be taken when an alarm is activated. The plan shall identify clinical areas requiring an alternate oxygen supply until the central oxygen supply is functioning properly.

2–16. Suspension of medical materiel

a. Suspension instructions.

(1) USAMMA will publish suspension instructions for medical materiel by means of MMQC messages. When requested, consolidated reports of quantities suspended and quantities involved in a specific action will be submitted by the following:

(a) Each IMSA in the continental United States(CONUS). Reports will include all activities logistically supported to include the USAR and the ARNG.

(b) Each major OCONUS medical supply activity that submits requisitions directly to DPSC.

(c) Other activities listed for action on USAMMA messages.

(2) Consolidated reports will be submitted to Commander, USAMMA, ATTN: SGMMA–O, Fort Detrick, Frederick, MD 21702–5001, unless another reply point is specifically cited in the action document.

b. Accountability. Upon receipt of USAMMA MMQC messages, IMSA personnel will account for suspended materiel as follows:

(1) Enter the appropriate data in the MMQC message register. Verify the message number against the register to ensure that all messages were received. In TAMMIS activities, this is done automatically by the quality control module.

(2) Suspend the issue and use of stocks designated.Additionally, all customers will be instructed to suspend all stocks designated. Suspended stocks will be physically segregated from other stock and identified as suspended.

c. Reinstatement of previously suspended materiel. When USAMMA announces that suspended materiel is serviceable for its intended purpose, the stock affected will be returned to issuable status.

2–17. Surveillance of materiel

a. Chiefs of logistics at AMEDD activities and commanders of MEDLOG battalions and other medical units as determined by MACOM or theater MEDCOM will establish a surveillance program to provide for the scheduled inspection of medical materiel. The activity's ability to rotate mobilization reserve stocks with operating stocks will be emphasized.Timely action is necessary to preclude undue loss through deterioration or destruction.

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

(1) AMDF.

(2) TB 740–10/DLAM 4155.5/AFR 67–43, appendix M.

(3) SB 8–75 series.

(4) TB MED 1.

(5) DOD Medical Catalog, Volumes II and III.

(6) FEDLOG.

c. TB 740–10/DLAM 4155.5/AFR 67–43, 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.

d. The following actions may result from an inspection of estimated storage life items or in-date shelf life items:

(1) Items that do not show physical signs of deterioration may be considered suitable for continued issue and use until the next inspection date.

(2) Items that show signs of physical deterioration will be reported in accordance with chapter 3, section XI. Quantities on hand will be held in suspension for 6 months. If disposition instructions are not received through a USAMMA MMQC message, suspended

stocks will be destroyed in accordance with procedures in this section.

2–18. Inspection of locally purchased materiel

a. All materiel will be inspected prior to acceptance. Inspections will normally be performed by personnel assigned to the receiving section of the IMSA. For specialized materiel requiring inspection expertise beyond the capabilities of the IMSA, the requester or other appropriate specialist should be contacted to assist in the inspection.The supporting medical maintenance activity or general maintenance activity will perform technical inspection of equipment as appropriate. Receiving reports will be processed in accordance with the prescribed timeframe.Problems with materiel that are identified after the receiving report has been processed should still be reported to the supporting contracting officer for appropriate resolution with the supplier. USAMMA (SGMMA–MP) may be contacted for assistance in conducting specialized or technical inspections.

b. It is possible that materiel similar to that suspended in the military medical supply system is sold locally. For this reason, inspection procedures will incorporate quality control considerations to ensure that suspended or defective materiel is not accepted.

2–19. Storage periods for medical materiel

a. For medical materiel, "shelf life" is used only when referring to expiration-dated (potency)items. 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 nonextendable 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 FDA/Quad-Service Shelf Life Extension Program (see below). This program requires testing by the FDA. Type I shelf items are identified by "01" in the fourth and fifth positions of the Materiel Category Structure Code (MCSC) and by an alpha character in the 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) *Selected Type II shelf life items.* Certain Type II items can require specific actions by the local activity prior to extension or prior to requesting extension of the expiration date. (See TB 740–10/DLAM 4155.5/AFR 67–43, app M for more details.)

(4) *Estimated storage life items.* These are items of supply with an estimated storage period during which time the item is expected to retain its serviceable qualities. These items are identified by "03" or "08" in the fourth and fifth positions of the MCSC and by a zero in the SLC.

(5) *Minimum shelf life items.* These items are shelf life medical materiel with a potency date having a minimum shelf life potency acceptable for procurement, which is identified by the SLC and published in TB 740–10/DLAM 4155.5/AFR 67–43, appendix M.

(6) *Shelf life condition codes.* Shelf life medical materiel is condition coded in accordance with TB 740–10/DLAM 4155.5/AFR 67–43, appendix M as follows:

(a) Condition code A—shelf life remaining is more than 6 months.

(b) Condition code B—shelf life remaining is from 3 to 6 months.

(c) Condition code C—shelf life remaining is less than 3 months.

(7) *Reclassified materiel.* Medical materiel bearing expiration dates are reclassified from condition code A to condition code B or C based upon the number of months remaining in the unexpired dating period. For shelf life materiel issued from DPSC, condition code A stocks may be issued to CONUS and OCONUS activities. Condition code B stocks are issued to CONUS activities but may be issued to OCONUS activities with prior approval from the requisitioner. Activities will report in accordance with chapter 3, section XI, any newly procured potency dated materiel, which for OCONUS activities upon receipt is shelf life condition coded as B or C, or for CONUS activities is shelf life condition coded as C.

b. The FDA, under the FDA/Quad-Service Shelf Life Extension Program and other FDA sponsored shelf life extension initiatives, has approved and directed the shelf life extension of shelf life items. Items nominated for extension programs will be considered eligible for shelf life extension.

c. The relationships and differences between shelf life items and estimated storage life items are shown below.

(1) Shelf life items have specific storage periods that are terminated by an expiration date. Certain shelf life items can be extended after accomplishing prescribed actions at the local level. Others require inspection and testing by DPSC, the FDA, or the manufacturer.

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

2–20. Management of shelf life items

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

(1) Establishing procedures that support the optimum use of shelf life items, both contingency and peacetime, and that ensure the earliest dated materiel is issued first.

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

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

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

b. Local testing procedures. X-ray film, adhesive tape, microscope slides, and certain blood collecting tubes are Type II expiration-dated items that may be tested and extended utilizing local testing procedures, which are contained in TB 740–10/DLAM 4155.5/AFR 67–43, appendix M, section III. All other outdated medical items will not be used unless an extension of the expiration date has been received from USAMMA or other official source.

c. Potency extension. Medical materiel may receive extension of potency as a result of three procedures—

(1) *Quad-Service/FDA Potency Extension Program.* Under this program, the FDA tests shelf life materiel for the military Services. Each Service nominates specific materiel for FDA testing by NSN, manufacturer, lot number, and expiration date.Materiel that tests successfully is extended worldwide by the FDA provided it has been stored properly. USAMMA coordinates this program for the Army.

(2) *Field initiated extension requests.* Army activities will initiate extension requests for materiel that meets the extension criteria in *e* below. Extensions received are applicable only to the storage location initiating the extension request.

(3) *Military-unique mandatory extension actions.* Each year USAMMA will publish a list of military-unique items that AMEDD activities must report for potency extension action regardless of the dollar value of stocks on hand. These lists will be published by messages and will consist of items designated as military unique by the DMSB.

d. Biologicals. The FDA will not accept shelf life extension requests for federal supply classification (FSC)6505 items classified as "biologicals." USAMMA will provide guidance through MMQC messages on reporting and disposal of biologicals.

e. Criteria for field initiated extension requests. Items reported for potential extension should meet the following criteria:

(1) Stocks projected to be on hand at expiration date cannot be used prior to the expiration date of the assigned shelf life.

(2) The quantity projected to be on hand at the time of shelf life expiration must have an acquisition cost of $1,000 or more per lot.

Destruction of lines with an acquisition cost of less than $1,000 per lot is authorized upon reaching the assigned expiration date unless authority to extend the item has been received.

f. Potency extension requests.

(1) Any activity managing and storing medical materiel that meets the criteria in *e* above may request storage period extensions by submitting a letter or message request to the Commander, USAMMA, ATTN: SGMMA–OC, Fort Detrick, Frederick, MD 21702–5001. Extension requests should be submitted not earlier than 180 days nor later than 120 days before the expiration date. This lead time is needed to perform administrative and technical reviews to determine if an expiration date may be extended.

(2) Users should provide the following with each request:

(a) NSN.

(b) Item description.

(c) Manufacturer.

(d) Contract number.

(e) Lot or batch number.

(f) Original expiration date.

(g) Current expiration date.

(h) Projected quantity on hand at shelf life expiration.

(i) Extended dollar value per lot or batch.

g. Test considerations. Since the cost of testing varies with each item depending on the protocol, it is possible for an activity to meet the minimum dollar criteria but have its request returned because the cost of the test is more than the potential savings achieved through extension.

h. Submission of samples. When a potency testing project is established, the requesting activity will be advised by USAMMA to forward samples. The activity must respond quickly to ensure the timeliness of the testing process.

i. Guidance for materiel pending extension action. Items meeting the criteria in *e*above will be suspended for 180 days beyond their expiration date, pending notification by USAMMA of results of the extension request. If extension instructions or other guidance from USAMMA is not received by the 180th day, the suspended stock will be destroyed in accordance with procedures in this section.

j. Quad-Service/FDA Potency Extension Program.

(1) USAMMA will identify the items to be nominated under this program. Items to be extended under this program may be either Type I or Type II shelf life items.

(2) Extreme care must be exercised by activities submitting asset information for this program. USAMMA will identify the items to be nominated but activities will provide specific data for on-hand assets;e.g., manufacturers, lot numbers, and expiration dates. The accuracy of the data submitted to USAMMA is essential to the success of the program.Activities will, unless otherwise advised by USAMMA, suspend nominated materiel upon reaching the expiration date. Under this program, activities will hold materiel in suspension until notified by USAMMA to either extend the materiel or destroy the materiel.

(3) While only selected activities will be requested to submit asset information for the program, extensions granted by the FDA will be applicable to all activities that have maintained materiel under the prescribed storage conditions.

(4) The SB 8–75 series, MMQC messages, and other USAMMA messages will provide guidance for the Army's participation in the program.

2–21. Disposition instructions for medical materiel

a. Materiel determined unsuitable for issue and use will be disposed of as follows:

(1) Return to the DLA supply system with or without credit. This is done only when directed by USAMMA or DPSC.

(2) Return to the contractor with or without credit. This is done only when directed by USAMMA, DPSC, the contractor, or a contracting officer.

(3) Use for purposes other than originally intended. This may be locally determined by qualified personnel or may be directed by USAMMA or DPSC.

(4) Send through DRMO channels or destroy the stock. This will be based on instructions from USAMMA, DPSC, or authority contained herein.

b. Accounting for the disposition of materiel is described below.

(1) Use the shipping document, citing the disposition instructions as authority for shipment, to document returns to the DLA supply system or contractor.

(2) Use DA Form 444 (Inventory Adjustment Report(IAR)) to document the use of materiel for purposes other than originally intended. Delete the NSN, and designate a locally assigned management control number (MCN). Such materiel will be re-marked to show the new MCN and accounted for and controlled under that MCN.

2–22. Recall of nonstandard drugs and devices

a. Nonstandard drugs and devices announced by the FDA as being recalled by manufacturers or distributors will be published in MMQC messages.

b. Activities having quantities of these items on hand will suspend the materiel from issue and use.

c. CONUS activities will contact the respective manufacturer or distributor for disposition instructions.

d. OCONUS activities will report quantities suspended to Commander, USAMMA, ATTN: SGMMA–O, Fort Detrick, Frederick, MD 21702–5001, except as indicated in *f* below.Reports must include—

(1) MMQC message reference.

(2) Nomenclature.

(3) Lot or batch number.

(4) Requisition number under which the materiel was obtained.

(5) Purchase order or contract number.

(6) Location of the materiel.

e. USAMMA will coordinate with DPSC or the manufacturer for disposition instructions and advise reporting activities.

f. OCONUS activities may contact the responsible manufacturer or distributor for items procured directly from an overseas acquisition source other than DPSC.

2–23. Disposal policy

a. Excess or unserviceable medical materiel not authorized for return to the DPSC, redistribution within the AMEDD, or retention at Army health care activities will be disposed of through DRMO channels or destroyed.

b. Disposal will result from either of the following conditions:

(1) Materiel is determined unsafe or unsuitable for issue or use when disposal is—

(a) Directed by TSG, USAMMA, DPSC, MEDCOM commanders, command surgeons, or the FDA.

(b) Directed by conditions outlined in this regulation.

(c) Indicated because the materiel is classified as unserviceable (uneconomically repairable) or scrap by qualified medical equipment maintenance personnel.

(2) Materiel is excess to AMEDD needs according to chapter 3, section VII.

2–24. Destruction

a. Drugs, biologicals, reagents, needles, syringes, and sutures determined to be unsafe or unsuitable for use will be destroyed. The Military Item Disposal Instructions/Military Environmental Information Source (MIDI/METS) provides guidance for the destruction of materiel. Disposal codes are also contained in the DOD Medical Catalog and reflect incorporated requirements, standards, and guidelines issued by Federal agencies. Applicable State and local laws and regulations may not be reflected, but should be determined and followed. If a method of destruction code is required but not assigned, contact the U.S. Army Environmental Hygiene Agency, ATTN: HSHB–ME–SH, Aberdeen Proving Ground, MD 21010–5422. Items that are included are—

(1) Unidentifiable items or items which, when intended to be disposed of, are hazardous wastes according to criteria developed under the authority of the Resource Conservation and Recovery

Act(RCRA) of 1976 (Public Law 94–580) and its implementing Federal and State regulations, such as parts 260–270, title 40, Code of Federal Regulations (40 CFR 260–270).

(2) Partially used items that are station excess.These items tend to deteriorate faster after the opening of a container.Also, it cannot be assured that the covering label actually describes the contents of an opened container.

(3) Items that have exceeded their shelf life and do not qualify for potency extension projects in accordance with this chapter.

(4) Items cited for destruction by USAMMA MMQC messages and the SB 8–75 series.

b. Medical materiel that is authorized to be destroyed will be processed as follows:

(1) The commander of the medical facility or TOE unit will appoint a disinterested officer to be responsible for all destruction at the IMSA or TOE unit and for controlled substances at the user level.

(2) The destruction officer will certify as to the accuracy of all facts entered on destruction documents. Units not authorized Theater Army Medical Management Information System—Medical Supply(TAMMIS–MEDSUP) may use DA Form 3161 (Request for Issue or Turn-In) as their destruction documents. Activities utilizing TAMMIS-MEDSUP will use the system-generated destruction document. The statement shown in figure 2–1, signed by two witnesses, will be placed on the destruction document below the signed certificate of the destruction officer.

(a) When hazardous medical waste is disposed of by contractor, contracts will contain a statement requiring the contractor to furnish a certificate of destruction with the invoices for payment. Followup 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 destruction of hazardous medical waste is accomplished by a contractor.

(c) Local controls will be established to ensure that the contractor is given an itemized listing indicating the NSN, 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.

(3) 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) (SB 8–75–S9 of the SB 8–75 series), and the location of destruction.

(4) Accountable officers will establish a chain of control for destruction documents to ensure their posting. A sample completed transmittal control document (informal memorandum) is shown in figure 2–2.

(5) When instructed by USAMMA or the DPSC, the medical activity will submit certificates of destruction. Where credits are involved, Military Standard Requisitioning and Issue Procedures (MILSTRIP)DIC FAE (request for billing adjustment) cards must also be submitted by the local finance and accounting division. This card is used to generate interfund credits from the DPSC while the certificate is used by the DPSC to support claims for reimbursement against contractors. (See AR 725–50.)

(6) The Chief, Preventive Medicine Service, will review destruction documents from MEDDAC/MEDCEN customers and certify that the destruction codes assigned to the items are correct. The installation environmental coordinator will review destruction documents from TOE 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 be signed by the environmental science officer 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.

(7) Materiel in less than unit of issue quantity will be informally accounted for pending destruction. A copy of the turn-in document will be kept with the materiel until it is destroyed. On destruction, that copy will be filed with the destruction certificate.

(8) Note R and Q drugs will not be turned in to IMSAs in less than unit of issue quantity. They will be returned to the supporting pharmacy for destruction.

Section V
Logistics Assistance

2–25. Logistics Assistance Program

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

a. Assist commanders in improving medical logistics readiness.

b. Recommend improvements in unit medical logistics management.

c. Provide medical maintenance assistance.

d. Provide information on current logistical issues.

e. Resolve medical logistical problems in the unit.

2–26. Program elements

a. USAMMA and Army MEDCOMs are responsible to TSG for Army medical materiel logistics assistance. This includes—

(1) Resolving problems related to medical materiel support and medical equipment maintenance.

(2) Conducting liaison and logistics assistance visits (LAVs) to medical units and activities.

(3) Providing technical guidance and assistance to Army activities.

(4) Conducting follow-on evaluation of newly introduced items of materiel for TOE activities.

b. Army MEDCOMs are responsible for providing logistics assistance to TDA subordinate activities and installations by—

(1) Providing periodic visits, usually every 12 to 18 months.

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

(3) Reviewing logistics operations to include—as appropriate—supply, medical maintenance, property management, MEDCASE, logistics transportation, services, and facilities engineering functions with major logistics impacts.

(4) Identifying problems at all levels so commanders and staff can take corrective action.

(5) Providing a vertical assessment through command and technical channels to identify the root causes of problems; that is, at the customer, IMSA, or wholesale level.

2–27. USAMMA logistics assistance visits

a. USAMMA LAV teams will visit field medical units based on MACOM determination of need and availability of USAMMA resources.When possible, LAVs will coincide with USAMMA modernization efforts, e.g., major fieldings.

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

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

(3) Copies of customer assistance visit reports will be provided to the visited commander, the MACOM or command surgeon, the U.S. Army Logistics Evaluation Agency (LOEA–OS), and HQDA(DASG–LO). In addition, common findings and responses made during visits will be summarized and published in the SB 8–75 series periodically to assist all medical units Army-wide.

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

(1) Medical materiel support to the unit.

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

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

(4) Quality assurance of medical materiel.

(5) Medical equipment maintenance support.

c. Direct communication between field medical units and USAMMA is authorized and encouraged.

d. USAMMA may provide assistance concerning problems with unsatisfactory support from other than medical supply sources if these problems cannot be resolved at the MACOM level.

2–28. ARNG and USAR considerations for logistics assistance

a. ARNG and USAR units can obtain medical logistics assistance from their supporting MEDCOM. Specific points of contact(POCs) will be periodically published in the SB 8–75 series.

b. ARNG and USAR MACOMs may seek assistance from USAMMA as described in paragraph 2–27*a*.

Section VI
Identification of Nonstandard Medical Materiel

2–29. Medical item identification numbers and local management control numbers

a. Medical items without an NSN will be identified by either a MIIN (preferred) or by a locally assigned MCN.

b. MIINs are normally used to identify nonstocked medical items without an NSN. They are numbers that help customers, vendors, DPSC, and procurement offices identify an item. Examples of MIINs are:F1284310110 for a drug; P73462 for a repair part; and H8137023590 for an item other than a drug or repair part. (See para 2–30.)

2–30. Medical item identification numbers

a. Medical supply activities will use MIINs for the identification, ordering, and accounting of medical items that are not centrally managed by DPSC (medical items identified with an acquisition advice code of A, D, H, or K in the AMDF). The use of MIINs is mandatory when automated medical supply systems facilitate their use. Demand data will be accumulated under the MIIN.

b. MIINs should be constructed as follows to be consistent with other Army activities as well as other Services.

(1) *Drugs with NDCs.* The identification numbers for NDC items will always start with an "F"(FDA item) followed with a 10-position NDC number. This number will correspond with the bar code label on drug items unless the item has been repackaged by another vendor. For example, an identification number for a drug with an NDC of 12843–101–10 will be constructed as F1284310110, a drug with an NDC of 11414–0202–01 will be identified as F1141420201, and a drug with an NDC of 009–0012–01 will be identified as F0009001201.

(2) *Repair parts.* The identification numbers for repair parts will start with a "P" (parts item)to be followed either by the part number or by the Commercial and Government Entity (CAGE) code (formerly the Federal Supply Code for Manufacturers(FSCM)) and then the part number. For example, an identification number for a part with the part number of 73–462, made by manufacturer with a CAGE code of 23456, would be constructed either as P73462 or as P2345673462.

(3) *Cataloged numbered items.* The identification numbers for catalog numbered items will start with "H"(health related item). The "H" will be followed by a health related product number (HRPN) when available. This is a 9–11 position number assigned to many health care products that is similar to an NDC but is used for nonpharmaceutical items. It may also serve as the bar code number for the item on the manufacturer's package. The first four or five positions identify the manufacturer or vendor of an item. For example, 8137023590 is an HRPN that identifies an item from Johnson and Johnson. Its identification number would be followed by the vendor's catalog number. As an option the CAGE code for the vendor may be added between the "H"and the catalog number. For example, the identification number for an item with a catalog number of 97800 and a vendor CAGE code of 23456 would be constructed either as H97800 or as H2345697800.

2–31. Management control numbers

a. The use of MCNs by medical supply accounts is discouraged and will only be used if the supporting procurement activity will not accept MIINs.

b. MCNs used for the identification of nonstandard medical materiel will be constructed as shown below.

(1) The first four characters will identify the FSC for the item.

(2) The fifth and sixth characters will be codes "00"or "01." Code "00" is reserved for use by USAMMA only to identify items for special projects. Code"01"designates local activity MCNs.

(3) The seventh character is the letter "C,"which identifies medical materiel. Commodity designators "C01" through "C79" will be used for medical items, and "Q01" through "Q99"will be used for nonmedical items (for example,6515–01–C56–1043 or 4110–01–Q33–8643).

(4) The tenth through thirteenth characters are numbers assigned sequentially to distinguish one item from another.

c. Each medical supply activity assigning MCNs to stocked items and equipment items will maintain a register of their assignment. The register will contain complete item identification, manufacturer, and manufacturer's catalog or model number.

I have witnessed the destruction of the materiel described and it was destroyed on the date and in the manner stated.

(Signature—Witness 1)

(Signature—Witness 2)

Figure 2-1. Destruction statement format

(office symbol) *(MARKS number)* *(date)*

MEMORANDUM FOR *(commodity manager's address)*

SUBJECT: Destruction Certificates

1. The attached Certificates of Destruction are forwarded for processing.

2. Request one copy of each certificate be annotated and returned to this office.

5 Encls *(quality control clerk's signature*
1. *and signature block)*
2.
3.
4.
5.

(office symbol of commodity manager) 1st End *(name/initials/telephone no.)*

(commodity manager's address and date)

FOR *(quality control clerk's address)*

1. Items have been dropped from suspension to destruction and the transaction is reflected on the Transaction Register *(date).*

2. Annotated copies are returned as requested.

5 Encls *(commodity manager's signature*
nc *and signature block)*

Figure 2-2. Sample memorandum for transmittal control document

Chapter 3
Operating Supply Support Activities and Other Supply Operations for Medical Materiel

Section I
Supply Support Activity Guidance

3–1. Medical supply operations

This chapter provides policy and procedures for operation of SSAs and other supply operations for medical materiel.

a. SSAs for medical materiel include—

(1) IMSAs.

(2) MEDLOG battalions. In peacetime, MEDLOG battalions may perform the full functions of an SSA or may perform primarily a training mission requiring direct support or area supply in an informal manner similar to the other medical supply operations identified below. Upon mobilization and/or deployment, the MEDLOG battalion will normally perform all functions of an SSA. This regulation distinguishes policy and procedures for MEDLOG battalions operating as formal SSAs, referred to as "MEDLOG battalion SSAs," and MEDLOG battalions performing primarily a training mission, referred to as "MEDLOG battalions not operating as formal SSAs." When policy and procedures apply to both types, the term "MEDLOG battalions" will be used.

b. Other supply operations for medical materiel include—

(1) Combat division level medical supply support provided by the division MSO (DMSO).

(2) Medical supply detachments.

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

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

c. SSAs for medical materiel are distinguished from other medical supply operations in that they operate a stock record account in accordance with AR 710–2, perform the full range of supply functions identified for SSAs in AR 710–2, chapter 3, and appoint an accountable officer in accordance with AR 735–5. SSAs for medical materiel normally requisition materiel directly from the wholesale level system or from a major, intermediate level medical materiel SSA (for example, MEDLOG battalion (rear)). 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 wholesale system and do not perform the full range of supply and FIA functions required of an SSA.

3–2. Supply support activities

SSAs for medical materiel provide direct, general, and/or installation support to units and activities within a designated command or area. The mission to provide this support is specifically stated in the unit's or activity's TOE or TDA or by MACOM directive. The SSA will—

a. Maintain accountability and manage medical supply stocks that are stored for issue to authorized supply customers.

b. Operate a stock record account in accordance with AR 710–2 and this regulation.

c. Operate with a standard automated system (for units or activities provided automated data system support) in accordance with the approved system's prescribed procedures.

d. Conduct prescribed FIA and financial management of the installation or command portion of the stock fund or Operation and Maintenance, Army (OMA) fund, which finances acquisition and distribution of SSA stocks.

3–3. Installation medical supply activity

a. The IMSA is normally the SSA for medical materiel for a designated installation and/or geographical area. It is controlled by the commander of the MEDDAC or MEDCEN and is staffed by the MEDDAC or MEDCEN logistics division personnel. The IMSA is maintained separately from the installation's consolidated SSA.

b. The MEDDAC or MEDCEN commander is responsible for medical supply support to designated units and activities on the installation and within the assigned geographical support area of the installation.

c. The chief, logistics division, is responsible to the MEDDAC or MEDCEN commander for operation of the IMSA in accordance with AR 710–2 and this regulation.

d. The IMSA accountable officer MSO directs the operations of the IMSA. The MSO is responsible for total medical supply support to all supported units and activities. The MSO is responsible for security of materiel in accordance with AR 190–50.

e. Medical IMSAs may be established or discontinued by USAMEDCOM and theater MEDCOMs as coordinated with the appropriate stock fund home office. When neither of these commands are in a unit's command channel, the request to establish or discontinue an IMSA will be sent to HQDA (DASG–LO), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

f. The IMSA is the manager of the installation or command portion of the stock fund or OMA fund that finances medical-dental materiel stocks.

g. IMSAs must be assigned a DOD Activity Address Code (DODAAC). (See AR 725–50.) MACOM will provide information on additions, deletions, and changes in DODAACs to Commander, USAMMA, ATTN:SGMMA–ZA, Fort Detrick, Frederick, MD 21702–5001.

h. IMSAs are authorized direct contact with customers, USAMMA, DPSC, and supporting medical supply and local purchase activities on medical supply matters.

3–4. MEDLOG battalions and other medical supply operations

a. MEDLOG battalions assigned to a medical SSA mission will support all customer units according to the logistics support plan developed for their command or area of operation. The relationship between MEDLOG battalions and the wholesale level will be according to the logistics support plan developed for their command or area of operation. In CONUS, the logistics support plan will be coordinated by the MEDLOG battalion's supporting command with the supporting MEDDAC/MEDCEN commander.

b. MEDLOG battalions supported by an IMSA must conduct all interface with the wholesale system through the IMSA until directed otherwise by the MEDLOG battalion's MACOM in coordination with HQDA(DASG–LO).

c. TOE hospitals and other units may be directed by their commands to perform SSA missions.

3–5. ARNG units

U.S. property and fiscal offices (USPFOs) may provide IMSA-type support to ARNG units. USPFOs and ARNG TOE units assigned a medical supply support mission will operate in accordance with this regulation.

3–6. Consolidated supply activities on AMEDD installations

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

b. AMEDD installation consolidated supply activities will operate under a structure similar to that described in paragraph 3–3.

c. AMEDD installation consolidated supply activities are authorized direct contact with nonmedical supply activities, SICCs, and national inventory control points (NICPs), as appropriate.

Section II
Stockage Policy

3–7. Stockage

Materiel is authorized for stockage as follows:

a. IMSAs and MEDLOG battalion SSAs are authorized to stock all items of medical materiel to include—

(1) Standard items appearing in the Federal Supply Catalog, DOD Section, Medical Materiel.

(2) Nonstandard items for which no comparable standard item is available to meet the essential needs of supported activities.

b. MEDLOG battalions not operating as formal SSAs and other TOE medical supply operations are authorized to stock consumable items authorized in the medical SKOs they support. For TOE hospitals, the required resupply module fulfills this requirement. Items used to meet contingency missions and training requirements or to provide garrison medical support may be stocked 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. Nonmedical commodities required to support installation operations may be stocked by AMEDD installation consolidated supply activities.

3–8. Vendor inventory service

IMSAs are authorized to use direct-order inventory services provided by commercial medical materiel distribution organizations. Such services may provide for either automatic or on-demand shipment of materiel.These services may be used to augment in-house capability for nonstandard items and services that provide significant benefits for managing short shelf life items. IMSAs may also use vendor inventory services as an alternative to stocking and maintaining inventory at the installation level.

3–9. Stockage criteria

a. IMSAs and MEDLOG battalion SSAs will stock frequently requested items to support their customers.

(1) Initial stockage will normally be established when six requests have been received for an item within 360 days. Systematic reviews will be conducted to assure items with six or more demands are added to stock. Accounts on automated systems with "memo entry" capability will document (date and reason) why items with over six demands are not stocked.

(2) Stockage can be established when less than six requests have been received on an item if a supported customer requests in writing that an item be stocked. Stockage will be based on estimated requirements for the item. If the customer does not use the item in the quantities that they forecast, they can either be charged for or force-issued the excess stock in the medical supply account.

(3) Items required for emergency situations can be approved for stockage by the senior logistics officer in the unit.

(4) Stockage will normally be maintained if there are at least three recurring demands within 360 days.

b. As an alternative to stockage, IMSAs may utilize vendor inventory services such as prime vendor distribution contracts to satisfy customer demands for frequently requested items.

(1) For recurring demand items that will be managed under a prime vendor distribution contract, the governing P&T committee for pharmaceuticals or the materiel standardization committee (MSC) (see para 8–20) for medical surgical products will locally

establish the demand criteria for adding new lines. The P&T committee or MSC will locally recommend to the commander additions of new items prior to incorporating the new items into the contract.

(2) For items managed under a prime vendor distribution contract, the P&T committee or the MSC, in conjunction with the contractor, will review demand history to identify items to locally recommend to the commander for removal or retention. The P&T committee and the MSC will locally develop and apply demand criteria to identify items to recommend to the commander for deletion or retention to the contract.

c. MEDLOG battalions not operating as formal SSAs and other TOE medical supply operations will normally establish initial stockage for an item when there are six demands within 360 days. Stockage may be maintained if there are at least three demands in 360 days. MACOM guidance will establish stockage criteria for items to support ASLs and mandatory parts lists (MPLs) or resupply of medical set components.

3–10. Stockage lists

a. IMSAs and MEDLOG battalion SSAs operating with support of an automated inventory management system, and a capability for production of an automated stockage list report, will provide copies of the stockage list to supported activities. Local policy will govern frequency and recipients.

b. MEDLOG battalions not operating as formal SSAs and other TOE medical supply operations are required to maintain ASLs. Local policy will govern the distribution of the ASLs.

3–11. Stockage of D-Day Significant items

IMSAs and MEDLOG battalions will stock D-Day Significant items to the maximum extent possible. The purpose for the emphasis on stockage of D-Day Significant items is to maintain adequate quantities in support of TOE units and maintain an adequate stock rotation base for these items. The IMSA will coordinate with the governing P&&T committee for designated FSC 6505 items and review through the materiel standardization program (MSP) for other designated consumable medical supplies to determine the utilization of the item by the health care activity. Items with an appropriate equivalent relationship (same item but different quantity packaging) may be stocked in place of the specific D-Day Significant designated item. When there is a substitute relationship between a D-Day item and a non-D-Day item, the D-Day item will be designated as the primary substitute. A current list of D-Day Significant items may be requested from the Commander, USAMMA, ATTN:SGMMA–OC, Fort Detrick, Frederick, MD 21702–5001.

3–12. Stockage levels

a. Computing reorder points for IMSAs.

(1) Reorder points will be computed with a 30-day safety level and the actual order and shipping time (OST) for each item.Variable safety levels in automated systems are authorized when approved by HQDA (DASG–LO). For nonstandard items, the OST will include the average time used for processing a procurement request.

(2) When using economic order quantity (EOQ)procedures, table 3–1 may be used to compute reorder point quantities.

Table 3–1
EOQ reorder point quantity, 30-day safety level

Order and shipping time (in days)	Quantity demanded during control period (360 days)	EOQ reorder point quantity
1–5	3–12	1
	13–24	2
	25–36	4
	37–48	5
	49–60	6
	61–72	7
	73–84	8
	85–96	9
	97–108	11
	109–120	12
	121–132	13
	133–144	14
	145–156	15
	157–168	16
	169–180	18
	181–192	19
	193–204	20
	205–216	21
	217–228	22
	229–240	23
	241–252	25
	253–264	26
	265–276	27
	277–288	28
	289–300	29
6–10	3–12	1
	13–24	3
	25–36	4
	37–48	5
	49–60	7
	61–72	8
	73–84	9
	85–96	11
	97–108	12
	109–120	13
	121–132	15
	133–144	16
	145–156	17
	157–168	19
	169–180	20
	181–192	21
	193–204	23
	205–216	24
	217–228	25
	229–240	27
	241–252	28
	253–264	29
	265–276	31
	277–288	32
	289–300	33
11–15	3–12	2
	13–24	3
	25–36	5
	37–48	6
	49–60	8
	61–72	9
	73–84	11
	85–96	12
	97–108	14
	109–120	15
	121–132	17
	133–144	18
	145–156	20
	157–168	21
	169–180	23
	181–192	24
	193–204	26
	205–216	27
	217–228	29
	229–240	30
	241–252	32
	253–264	33
	265–276	35
	277–288	36
	289–300	38
16–20	3–12	2
	13–24	3
	25–36	5
	37–48	7

Table 3–1
EOQ reorder point quantity, 30-day safety level—Continued

Order and shipping time (in days)	Quantity demanded during control period (360 days)	EOQ reorder point quantity
	49–60	8
	61–72	10
	73–84	12
	85–96	13
	97–108	15
	109–120	17
	121–132	18
	133–144	20
	145–156	22
	157–168	22
	169–180	25
	181–192	27
	193–204	28
	205–216	30
	217–228	32
	229–240	33
	241–252	35
	253–264	37
	265–276	38
	277–288	40
	289–300	42
21–25	3–12	2
	13–24	4
	25–36	6
	37–48	7
	49–60	9
	61–72	11
	73–84	13
	85–96	15
	97–108	17
	109–120	18
	121–132	20
	133–144	22
	145–156	24
	157–168	26
	169–180	28
	181–192	29
	193–204	31
	205–216	33
	217–228	35
	229–240	37
	241–252	39
	253–264	40
	265–276	42
	277–288	44
	289–300	46
26–30	3–12	2
	13–24	4
	25–36	6
	37–48	8
	49–60	10
	61–72	12
	73–84	14
	85–96	16
	97–108	18
	109–120	20
	121–132	22
	133–144	24
	145–156	26
	157–168	28
	169–180	30
	181–192	32
	193–204	34
	205–216	36
	217–228	38
	229–240	40
	241–252	42
	253–264	44
	265–276	46
	277–288	48

Table 3–1
EOQ reorder point quantity, 30-day safety level—Continued

Order and shipping time (in days)	Quantity demanded during control period (360 days)	EOQ reorder point quantity
	289–300	50
31–35	3–12	2
	13–24	4
	25–36	7
	37–48	9
	49–60	11
	61–72	13
	73–84	15
	85–96	17
	97–108	20
	109–120	21
	121–132	24
	133–144	26
	145–156	28
	157–168	30
	169–180	32
	181–192	35
	193–204	37
	205–216	39
	217–228	41
	229–240	43
	241–252	46
	253–264	48
	265–276	50
	277–288	52
	289–300	54
36–40	3–12	2
	13–24	5
	25–36	7
	37–48	9
	49–60	12
	61–72	14
	73–84	16
	85–96	19
	97–108	21
	109–120	23
	121–132	26
	133–144	28
	145–156	30
	157–168	33
	169–180	35
	181–192	37
	193–204	39
	205–216	42
	217–228	44
	229–240	47
	241–252	49
	253–264	51
	265–276	54
	277–288	56
	289–300	58
41–45	3–12	3
	13–24	5
	25–36	8
	37–48	10
	49–60	13
	61–72	15
	73–84	18
	85–96	20
	97–108	23
	109–120	25
	121–132	28
	133–144	30
	145–156	33
	157–168	35
	169–180	37
	181–192	40
	193–204	43
	205–216	45
	217–228	48

Table 3–1
EOQ reorder point quantity, 30-day safety level—Continued

Order and shipping time (in days)	Quantity demanded during control period (360 days)	EOQ reorder point quantity
	229–240	50
	241–252	53
	253–264	55
	265–276	58
	277–288	60
	289–300	63

b. Computing requisitioning objectives (ROs) for IMSAs.

(1) When using EOQ, see the tables in DA PAM 710–2–2.

(2) When using the days of supply method, the operating level will be 90 days or as established by the major MEDCOM or command surgeon. Levels for nonstandard items acquired under vendor service will be based on quantities necessary to sustain operations between resupply cycles. (See para 3–8.)

c. Calculating retention levels. When stocks on hand exceed the RO, medical activities may compute retention levels under the provisions of AR 710–2, DA PAM 710–2–2, and appropriate Army Stock Fund policy for stock funded activities. Stocks exceeding authorized retention levels will be processed according to section VII of this chapter.

d. Calculating stockage levels. The peacetime stockage objective for MEDLOG battalions and other TOE medical supply operations will be determined by the command surgeon but should not exceed 90 days. The days-of-supply method or the inventory management module of an approved automated system will be used for calculating the RO.Logistics support plans will establish days of supply required to support designated unit operations upon mobilization.

3–13. Inventory accounting

Stocks will be accounted for by the methods cited below. Although these methods are for manual systems, automated systems developed on these principles will be used when approved by TSG, major Army MEDCOMs, and command surgeons.

a. IMSAs and MEDLOG battalion SSAs will maintain accountable records in accordance with AR 710–2, DA PAM 710–2–2, and this regulation. MEDLOG battalions not operating as formal SSAs, but training with support of an automated inventory management system, will maintain inventory records in accordance with the automated supply system.

b. Other TOE medical supply operations will maintain informal inventory accounting records. To maximize efficiency and accuracy of records and effectiveness of training, item records will be maintained in accordance with procedures in AR 710–2 and DA PAM 710–2–2 to the maximum extent possible.

c. Medical TOE units will account for items stocked and for components of medical assemblages in accordance with chapter 5.

Section III
Requisition and Receipt

3–14. Requisition procedures

a. CONUS IMSAs will submit requisitions for AAC D and H items directly to the DPSC. Requisitions for AAC A items will be submitted in accordance with paragraph 3–62. Requisitions for AAC W and J items will be submitted in accordance with paragraph 3–63. Submit requisitions for AAC L items according to paragraph 3–28. The Defense Automatic Addressing System (DAAS) will be used to electronically transmit requisitions to DPSC.

b. OCONUS IMSAs and MEDLOG battalion SSAs will submit requisitions as directed by the theater surgeon. Requisitions that cannot be filled for stocks available within the theater will be forwarded to CONUS as follows:

(1) Requisitions that can be processed by DAAS, including document identifier codes (DICs) A01, A02, and A04, will be forwarded through DAAS to DPSC. DPSC will process the requisition for shipment to the theater level medical materiel activity or directly to the IMSA or MEDLOG battalion SSA.

(2) Requisitions that cannot be sent through DAAS will be transceived or mailed directly to the source of supply depending on the AAC and any special instructions that may apply (for example, medical care support equipment (MEDCASE) or service-regulated items).

(3) Requisitions for regulated medical items from OCONUS medical materiel activities will be submitted in accordance with paragraph 3–62.

(4) Requisitions for provisioned medical equipment items from OCONUS medical materiel activities will be submitted in accordance with paragraph 3–63.

c. Newly standardized items for DPSC stockage and issue will have phrase code "R—Not Yet Available" in the AMDF. Prior to depot availability, all CONUS customers will receive a "CV—Item Prematurely Requisitioned" rejected status. The effective date for requisitioning is contained in columns 70–73. All OCONUS customer requisitions will be honored and purchased for direct vendor delivery.

d. Equipment items to be acquired through the MEDCASE program will be requisitioned in accordance with SB 8–75–MEDCASE, and other guidance published by USAMMA or parent commands. MEDCASE requisitions will be forwarded directly from the supporting property account and will not be processed through the IMSA.

e. MEDLOG battalions not operating as formal SSAs will requisition medical materiel from the supporting IMSA. Other TOE medical supply operations will requisition from a supporting MEDLOG battalion or the IMSA as directed by the command surgeon or the logistics support plan in the specific area of operations.

3–15. Emergency requisitions

a. IMSAs and MEDLOG battalion SSAs may submit requisitions for supported MEDDAC or MEDCEN activities using issue priority designator "03" (life or death requisitions) when emergency or urgent medical materiel requirements exist to save life or prevent suffering or distress.

b. The health care activity commander or senior medical logistics officer present for duty will personally review all property account, IMSA, or MEDLOG battalion SSA Urgency of Need Designator "A and B" requisitions to ensure compliance with DA PAM 710–2 series review procedures. This review will be documented. IMSAs and MEDLOG battalion SSAs will perpetuate all Urgency of Need Designator "A and B" requisitions submitted by supported activities other than a MEDDAC or MEDCEN activity after ensuring compliance with DA PAM 710–2 series review procedures.

c. Requests for shipment using the fastest traceable means or shipments by specific mode (for example, shipment by commercial air) are valid exception data for these requisitions. IMSAs and MEDLOG battalion SSAs will provide an appropriate transportation fund citation if commercial air transportation is requested. Life or death "03" requisitions will not be delayed to verify or determine the appropriate fund cite. Other Urgency of Need Designator "A and B " requisitions may be delayed pending verification of fund cites.

d. MEDLOG battalions not operating as formal SSAs and other TOE medical supply operations will submit emergency requisitions to their supporting IMSA. The unit commander of the medical supply operation will authenticate the priority assigned to the requisition in accordance with DA PAM 710–2 series. The medical supply operation will perpetuate emergency requisitions from supported units that have been properly authenticated, provided the requisition cannot be filled from on-hand stocks.

3–16. Requisitioning nonstandard medical materiel

a. OCONUS IMSAs and MEDLOG battalion SSAs may transceive DIC A01 requisitions through DAAS to the supply source if they—

(1) Comply with local command policies and procedures.

(2) Are in MILSTRIP format.

(3) Are for medical materiel centrally cataloged by DPSC and listed in the DOD Medical Catalog, Volume III, or the AMDF.

b. OCONUS IMSAs and MEDLOG battalion SSAs may transceive DIC A05 requisitions to the supply source if they—

(1) Comply with local command policies and procedures.

(2) Are for medical materiel not listed in the Federal Supply Catalog (DOD Section, Medical Materiel), DOD Medical Catalog, volume III, or AMDF. Such requisitions will be accompanied by all applicable exception data. AR 725–50 prescribes the format for DIC A05 documents.

c. CONUS IMSAs normally purchase nonstandard medical materiel locally in accordance with section IV of this chapter.However, they may submit requisitions to DPSC citing DIC AOE, pertinent exception data, and advice code 2A in card columns 65–66 of the requisition when the item is not locally obtainable.

d. When requisitioning nonstandard equipment through the MEDCASE Program, follow the procedures in SB 8–75–MEDCASE.

e. MEDLOG battalions not operating as formal SSAs and other TOE medical supply operations will submit requisitions for nonstandard materiel to their supporting IMSA.

3–17. Requisitioning preferred medical items

a. The DMSB authorizes the substitution of medical materiel to effect maximum use of existing stocks where the substitution is professionally acceptable. Authorized substitutions are listed in the AMDF and DOD Medical Catalog, volumes II and III.

(1) DPSC will direct the issue of authorized substitutes without consulting the requisitioner, except when advice code 2B is entered on the requisition.

(2) Where an authorized substitute is not acceptable, DPSC will process the requisition for the preferred item.

b. A negative preference that limits substitution of an item can be indicated in requisition exception data. This can occur where materiel has been suspended because of a materiel complaint, where one manufacturer's modular system is not compatible with another manufacturer, or if otherwise completely justified.

c. USAMMA will publish annually in the SB 8–75 series a list of items required in the medical evacuation system.This list will include announcement of a project code to be used when requisitioning these items for specific use in medical evacuation. During wartime, USAMMA may announce additional items by message and subsequent publication in the SB 8–75 series.

(1) Requisitions citing the appropriate project code will be submitted to DPSC. DPSC will satisfy the requisition from a special pool of assets, when available. Requisitions that are satisfied with assets from the special asset pool will be billed at 10 percent of the standard unit price. Requisitions that are not satisfied from the special asset pool will be billed at the standard unit price. DPSC will provide the appropriate MILSTRIP supply status. Materiel issued from the special asset pool to satisfy requisitions will consist of used, serviceable stocks rather than new, unused stocks.

(2) Issues made to supported activities by IMSAs of these used, serviceable items will be charged at only 10 percent of the standard unit price.

(3) Requisitions for these items when not specifically for medical evacuation issues will not cite the project code.

3–18. Shipment discrepancies

a. When shipments received at IMSAs or MEDLOG battalion SSAs are found to be deficient in quantity or condition, they will be inspected by the IMSA or MEDLOG battalion SSA accountable officer or an alternate. (See AR 55–38/NAVSUPINST 4610.33/AFR 75–18/MCO P4610.19/DLAR 4500.15, AR 710–2, or AR 735–11–2/DLAR 4140.55/SECNAVINST 4355.18/AFR 40–54.)

b. Hazardous materiels shipments will not be accepted unless accompanied by Materiel Safety Data Sheets (MSDS). The only exception to this is if the nonacceptance of the shipment causes a life-threatening emergency.

c. IMSAs and MEDLOG battalion SSAs will adjust and report these discrepancies according to references cited in (1), (2), and (3)below. The discrepancy reports most commonly used for medical materiel are as follows:

(1) SF 361 (Transportation Discrepancy Report) (AR 55–38/NAVSUPINST 4610.33/AFR 75–18/MCO P4610.19/DLAR 4500.15).This form is used to report damage or loss that can be attributed to a carrier or to improper carrier facilities. It is normally prepared in coordination with the installation transportation office.

(2) SF 364 (Report of Discrepancy) (ROD)) (AR 735–11–2/DLAR 4140.55/SECNAVINST 4355.18/AFR 40–54 and AR 12–12/DLAR 4140.60/SECNAVINST 4355.17/AFR 67–7/MCO 4140.1E). This form is used to report supply and packaging discrepancies that are obviously the responsibility of the supplier or supporting supply activity.

(3) Serious Incident Report (AR 735–11–2/DLAR 4140.55/SECNAVINST 4355.18/AFR 40–54 and AR 190–40). This is used to report theft or suspected theft of high value or controlled substances.

d. Copies of reports will be distributed in accordance with the governing regulation. The IMSA or MEDLOG battalion SSA may request assistance from DPSC (DPSC–MO), DLA customer assistance teams, or USAMMA (SGMMA–O) when discrepancies are not satisfactorily resolved using procedures in the regulations outlined in (1), (2), and (3)above.

e. MEDLOG battalions not operating as formal SSAs and other TOE medical supply operations will report supply discrepancies to the supporting IMSA in accordance with local procedures.

3–19. Materiel obligation validation

a. IMSAs and MEDLOG battalion SSAs will conduct monthly customer dues-out reconciliations (called materiel obligation validation (MOV)) with supported customers. A local reconciliation will always be completed prior to the SSA's processing of the quarterly NICP MOV process.

b. MOV procedures are prescribed by AR 725–50. MOV requests will be reviewed with the user to validate the requirement to ensure the proper use of funds and the need for continued supply action. Timely response by IMSAs and MEDLOG battalion SSAs to validation requests from supply sources is essential to ensure ongoing supply action.

c. MEDLOG battalions not operating as formal SSAs and other TOE medical supply operations will validate requisitions in accordance with the local IMSA procedures for reconciliation. These TOE medical supply operations will respond to IMSA requests for MOV.

Section IV
Local Purchase of Medical Materiel and Services

3–20. Local purchase policy

a. Local purchase will be performed by the supporting contracting office in accordance with the FAR, as supplemented, and parent command contracting activity instructions.

b. In the IMSA, the chief of the logistics division and/or MSO (MEDDAC or MEDCEN) coordinates local purchase support for the health care activity with the supporting contracting officer. Special arrangements, as indicated below, should be sought to improve acquisition of medical support materiel and services.

(1) Physically locate purchasing agents in the health care activity.

(2) Establish blanket purchase agreements (BPAs)with designated health care activity personnel authorized to place calls.Utilize DPSC decentralized blanket purchase agreements (DBPAs) as appropriate.

(3) Appoint health care activity personnel as properly authenticated ordering officers. Authorize them to effect over-the-counter and collect-on-delivery purchases using imprest funds. Grant authority to place delivery orders against indefinite-delivery-type contracts awarded by contracting officers.

c. Health care facility commanders will ensure that local purchase is used only when—

(1) A comparable standard item is not available or cannot be requisitioned in time to meet the requirement.

(2) Dictated by immediate patient care needs.

(3) Judged to be in the best interest of the Government in terms of quality, timeliness, and cost.

d. Centrally managed items may be purchased locally if such action is judged to be in the best interest of the Government in terms of quality, timeliness, and cost. Cost is not a basis unless the local price plus the current DLA medical surcharge is less than the DLA price.

(1) Excluded items are as follows:

(a) Items with AR requirements.

(b) Items necessary for the wartime mission.

(c) Items required to execute the unit deployment mission.

(d) Items required to support the industrial mobilization base.

(e) Items directly related to the operation of a weapon system or its support equipment.

(f) Items with special security characteristics.

(g) Dangerous items (e.g., explosives and munitions).

(2) For local purchase of DLA and General Services Administration (GSA) stock items, the procedures apply as defined in DFARS 8.7100–1, 8.7100–2, and 8.470–2. MACOMS and MEDCOMs will publish implementing instructions for their activities as required.

(3) This policy gives the local commander more financial control by allowing the purchase decision to focus on the cost of an item. However, prior to conducting local procurement of a standard item under this process, the following factors will be reviewed:

(a) Capability of the supporting contracting office and finance office to perform additional workload.

(b) Local purchase lead time and OST as opposed to depot OST.

(c) Administrative overhead costs associated with a local purchase procurement action.

(4) A price challenge will be submitted to DPSC whenever a DLA or GSA stocked item is purchased locally under these procedures and annual procurement savings exceed $5,000 for that item.

e. Commanders and surgeons cited in AR 40–2 are delegated approval authority to use local acquisition for pharmaceuticals. They may further delegate this authority.

f. MEDLOG battalion SSAs will obtain local purchase support for medical materiel through their supporting contracting office. MEDLOG battalions not operating as formal SSAs and other medical supply operations will obtain local purchase support through their supporting IMSA. These activities will comply with the IMSA procedures for submission of purchase requests (PRs).

3–21. Defense Personnel Support Center price challenge and price verification procedures

a. Depot prices can be challenged when a cheaper source for a depot-stocked item is located. DPSC will respond to price verification requests within 30 days and report the results of a price challenge back to the inquirer within 90 days. DPSC will take action within 30 days to correct erroneous information.

b. To assist DPSC in their research, submit as much information as possible, including but not limited to: NSN, part number, CAGE code, nomenclature, price, contract number, requisition number, price challenge/verification, manufacturer's address and phone number, drawing/sketch/photograph, and POC of the submitter.

c. Send price challenges to—

ATTN DPSC–PM
DEFENSE PERSONNEL SUPPORT CENTER
2800 SOUTH 20TH STREET
PHILADELPHIA, PA 19101–8419

d. Send price verifications to—

ATTN DPSC–RM
DEFENSE PERSONNEL SUPPORT CENTER
2800 SOUTH 20TH STREET
PHILADELPHIA, PA 19101–8419

3–22. Materiel standardization program role in local purchases

The MSP should play a role in managing the use of nonstandard items for fixed (TDA) health care facilities. Local procedures should be established to ensure that the MSP reviews selected nonstandard items for the appropriateness of continuing local purchase. The decision to review may be based on one-time cost or cumulative cost of purchases exceeding a designated cost threshold or on the determination by the MSP that a comparable depot item is available and should be considered for use. Operating procedures for the MSP are further discussed in chapter 8.

3–23. Unsatisfactory local purchase support

Support adversely affecting the health care mission that cannot be resolved within channels will be reported to HQDA (DASG–LO), 5109 Leesburg Pike, Falls Church, VA 22041–3258. Such reports will be forwarded through MEDCOM channels. They will cite a POC, a statement of the problem, and actions taken to resolve the problem.

3–24. Items authorized for local purchase

The following medical materiel and equipment are authorized for local purchase:

a. Items (including repair parts) required immediately to save life or prevent suffering where it is impossible to follow normal supply and financial procedures. If necessary, such purchases may be made in the absence of funds according to AR 37–1. Drugs and immunizing agents must conform to standards for medical agents as outlined in AR 40–2 and this regulation.

b. Newly standardized items not yet announced as available in the SB 8–75 series.

c. Standard items identified by AAC I, K, or L in the AMDF.

d. Expendable and durable standard items to meet immediate requirements when any of the following conditions exist:

(1) Installation or OCONUS command stocks are exhausted.

(2) Standard stocks are suspended.

(3) A backorder is established by DPSC and the supply status provided indicates that materiel will not be delivered by the required delivery date.

e. Occupational therapy supplies and equipment at health care activities authorized occupational therapists.

f. Professional books and periodicals. These include all library materiel required for health care personnel involved in direct or indirect patient care.

(1) OCONUS activities may order medical books and periodicals by using DBPAs awarded by DPSC. Requisitions may be sent to DPSC if the required materiel is not available through a DBPA.

(2) Subscriptions for medical periodicals and journals may exceed 1 year when it is more economical.

(3) Federal supply schedules (FSSs) for Federal Supply Group 76 are a source for a limited number of medical books.

g. Wigs, for active duty and retired members of the uniformed services only, when the following conditions exist:

(1) Females with alopecia (hair loss).

(2) Males with alopecia secondary to specialized medical treatment, in conjunction with disfiguring scars, or resulting in psychiatric disorders when, in the opinion of the attending medical authority, furnishing a wig would be beneficial therapy.

h. Medicinal gases when locally available in satisfactory quality (U.S. Pharmacopeia standards) and volume.

i. Furniture and furnishings for clinical, waiting, and lounge areas of health care activities.

j. Contact lenses when authorized by AR 40–63/NAVMEDCOMINST 6810.1/AFR 167–3.

k. Prosthetic devices, implants, appliances, and accessories for individuals in accordance with AR 40–3.

l. MEDCASE requirements in accordance with procedures in SB–8–75–MEDCASE.

m. Post-mastectomy brassieres authorized by MTF commanders as part of the overall course of treatment. The brassieres will not be accounted for on the activity property book.

n. As the SICC, USAMMA may also determine and approve centrally managed items to be locally purchased if such action is judged to be in the best interest of the Government.

3–25. Special dental materiel

DPSC has established indefinite requirements contracts and DBPAs with various companies to facilitate purchase of prosthodontic supplies, to include artificial teeth, facings, backings, and mold guides; orthodontic supplies; partial denture casting alloys and their accessories; and other dental accessories and materiel. Local purchase procedures are as follows:

a. USAMMA will forward copies of the contracts on artificial teeth and denture casting alloy to activities that need them.Delivery orders against these contracts will be placed by the ordering officer specified by the contract or DBPA.

b. Activities that provide orthodontic care will receive DBPAs for these supplies.

c. Contractors can handle orders faster if activities use the company's individual order forms in addition to required Government contract forms. Order forms may be obtained directly from contractors.

3–26. Local purchase restrictions

a. No drug will be purchased until it is approved by the FDA for commercial sale and use, except as provided in AR 40–2 and AR 40–7. The term "drug" as used in this regulation does not include vaccines and immunizing agents.

b. Vaccines and immunizing agents will not be purchased locally unless one or more of the following conditions are met:

(1) The item is included in the DOD Medical Catalog, volumes II and III.

(2) The item is approved or recommended for use in official Army publications.

(3) The item is specifically approved by TSG(DASG–LO).

c. Nonstandard equipment for which a standard comparable item is available should not be purchased locally unless it provides features which are clearly necessary in the health care service.

d. Standard or nonstandard items needed in connection with facility alterations, additions, expansions, or minor new construction will not be purchased locally before approval and funding of the construction project.

e. Items of foreign origin are subject to the restrictions contained in the FAR as supplemented.

f. Local purchase of tax-free alcohol will not be made without prior approval in accordance with paragraph 3–53.

g. Local purchase of infant transport is authorized under the following conditions:

(1) Transport incubators or bassinets used solely for ground transport must be FDA approved.

(2) Infant incubators used for air transport must be units approved by the U.S. Air Force Aeromedical Systems Branch, Brooks Air Force Base, TX.

h. Investigational drugs will not be used or purchased without the prior written approval of TSG in accordance with AR 40–2. Requests for approval to use investigational drugs will be submitted to Commander, USAMRMC, ATTN: MCMR–HR, Fort Detrick, Frederick, MD 21702–5001. (See AR 40–7 for additional guidance.)

i. Drugs classified "ineffective 1A" by the FDA will not be purchased or issued.

j. Regulated medical items listed in table 3–2 and those regulated items listed in the SB 8–75 series will not be purchased locally without approval of TSG.

k. Orthopedic footwear for authorized individuals will be obtained in accordance with AR 32–4/DLAR 4235.18/AFR 67–125/NAVSUPINST 4400.70C/MCO 4400.137A and AR 40–3 from the Defense Orthopedic Footwear Clinic.

l. Hearing aids will be obtained through medical supply channels from the Department of Veterans Affairs acquisition sources (AR 40–3). Local purchase of hearing aid batteries and replacement ear molds will comply with AR 40–3, chapter 9.

m. The local purchase of diagnostic imaging systems is not authorized except when authorized by USAMMA.

n. Local purchase of infant feeding formula will be executed by purchase order or BPA. IMSAs may receive formula at no cost provided that the authorized purchase order or BPA call has been executed in accordance with prescribed procurement procedures established by the supporting contracting officer.

o. Investigational equipment not yet certified by the FDA will not be obtained without TSG approval. Submit requests for approval through command channels to HQDA (DASG–LO), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

p. The Preventive Medicine Service, in coordination with the Safety Committee, will define, develop, and/or review approval procedures to mitigate potential harmful health and environmental effects from locally purchased materials. They will request MSDS from the manufacturer.

3–27. The Department of Veterans Affairs as a source of medical materiel

The Department of Veterans Affairs may be considered a source of medical materiel authorized for local purchase. It has contracts with firms for common use supplies and services. These contracts are summarized in FSSs.Note the provisions in the FAR when making local purchases from FSSs.

3–28. Local purchase of acquisition advice code L items

a. Standard items are designated as AAC L to—

(1) Preclude central stockage of short shelf life items or highly complex and specialized equipment that may become obsolete in storage.

(2) Ensure that equipment is professionally acceptable and the most modern available at the time of acquisition.

(3) Enhance standardization of equipment within one installation. (See chap 8, sec V.)

(4) Provide closer customer-manufacturer relationships to ensure proper installation, maintenance, repair parts stockage, and operational guidance.

b. Items coded AAC L are obtained as follows:

(1) CONUS IMSAs and MEDLOG battalion SSAs will send local PRs to the supporting contracting office. CONUS IMSAs may also submit requisitions to the DPSC or place delivery orders against any legally established contract.

(2) OCONUS IMSAs and MEDLOG battalion SSAs will submit PRs in accordance with local policies, balance of payment directives, and the FAR. If unable to purchase locally, requisitions will be sent to a wholesale supply source. Use 2A advice code. Requisitions may be submitted without referral to the supporting contracting office.

(3) MEDLOG battalions not operating as formal SSAs and other medical supply operations will submit PRs to their supporting IMSA.

3–29. Funding local purchases

a. Consumer funds (OMA) will finance local purchase of medical supplies and capital expense equipment for installations where stock funds have not been extended.

b. At installations where stock funds have been extended, local purchases will be financed as directed by command stock fund policy.

c. Capital investment equipment for fixed MTFs is acquired through the MEDCASE program using procurement or construction appropriation funds. MEDCASE policy is contained in chapter 4. PA funded equipment for field medical units is requisitioned in accordance with section X of this chapter.

3–30. Planning local purchases

Personnel should consider the following when local acquisition of materiel is necessary:

a. Contracts must be made on a competitive basis to the maximum extent possible. Requirements for products and services must be established and described on the basis of actual needs of the Government, not personal preference. Requirements will be based on the minimum essential characteristics required to perform the mission. When Government needs are such that only a particular

product is acceptable, the PR will include a factual statement prepared by the user justifying sole source procurement.This statement will cite the physical, functional, or other characteristics essential to the needs of the Government. It will also identify those peculiar to the requested product or service. Activities should consider equipment compatibility and other conditions or circumstances that may necessitate sole source procurement. PRs shall include facts concerning test and evaluation of potential products and identify competitive products to the maximum extent possible.

b. PRs will include all available information to ensure receipt of desired materiel. Providing complete information will prevent unnecessary correspondence and reduce lead time.

c. Coordination between the user, the supporting medical maintenance activity, and the facility engineer in the planning stage is necessary to determine structural and utility requirements when purchasing equipment that requires installation.

d. All AAC L items have purchase descriptions(PDs) that are available from the Technical Services Branch, DPSC, or USAMMA.The PD may range from the manufacturer's name and part number, to a medical procurement item description, to a Federal specification. Federal specifications are available from the U.S. Naval Publications and Forms Center, 5801 Tabor Avenue, Philadelphia, PA 19120. They may be ordered on DD Form 1425 (Specifications and Standards Requisition). PDs for items standardized by the DMSB contain technical data and item-essential characteristics established by the DMSB. These characteristics are minimum requirements and will not be waived. However, the requesting activity may specify additional characteristics necessary to meet mission needs.

e. All PRs shall be reviewed by medical maintenance activities to identify maintenance significant equipment, determine maintenance requirements, and assist the requester in procurement specifications.

f. PRs for maintenance significant equipment will specify the requirement for two sets of operator and maintenance manuals.

(1) The operator manuals will include instructions on the assembly, operation, services, accessories, and calibration as applicable.

(2) The maintenance manuals will include instructions on the assembly, installation, troubleshooting, and calibration requirements. In addition, the manual will include utility schematics/wiring diagrams and a complete listing of parts as applicable.

3–31. Renovation of medical treatment facility areas

a. Equipment and furnishings required in support of medical military construction (MILCON) projects will be obtained using MEDCASE procedures. (See SB 8–75–MEDCASE for details.)

b. GSA or commercial interior design services may be used to determine entire furnishing requirements and design decor when renovating entire offices or areas. Design services will be funded from local operating funds.

3–32. Decentralized blanket purchase agreements

a. DPSC will establish DBPAs with suppliers to facilitate the purchase of a wide variety of medical supplies and equipment and the limited repair and return of medical equipment. DBPAs are established primarily to assist OCONUS units in obtaining direct access to CONUS companies. These DBPAs may be used by CONUS IMSAs if authorized by the DBPA.

b. The supported Services will identify DBPA management POCs and submit these POCs to DPSC. The POCs are responsible for maintaining and updating authorized ordering officer lists, distributing DBPAs, and providing management information to DPSC concerning inspections and usage.

c. To use a DBPA, activities will submit a request with the names of ordering officers to their commands. Requests to add or delete DBPAs will be coordinated by the command POCs and submitted to DPSC–MPD for consideration. DPSC will then advise the appropriate supplier in writing and provide a copy to the requesting activity. Once this copy is received, the activity may begin using the DBPA.

d. Information on DBPA procedures will be published as necessary by the MACOMs.

3–33. Purchasing services and rentals

a. Services. The FAR, as supplemented, provides guidance concerning contracting for personal and nonpersonal services. Nonpersonal services may be locally purchased. Examples of such services are shown below.

(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. Rental or lease of equipment. Equipment may be rented or leased when necessary to satisfy an emergency of short-term requirement, when available only through lease, or where the lease is more economical than purchase.

3–34. Obtaining replacement or credit for expired nonstandard drugs and biologicals

The following policies apply to expired stock with a line acquisition value of $100 or more:

a. CONUS IMSAs will seek replacement or credit for expired stocks and condition code B and C stocks of nonstandard drugs and biologicals when possible. Before destroying expired stock of these items, the IMSA will coordinate with the supporting contracting office. The contracting office will contact the manufacturer to determine whether like-item replacement or credit is available.

b. If replacement or credit is not available, destroy the item according to paragraph 2–24. Include a statement on the destruction certificate that credit was sought but not granted.

c. If replacement or credit is allowed, it must be arranged through the supporting contracting office. Follow the instructions of the manufacturer, to include—

(1) Destroying the materiel and providing a copy of the destruction certificate if requested.

(2) Shipping the materiel to the manufacturer if requested.

(3) Holding the materiel for inspection by a manufacturer's representative.

d. OCONUS IMSAs and MEDLOG battalion SSAs seeking replacement or credit for expired stock must contact USAMMA (SGMMA–O).USAMMA will coordinate with the manufacturer to determine if replacement or credit is available and will provide instructions for disposition of any returned or credited materiel. If replacement or credit cannot be obtained the materiel will be destroyed in the same manner as indicated in *b*above.

Section V
Storage of Medical Materiel

3–35. Storage policy

a. The chief of the logistics division at each MEDDAC or MEDCEN—

(1) Is responsible for the care, preservation, and surveillance of medical materiel in the IMSA.

(2) Will establish storage policy for all MEDDAC or MEDCEN elements.

(3) Will provide technical advice and assistance to all supported units.

b. The commanders of MEDLOG battalions and other medical supply operations are responsible for the care, preservation, and surveillance of medical materiel in their activities.

3–36. Storage methods for IMSAs, MEDLOG battalions, and other medical supply operations

a. Loose-issue stock and vault, refrigerated, flammable, and security items will normally be stored in NSN sequence.

b. Bulk storage at IMSAs and MEDLOG battalions will normally not be in NSN sequence. IMSAs and MEDLOG battalions will

normally store bulk stocks in accordance with the best use of available storage space. Activities should organize bulk storage with consideration of quantity of bulk stocks, available space, ease of item identification, and efficiency for distribution and handling of bulk stocks. Bulk stocks of each item should be stored in one location for ease of inspection and to facilitate stock rotation.

c. Medical materiel may be stored at IMSAs, MEDLOG battalions, and other medical supply operations in less than unit of issue quantity if the lesser quantity is clearly a more economical and practical quantity to be issued to customers. Stock control records must properly reflect the lesser quantity and unit price as the revised unit of issue.

3–37. Care of medical materiel in storage

The procedures of IMSAs, MEDLOG battalions, and other medical supply operations will provide for the special storage needs of medical materiel, as follows:

a. Controlled items require special storage and handling procedures to protect them against pilferage. (See para 3–56 for guidance.)

b. Hazardous materiel, including acids, flammables, corrosives, gases, and poisons, will be stored and handled in accordance with TM 743–200–1, TM 38–410/DLAM 4145.11/NAVSUP PUB 573/AFR 69–9/MCO 4450.12, AR 200–1, and applicable Federal, State, and local laws. At a minimum, the compatibility of chemicals, ventilation, fire protection, spill prevention and response, containment, and protection from the weather must be considered. The IMSA must ensure that an inventory list and all applicable MSDS are located near the storage area for all hazardous materiels/chemicals stocked and used within the MTF.

c. Radioactive materiel will be handled as prescribed in paragraph 3–68.

d. Medical materiel mobilization stocks and medical assemblages will be stored and handled according to chapter 9, section II, and chapter 5, sections II through IV, of this regulation and the SB 8–75 series.

e. Heat, refrigeration, and humidity control will be provided where necessary to protect stock in accordance with TM 743–200–1. Suspended materiel will be physically separated from other stock and marked with the authority for suspension.

3–38. Stock locator system

a. IMSAs and MEDLOG battalion SSAs will establish stock locator systems at each storage site to facilitate control and the efficient use of storage space. All storage locations will be surveyed at least annually and the result reconciled with the locator file.

b. Stock locator systems at IMSAs and MEDLOG battalion SSAs will be constructed in accordance with supporting automated system procedures or FM 10–15, TM 743–200–1, and TM 743–200–2 procedures. If items are stored in NSN sequence, one location can be assigned to an entire area of the warehouse; for example, LOOSE, VAULT, FLAMM, SECUR, REFRG, and so forth.

c. DA Form 4997–R (Locator Card) will be used by activities that maintain a manual stock locator file. DA Form 4997–R will be reproduced locally on 5- by 3-inch card stock. A copy for reproduction is located at the back of this regulation.

d. Stock locations in automated IMSAs and MEDLOG battalion SSAs will be recorded in the automated system's file. Automated locator cards may be used if produced by the automated system.

e. MEDLOG battalions not operating as formal SSAs and other medical supply operations will establish a stock locator system in accordance with MACOM or command surgeon guidance, AR 710–2, and DOD 4145.19–R–1.

3–39. Inventory and adjustment

a. Inventory and adjustment procedures at IMSAs, MEDLOG battalions, and other medical supply operations will be as prescribed in AR 710–2, DA PAM 710–2–2, AR 37–1, and AR 735–5.

b. Either the cyclic inventory method or the wall-to-wall inventory method may be used. The method chosen should provide the most accurate inventory possible while minimizing disruption to the account and to customer support. The cyclic method provides for the phasing of inventories of FSCs throughout the fiscal year. If this method is used, the warehouse should be structured to consolidate and segregate each FSC or a group of FSCs in separate storage areas to facilitate the inventory process.All classes will be inventoried annually. Using this method, each inventory should not exceed 5 workdays. The wall-to-wall method is conducted at a single point in time during the fiscal year. All FSCs are inventoried and reconciled during the inventory period. The inventory period may vary depending upon the size of the activity, but every effort should be made to conduct the inventory within 5 workdays. During a wall-to-wall inventory, requisitions citing priority 01 through 08 will be issued with adjustments made to inventory counts as infloat transactions. During a cyclic inventory, priority 01 through 08 requisitions for FSCs under inventory will be issued with adjustments made to inventory counts as infloat transactions.Requisitions for FSCs not under inventory are processed normally.

c. MTF commanders will approve inventory adjustments for IMSAs. Commanders may delegate this authority to the chief of the activity's logistics division. Inventory adjustments for MEDLOG battalions and other medical supply operations will be approved in accordance with MACOM or command surgeon guidance.

d. Controlled medical items will be inventoried and accounted for in accordance with paragraphs 3–56 and 3–57.

Section VI
Medical Materiel Issues

3–40. Issue policy

a. IMSAs will issue medical materiel to MEDDAC and MEDCEN elements and other units or activities authorized medical supply support from the IMSA.

b. MEDLOG battalions and other medical supply operations will issue medical materiel to activities in accordance with the logistics support plan for the command area.

c. Medical materiel will be issued according to AR 710–2, DA PAM 710–2–2, and this regulation. To ensure maximum stock rotation, issues will be as follows:

(1) Shelf life items with the shortest usable potency life will be issued first.

(2) Nonshelf life items with the earliest date of manufacture will be issued first.

(3) As an exception to (1) and (2) above, materiel intended for medical assemblages will have the longest remaining shelf life and latest date of manufacture.

d. Issue procedures will include appropriate quality control measures. (See chap 2, sec IV.)

e. Emergency or urgent requests will be honored whether the request is in written or verbal form. Issues will be made on such requests at any time, regardless of administrative shutdown for inventory or other reasons, with subsequent adjustment of stock record accounts. IMSAs will establish a suspense system for walk-through transactions to ensure that they are posted to the accountable record.

f. All issues from IMSAs will be in unit of issue quantity unless the supporting automated medical supply system has the capability to issue stock in both unit of issue and less than unit of issue quantity. Drugs, biologicals, and reagents found in less than unit of issue opened containers will, after investigation, be destroyed in accordance with section VIII of this chapter.

g. All issues from MEDLOG battalions and other medical supply operations should be in unit of issue quantity. Deviation is authorized only when individual troop issue items or issues to small units make smaller than unit of issue quantities more economical. Stock accounting records must be annotated to reflect the less than unit of issue basis of issue.

3–41. Issue procedures for MEDDACs/MEDCENs

a. Organizational elements of MEDDACs, MEDCENs, and supported DENTACs may submit requests for expendable and durable medical materiel directly to the IMSA.

b. Requesting activities will assign organizational document numbers to requests. These numbers will consist of a Julian Date and four-digit serial number. Organizational elements will maintain control of these requests by the methods discussed below.

(1) Place a copy of the document in suspense in document number sequence to determine which orders are still open. Upon receipt of the materiel, the suspense copy may be destroyed. Activities supported by an automated system that provides a weekly due-out list and transaction register will—

(a) Maintain suspense copies of requests for issue until they appear on the weekly transaction register.

(b) Maintain the latest weekly due-out report showing the customer all items currently due-out.

(c) Maintain the current weekly customer transaction register and last six monthly customer transactions registers that show all requests listed or canceled.

(2) Activities using a customer reorder list or other automated system will use the system produced output as the document register to support the request for expendable medical supplies.

c. Requests for nonmedical materiel (expendable and nonexpendable) will be submitted to the property management office. These requests may be recorded on a DA Form 2064 (Document Register for Supply Actions) or a similar register based on local procedures. MEDDAC and MEDCEN commanders may authorize modified data entries on this form to satisfy local needs.

d. Other units and activities authorized medical supply support from the IMSA will follow the procedures given below.

(1) Non-MEDDAC and non-MEDCEN units and activities will submit requests to the IMSA in accordance with command procedures. ARNG will submit requests to the IMSA under instructions published in SB 8–75–S10.

(2) The IMSA will arrange pre-issue maintenance actions for equipment items issued to non-MEDDAC and non-MEDCEN units or activities.

e. Units and activities supported by MEDLOG battalions and other medical supply operations will request medical materiel in accordance with AR 710–2, DA PAM 710–2–1, DA PAM 710–2–2, and major MEDCOM and/or local command surgeon guidance.

f. Heads of requesting activities will designate personnel authorized to receive medical supplies and equipment. DA Form 1687(Notice of Delegation of Authority—Receipt for Supplies) will be used for this purpose. Distinctions will be made between those authorized to order and receive controlled and sensitive items and other medical materiel. IMSAs, MEDLOG battalions, and other medical supply operations will maintain a current file of completed DA Forms 1687. IMSAs, MEDLOG battalions, and other medical supply operations will issue materiel to persons cited thereon within the limitations imposed by the official issuing the DA Form 1687 per AR 710–2.

Section VII
Excess Management

3–42. Excess management policy and goals

a. The goals of the excess management program are to—

(1) Eliminate excess.

(2) Plan and manage programs and materiel to prevent the accumulation of excess whenever possible.

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

(4) Aggressively report and advertise excess to enhance asset redistribution and utilization and reduce disposal requirements.

b. Medical materiel on hand in medical units or activities will be declared excess when the materiel is no longer required to satisfy any peacetime or contingency mission requirements. The materiel must be—

(1) Consumables in condition code A.

(2) Equipment that is serviceable or economically repairable.

c. All activities will screen medical materiel against all requirements within their activity before reporting them excess.

d. The retail SSA operating a stock fund will be the activity responsible for reporting excess to the wholesale system. IMSAs and MEDLOG battalion SSAs represent examples of retail stock fund SSAs. The term IMSA will be used to represent all retail level SSAs in the following guidance.

e. The IMSA will establish local turn-in procedures.

f. The IMSA will accept excess medical materiel from supported units and activities. See AR 37–1 for the policy on granting credit for materiel returns.

g. Excess prepositioned Army reserve materiel stock (PARMS) will be clearly identified in local supply accounting records as PARMS materiel. Any credits received from the wholesale system will be properly recorded and reported for investment in accordance with the supply management, Army operating policy.

3–43. Excess materiel not reportable to DPSC, USAMMA, or MEDCOMs

a. Medical materiel (expendable and durable) eligible for processing or disposal in accordance with paragraphs 2–23,3–34, and 3–48.

(1) All materiel with an expiration date of 3 months or less.

(2) Nonstandard items, local purchase items (AAC L), and terminal medical materiel with a total excess value of less than $500.

(3) Repair parts with a line item acquisition cost of less than $100.

(4) All refrigerated and freezer items.

(5) All veterinary items.

b. Medical equipment eligible for disposal in accordance with paragraphs 2–23, 3–34, and 3–48.

(1) An item that is not economically repairable and has no recoverability code.

(2) Nonstandard equipment that meets any of the following conditions:

(a) Its manufacturer no longer exists.

(b) It lacks a model or part number.

(c) It is no longer manufactured or has exceeded its life expectancy as indicated in TB MED 7 or the manufacturer's literature.

(d) It has a line item value of less than $1,000.

(e) Its condition code is F.

c. Other categories.

(1) Medical books and scientific journals will be disposed of according to AR 40–2. However, volumes containing the official history of the AMEDD will be sent to the Center of Military History(DAHM–HM), Washington, DC 20314–0200. In OCONUS areas, obsolete, unserviceable, and excess medical books may be released to local medical facilities when approved by the appropriate MEDCOM or command surgeon.

(2) Radioactive materiel will be reported and disposed of in accordance with AR 385–11.

3–44. Excess medical materiel reportable to DPSC

a. IMSAs will report the following excess materiel to DPSC.

(1) All excess AAC D and K items that satisfy the following:

(a) Non-expendable medical equipment without recoverability codes D and L.

(b) Expendable items with at least 6 months of shelf life remaining.

(c) Durable items.

(2) Compressed gas cylinders (AAC D) should be reported for turn-in against the unserviceable (empty) NSN for return.Cylinders will be prepared as prescribed by AR 700–68/DLAR 4145.25/NAVSUPINST 4440.128C/MCO 10330.2C/AFR 67–12 prior to shipment to DLA depots.

b. Follow excess reporting procedures as prescribed in AR 725–50, chapter 7.

c. Materiel accepted by the DPSC for credit should be delivered

to the transportation officer within 10 days of receipt of the response from DPSC. Materiel accepted as noncreditable returns should be delivered to the transportation officer within 15 days of receipt of the turn-in authorization.

3–45. Excess medical materiel reportable to USAMMA

a. IMSAs and MEDLOG battalion SSAs will report the following excess medical materiel to USAMMA (SGMMA–R):

(1) Regulated medical items identified as AAC A in the AMDF. This includes major medical equipment sets (MES) listed in table 3–2. The report will include the set control code, the estimated dollar value of shortages, and a statement of the set's condition. (See chap 5 for unit turn-in instructions.)

(2) Medical materiel with recoverability codes D or L regardless of the condition code.

(3) Medical materiel and equipment for activities not supported by a MEDCOM/MACOM. USAMMA will establish reporting requirements. See paragraphs 3–46*a*(3) and 3–46*b*(3) for the minimum information required on these excess reports.

(4) Items of prepositioned Army reserve materiel stocks for medical facilities (PARMS–MF) that exceed requirements, are no longer authorized for stockage, and cannot be used through attrition.These items will be reported to USAMMA by mail or message clearly stating that the reported excess is PARMS–MF. An information copy of reported excess AR materiel will be sent to the MEDCOM; the MEDCOM may coordinate with USAMMA for redistribution.

b. Medical materiel reported to USAMMA will be screened to ensure assets are applied to known requirements. USAMMA will provide disposition instructions when a mobilization requirement exists.Materiel not identified for an existing requirement at USAMMA will be advertised for worldwide distribution. If redistribution is not accomplished after a worldwide advertisement period (minimum of 45 days), materiel will be eligible for processing to the DRMO.

c. After worldwide advertisement and cutoff date specified by USAMMA, if a mobilization requirement does not exist and the materiel cannot be applied to other DA approved OP requirements, the IMSAs and MEDLOG battalions will forward the excess report to the DPSC for disposition in accordance with AR 725–50. Any credits generated will be used to satisfy mobilization deficiencies in accordance with the directions provided for reinvestment of mobilization reserve credits in the Army Stock Fund by other regulations. Excess PARMS–MF that is not in an acceptable condition, as outlined in chapter 9, will be processed under paragraph 3–44.

d. Reports to USAMMA will include the following:

(1) NSN or locally assigned MCN.

(2) Descriptive data for each equipment item. This includes complete nomenclature, make, model, serial number, electrical characteristics, special features, year of acquisition, year of manufacture, total amount spent on repairs to date, and color of item, if applicable.Units using the Army Medical Department Property Accounting System (AMEDDPAS)will furnish a copy of the AMEDDPAS maintenance record in addition to the above data. Data elements need not be duplicated.

(3) Name of manufacturer or CAGE.

(4) Unit of issue.

(5) Quantity.

(6) Condition code. Use condition codes in TB 740–10/DLAM 4155.5/AFR 67–43, appendix M for shelf life items and AR 725–50 for other items.

(7) Unit price and total price.

(8) AAC.

(9) DODAAC of location where materiel is actually stored.

(10) Statement indicating whether materiel is stock funded or OMA owned.

3–46. Excess medical materiel reportable to MEDCOMs

a. Nonexpendable equipment (not AR and not reportable to DPSC or USAMMA).

(1) MEDCOMs will establish command-wide reporting, advertising, and redistribution programs for nonexpendable items owned by and determined to be excess to their subordinate units. USAMMA will be an addressee for all command-wide excess advertisements. If redistribution is not accomplished after a command-wide advertisement period (minimum of 45 days), equipment will be eligible for processing to the DRMO.

(2) Activities will report all serviceable nonstandard equipment with a line item dollar value (unit price times quantity) of over $1, 000 to their supporting MEDCOMs. CONUS activities not supported by a MEDCOM will report the equipment to USAMMA. Nonstandard medical equipment past its life expectancy will not be reported.

(3) MEDCOMs will determine the information that is to be reported on each excess item. At a minimum, the following information will be reported:

(a) Nomenclature, make, and model number.

(b) NSN, if assigned.

(c) Date placed in service.

(d) Quantity.

(e) Line item dollar value.

(f) Local POC.

(4) Excess materiel possessing electrical characteristics unique to a command (i.e., 220 volts, 50 HZ) will be retained within the command for redistribution or final disposal.

(5) MEDCOMs will screen excess advertisements from their activities against known MEDCASE requirements and will request transfers of equipment when appropriate.

(6) USAMMA will screen excess advertisements from the MEDCOM against known MEDCASE requirements from other MEDCOM and AR requirements and will request transfers of equipment when appropriate.

b. Medical materiel (expendable and durable).

(1) MEDCOMs will establish command-wide reporting, advertising, and redistribution programs for expendable and durable items owned by and determined to be excess to their subordinate units. USAMMA will be an addressee for all command-wide excess advertisements. If redistribution is not accomplished after a command-wide advertisement period (minimum of 45 days), items will be eligible for processing to the DRMO.

(2) The following items with a minimum line item dollar value (unit price times quantity) of over $500 and that are not returnable to DPSC or to the supporting MEDLOG battalion are reportable.CONUS activities not supported by a MEDCOM will report the items to USAMMA.

(a) AAC D and K items that have been reported to DPSC or the supporting MEDLOG battalion SSA and have not been accepted for return by that activity.

(b) Nonstandard items that could not be returned for credit to the vendor that the item was purchased from.

(c) Terminal items (AAC V and Y).

(d) Items with between 3 and 12 months remaining shelf life.

(e) Local purchase items (AAC L).

(3) Repair parts with a line item dollar value of$100 or more are also reportable.

(4) Since most of the items reported to MEDCOMs will be shortdated items, MEDCOMs will establish policies to allow activities to quickly redistribute items between their activities.

3–47. Aeromedical evacuation items

a. Reporting during peacetime. Medical materiel used in AE is subject to those reporting procedures outlined in AR 40–538/ BUMEDINST 6700.2B/AFR 167–5.This materiel includes litters, litter mattresses, pillows, blankets, litter straps, and patient restraints. However, critical, nonexpendable AE equipment such as patient monitors, defibrillators, pulse oximeters, and suction apparatus will be reported to USAMMA in the same manner as with AAC A, Service regulated items.

b. Reporting during wartime, contingency, humanitarian, and

peacekeeping operations. See paragraph 4–28*b* for specific procedures.

Section VIII
Disposal

3–48. Disposal through the DRMO

a. The IMSA or MEDLOG battalion SSA will manage the turn-in of medical materiel from installation and area activities to the DRMO. MEDLOG battalions not operating as formal SSAs and other medical supply operations will turn-in materiel through the IMSA to the DRMO. Local procedures will be established to minimize redundant storage and handling of turned-in materiel. Where conditions permit, property management officers may establish equipment turn-in procedures directly to the DRMO without physically moving the items through the IMSA's storage facility. These procedures must be approved by the IMSA. Documentation for turn-in of materiel in condition codes that indicate a value to the Government should be processed and approved by the IMSA with actual movement of equipment going directly from the unit to the DRMO. Medical equipment in condition codes H and S may be turned in directly from the property management officer to the DRMO. The IMSA will report material to the DRMO according to DOD 4160.21–M, AR 725–50, and this regulation. The IMSA will provide technical assistance to the DRMO as required.

b. Materiel that requires special handling by the DRMO will be processed as follows:

(1) Medical materiel that is unserviceable, uneconomically reparable, 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 equipment will be rendered unusable for its intended purpose prior to turn-in.

(2) Serviceable stock of lot or batch numbered materiel with an acquisition cost of $500 or more per lot or batch number will be processed according to DOD 4160.21–M. Materiel included is as follows:

(a) FSC 6505—drugs, biologicals, and reagents(excluding filled gas cylinders) will not be physically transferred to the DRMO until the DRMO provides final disposition instructions. IMSAs may request DRMO assistance in reutilization or donation processes for non-controlled, non-hazardous drugs following the procedures outlined in DOD 4160.21–M, chapter VII, paragraph 39.

(b) FSC 6510—surgical dressing materiel.

(c) FSC 6515—sutures only.

(3) Compressed gas cylinders other than oxygen and nitrous oxide will be prepared as prescribed in AR 700–68/DLAR 4145.25/NAVSUPINST 4440.128C/MCO 10330.2C/AFR 67–12 prior to transfer to the DRMO. Oxygen and nitrous oxide cylinders should be reported to DPSC and disposed of per paragraph 3–44 of this regulation.

(4) Pilferable items, shown below, will be reported to the DRMO. AMEDD personnel will retain physical custody of these items until disposition instructions are provided by the DRMO.

(a) Precious metals, as well as medical items containing recoverable amounts of precious metals directed to the DRMO will be precisely marked so that disposal personnel may take special handling precautions according to DOD 4160.21–M. Standard items are identified as Note M in the Federal Supply Catalog, DOD Section, Medical Materiel, and as Recoverability Code A in the AMDF. These instructions apply to similar nonstandard items.

(b) Tax-free alcohol and serviceable hypodermic needles and syringes will be clearly identified before transfer to the DRMO to ensure special processing according to DOD 4160.21–M.

(5) Shelf life medical materiel will be marked to show the expiration date before turn-in to the DRMO. This will ensure processing according to DOD 4160.21–M. Unexposed medical and dental x-ray film that is not outdated is included in this category.

c. MEDCOMs and command surgeons will establish property disposal policies and procedures based on the above guidance and local command and DRMO procedures.

d. Medical materiel eligible for disposal may be designated for training use with the approval of the medical activity commander. Expired drugs, biologicals, intravenous solutions, and reagents will not be used for training purposes. 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 training materiel is properly disposed of after it has completed its training mission.

e. To prevent needed medical materiel from being transferred to the DRMO or from being processed for disposal prematurely, obtain professional judgment as to the materiels further or potential use.Utilize the "Two-Man Rule" in all events as prescribed in AR 725–50.

3–49. Precious metals recovery program

a. A continuing requirement exists for precious metals to use in the manufacture of defense materiel. The AMEDD will participate in the DOD program for precious metal recovery described in DODD 4160.22, DOD 4160.21–M, and AR 755–3. Silverbearing scrap includes, but is not limited to, scrap silver cell batteries, silver turnings, silver alloys, film ash, exposed silver bearing film, silver recovered from spent x-ray film developing solutions, and dental scrap containing economically reclaimable silver.

b. MEDCOMs and command surgeons—

(1) Will follow guidance in DODD 4160.22, DOD 4160.21–M, chapters VI and XVIII, and AR 755–3 to develop a program for the recovery of precious metals. (See para 3–54*e*.)

(2) Will establish program implementation procedures either as a supplement to this regulation or as a separate command regulation for—

(a) Recovering precious metal-bearing scrap (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) Disposition of PMBS.
(h) Documenting the quantities recovered and their disposition.

(3) May establish central collection points at Army medical activities. These activities will accumulate, report, and ship recovered precious metals and PMBS.

c. The recovery of silver from spent x-ray film developing solutions is one of the most important elements of the program.Activities operating central collection points will be authorized recovery equipment commensurate with x-ray and photography equipment in use. In AMEDD activities where recovery equipment is not authorized, used film developing solutions will be processed by the nearest facility having silver recovery equipment. Silver recovery equipment may be obtained through precious metal recovery program channels from the DRMO. Spent fixer solution, even after recovery of silver, will not be allowed into the sanitary sewer system unless it meets the standards of 40 CFR, or local laws, whichever is more stringent.

d. The use of commercial sources for the recovery of silver is authorized only in extreme cases. Requests to use commercially owned equipment at AMEDD activities will be submitted through command channels, with complete justification, to Commander, USAMEDCOM (MCLO) with copy furnished to HQDA (DASG–LO).

3–50. Hazardous materiel/waste management program

a. The AMEDD will develop and procure materiel in such a way as to minimize potential hazards to public health and the environment. The applicable functions include research, development, testing, production, handling, use, storage, transportation, and/or disposal. AR 200–1 is the primary regulation addressing responsibilities and procedures for implementing the Hazardous Materiels/Waste Management Program.DOD 4160.21–M, AR 420–47, AR 40–5, SB 8–75–S9, and the AMEDD Environmental Management

Plan Policy and Guidance Letter distributed by HQDA (SGPS–PSP) further define responsibilities and procedures for managing hazardous materiels and hazardous waste. Technical guidance for disposal of small, unused quantities of medical materiel, hazardous waste, nonregulated special waste, regulated medical waste (RMW), and excess medical materiel is published in the MIDI/MEIS. This publication may be obtained from the U.S. Army Environmental Hygiene Agency(HSHB–ME–SH), Aberdeen Proving Ground, MD 21010–5422. If these publications contain conflicting guidelines, the most stringent rules will be adhered to.

b. MEDCEN/MEDDAC/DENTAC/veterinary activity commanders are responsible for the disposal of non-RCRA medical, dental, and veterinary supplies, hazardous waste, nonregulated special waste, and RMW in accordance with AR 40–5, AR 200–1, and the SB 8–75 series.All materiel and wastes will be managed in a manner that protects health and the environment and ensures compliance with appropriate Federal, State, local, Army, and host nation regulations.

c. The Pollution Prevention Program will be implemented to the maximum extent possible. Army policy is to reduce the quantity or volume and toxicity of hazardous wastes whenever possible.Program 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. Substitute items that reduce or eliminate hazardous waste will be used or introduced into the system whenever possible.

d. The Hazard/Communication Program will be implemented in accordance with 29 CFR 1910.1200 and DOD Instruction 6050.5.-Appropriate training will be provided (and documented) to persons who manage, use, store, transport, and/or ultimately handle or come into contact with hazardous materiels or waste.

e. Management of RMW will include the following:

(1) Hazardous and RMW will be strictly separated from the general waste stream and will be segregated at the point of generation. Mixing RMW with general wastes requires disposal of the entire mixture as RMW and is prohibited.

(2) Generally, RMW can include cultures and stocks of infectious agents and associated biologicals, pathological waste, blood wastes, all used and unused sharps, animal waste, and infectious waste. The infection control committee will develop for recommendation to the commander local segregation policy according to the RMW definition in AR 40–5 and Federal, State, and local regulations.

(3) Activities will—

(a) Train all employees on how to segregate waste.

(b) Maintain adequate control of all RMW to prevent unauthorized access.

(c) Collect, store, transport, and dispose of RMW in accordance with AR 40–5.

(d) Track all RMW from collection to final destination.

Section IX
Controlled Medical Items

3–51. Security precautions

Controlled medical items are those requiring security precautions. Included in this category are controlled substances, tax-free alcohol, precious metals, and other items so designated by the medical unit/activity commander. Research, development, test, and evaluation facilities will follow guidance in AR 385–69 for managing controlled substances, ethyl alcohol, and hazardous biological substances.

3–52. Controlled substances

a. Identification. Controlled substances are drugs so designated by the Drug Enforcement Administration(DEA). A list of these drugs and changes are published in the Federal Register and in the SB 8–75 series. Standard controlled substances are identified by Notes R and Q in the notes column of the Federal Supply Catalog, DOD Section, Medical Materiel and by controlled inventory item codes(CIICs) R and Q in the AMDF.

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

(1) Schedule I substances are drugs that have no accepted medical use in the United States.

(2) Schedule II substances are drugs that have a high abuse potential with severe psychic or physical dependence liability.Standard drugs in this schedule are identified by Note R and CIIC R.

(3) Schedule III substance are drugs that have an abuse potential less than those in Schedules I and II. Standard drugs in this schedule are identified by Note Q and CIIC Q.

(4) Schedule IV substances are drugs that have an abuse potential less than those in Schedule III. Standard drugs in this schedule are identified by Note Q and CIIC Q.

(5) Schedule V substances are drugs that have an abuse potential less than that listed in Schedule IV. Standard drugs in this schedule are identified by Note Q and CIIC Q.

c. Information on packaging. The labels on controlled substances packaged after 1 December 1971, or 180 days after their transfer or addition to one of the above schedules, must contain a symbol to designate to which schedule a substance belongs. Use a capital letter "C" followed by a dash and the schedule number (for example, C–1 for Schedule I substances;C–II for Schedule II substances, etc.). These symbols will be prominently placed on the label by the manufacturer.

d. Requisitioning of standard controlled substances.

(1) Only those Army activities identified in SB 8–75–S1 of the SB 8–75 series are authorized to requisition controlled substances. Shipments of controlled substances from the wholesale system will be made only to those DODAACs cited.

(a) Requests for additions and deletions to the list of authorized requisitioners will be submitted, with justification, through command channels to HQDA (DASG–LO), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

(b) HQDA (DASG–LO) will advise the submitting command of approved and disapproved requests. HQDA (DASG–LO) will in turn notify USAMMA of all approved changes to the list. USAMMA, as the data originator and SICC, will coordinate with DPSC to initiate all changes.

(2) Authorized requisitioners will—

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

(b) Ensure that supported activities demonstrate a valid need for controlled substances prior to issue.

(3) Units that are not authorized to requisition controlled substances directly from DPSC should, if such items are needed, contact the nearest authorized requisitioning medical activity for supply support.

(4) Requisitions from unauthorized activities will be rejected.

(5) Each month, the DPSC will provide MEDCOMs with a list of controlled substances issued to subordinate units by the DPSC.MACOMs will establish procedures with subordinate activities to ensure that these lists are reconciled with local supply account records on a timely basis. Unreconciled discrepancies will be reported to MACOMs and the DPSC.

e. Local purchase of controlled substances.

(1) The local purchase of controlled substances will comply with section IV of this chapter and DEA instructions.

(2) MEDDAC and MEDCEN commanders may designate a minimum number of key personnel within the IMSA to sign exempt certificates for the purchase of controlled substances for official use.

(a) Individuals designated will contact the nearest DEA regional office for DEA Form 224 (New Application for Registration Under Controlled Substances Act of 1970). After receipt of registration, the DEA will furnish exempt officials the necessary DEA order forms and instructions.Each certificate will be renewed annually.

(b) When an exempt official is replaced, the certificate and unused order blanks will be forwarded to DEA, 1405 I Street, NW, Washington, DC 20537.

(c) DEA ordering forms will be stored in a locked container.

(3) Exempt certificates may be requested by OCONUS activities when controlled items (not AAC A or D) are required for patient treatment.

f. Supplemental ARNG policy.

(1) Stocks of Note R controlled items acquired for a patient care mission (annual training (AT), inactive duty training, or site support) will, within 30 days of completion of the mission, be turned in to one of the following activities for proper control and accountability:

(a) ARNG TMCs that will accept the materiel.

(b) USPFO.

(c) Active duty IMSA.

(2) Stocks of Note Q controlled items acquired will—

(a) Be turned in if not required for future patient care missions. (See (1) above.)

(b) If retained, be stored in a field safe secured to the structure or in a more secure container as prescribed by paragraph 3–56.

3–53. Tax-free alcohol

Tax-free alcohol includes alcohol and alcoholic beverages identified as Note R in the Federal Supply Catalog, DOD Section, Medical Materiel, CIIC R in the AMDF, and similar locally purchased items.

a. Local purchase of tax-free alcohol will not be made without prior approval of the appropriate MACOM or command surgeon-.CONUS MEDDACs and MEDCENs will submit requests to Commander, USAMEDCOM, ATTN: MCLO, Fort Sam Houston, TX 78234–6000. OCONUS MEDCOMs will obtain approval from HQDA (DASG–LO) 5109 Leesburg Pike, Falls Church, VA 22041–3258. Tax-free alcohol purchased by OCONUS activities through the established military Class VI store system requires prior approval from the appropriate major MEDCOM. All requests will contain the following:

(1) Name of the facility for which the item is required.

(2) Name of the industrial alcohol plant or bonded warehouse, with location and registry number, from which the alcohol will be acquired.

b. MACOMs are referred to the FAR, as supplemented, for guidance concerning permits to procure tax-free alcohol.

c. Local purchase of taxed alcohol in support of patient care requirements may be made in accordance with the activity's routine local purchase procedures and this regulation.

3–54. Precious metals and precious metal-bearing scrap

Precious metals and PMBS are those items consisting of or containing metals such as gold, silver, and platinum.

a. Standard precious metals are identified as Note R in the Federal Supply Catalog, DOD Section, Medical Materiel.

b. Chromium-based metals, such as ticonium and vitallium, are special interest metals and are, therefore, considered controlled medical items. While in Army logistics channels, they will be handled in the same manner as Note Q drugs.

c. Precapsulated silver alloys will be managed as Note Q and CIIC Q items, due to their low precious metal content.

d. Even though x-ray film contains silver, it will not be coded Note R since x-ray film does not require vault storage.

e. Each MTF commander must appoint a precious metals coordinator (PMC) to manage an internal Precious Metals Recovery Program. At the user level, at least one precious metals monitor (PMM) shall be appointed to ensure the recovery of PMBS within the assigned area of responsibility.

f. The MTF PMM will assign a document number from the unit's expendable document register for each turn-in of PMBS.

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

3–55. Shipment of controlled medical items

a. The handling of controlled substances within the United States and its territories is governed by Federal laws. Controlled items must be safeguarded at all times to prevent illegal use and pilferage.

(1) Controlled items will be selected and prepared for shipment under the supervision of the custodian of controlled items. Such items will be packed, moved, and held in secure facilities until transferred to a carrier.

(2) Shipments will be covered by separate shipping documents and packing lists. Both will clearly indicate quantities shipped.The term "medical supplies" will be used as nomenclature on shipping documents for individual controlled items. All markings will be obliterated from external containers and the term "medical supplies" will be applied instead of the standard nomenclature.

(3) Controlled items may be shipped by registered parcel post (return receipt requested) when securely packed for safe transit.However, shipments must comply with weight and size limitations of the U.S.Postal Service.

(4) A customs declaration tag is not required on parcels of official matter addressed to a military organization by title (for example, commander or supply officer) at U.S. Military Post Offices OCONUS.

(5) If controlled items cannot be shipped by parcel post because of weight or size restrictions, they will be shipped according to AR 55–355/NAVSUPINST 4600.70/AFR 75–2/MCO P4600.14B/DLAR 4500.3, chapter 226.

(6) Shipping documents for controlled items sent to or from any OCONUS destination will be marked SPECIAL CARGO—PLACE IN CUSTODY OF CARGO SECURITY OFFICER.

b. Controlled items returned from CONUS and OCONUS installations to DOD depots will be handled as prescribed in *a*above to prevent theft. These items will be removed from assemblages and packed separately from other items prior to return of assemblages as excess.

3–56. Storage and issue of installation stocks of controlled medical items

a. Physical security. Storage facilities will meet the physical security standards in AR 190–50 for controlled medical substances and other medically sensitive items. AR 190–51 prescribes security measures for all other items.

(1) Stocks of controlled medical items will be stored in a security storage device commensurate with the type and quantity of materiel to be stored. At least annually, the IMSA accountable officer will request the local provost marshal to survey the adequacy of security.This survey will be documented.

(2) Note R controlled medical items will be safeguarded at each storage location. As a minimum, the storage device will be a vault of substantial construction with a steel door and combination or key lock. Where small quantities permit, a safe or steel cabinet (GSA) Class 5 or equivalent may be used. If the safe or cabinet weighs less than 750 pounds, it must be attached to a permanent structure to prevent ready removal. New vault construction will meet the minimum security standards of nonpractitioner handling of Schedule I and II controlled substances as established by the DEA. Additional features that should be considered for existing storage vaults include the following:

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

(b) A self-closing and self-locking device for use during normal hours of operation in which the vault door is open (frequently called a "day gate").

(3) Note Q controlled items may be stored in safes or vaults. Where space limitations preclude this type of storage, items will be stored in a locked cage or secure room, with access limited to selected persons. New construction of cage storage areas will meet the security standards as established by the DEA. Additional features cited in (2) above should also be considered for an existing cage storage area.

(4) The guidelines established in this regulation for bulk storage

of ethyl alcohol take precedence over AR 190–51 and AR 40–2 until superseded. Ethyl alcohol will be classified as a Note Q item. It will be stored in a flameproof container/cabinet or storage area capable of meeting National Fire Protection Association (NFPA) and Occupational Safety and Health Administration (OSHA) standards for storage of a flammable product. To the maximum extent practical, the standards for storage of Note Q items will be met as defined in AR 190–51. However, NFPA and OSHA fire protection standards will take precedence over security requirements. As a minimum, the container/cabinet will be locked or kept in a secure storage area with access limited to selected persons.

b. Managing controlled substances.

(1) Medical activity commanders will appoint the medical supply accountable officer as custodian of installation stocks of controlled medical items and will also appoint at least one alternate. All gain and loss transactions will be posted on a DA Form 1296 (Stock Accounting Record) whether for stocked or nonstocked items. Responsibilities of the custodian/alternates include—

(a) Maintaining current security container designations and records, using SF 700 (Security Container Information), SF 702 (Security Container Checksheet), and reversible OPEN-CLOSED signs according to AR 380–5.

(b) Maintaining a record of receipts, issues, and stock balances on DA Form 1296. These records will be located at the storage site and are in addition to the accountable stock records maintained by the appropriate materiel manager.

(c) Receipting for registered mail, parcels, and expressed packages addressed to the IMSA.

(d) Issuing controlled medical items directly to and obtaining the full signature of an authorized recipient, preferably at the security storage site.

(e) Accomplishing stock record accounting at the storage site immediately after effecting a transaction.

(f) Retaining accountable records and supporting documents for 3 years after the date of the last transaction.

(2) Personnel managing controlled substances will ensure issues are authorized by editing requisitions prior to issue.Transactions will be analyzed once each month. Shortages and unusual requisitions or expenditures will be investigated immediately. Chiefs of supported activities will be consulted, when necessary, and corrective action taken if needed.

(3) The stockage levels of controlled medical items in pharmacies will not exceed 1 month, based on average demands for the preceding 6 months and computed to the nearest unit of issue. Ward and clinic levels will not exceed a 2-week supply. However, controlled items required for emergency situations will be stocked in quantities determined by the medical activity commander.

(4) The issue of all controlled medical items will be further restricted by the chief of the logistics division as follows:

(a) DEA-designated controlled substances will be issued to the pharmacies of the hospital for dispensing to patients, wards, clinics, and other areas of the hospital. Only when authorized by the medical facility commander will they be directly issued to other activities. Hospital activities using controlled substances will maintain records of these items in accordance with AR 40–2.

(b) Tax-free alcohol will be issued only to hospital pharmacy and laboratory activities, and other activities authorized by the medical activity commander.

(c) Precious metals, PMBS, and chrome-based metals for dental use will be issued to and turned in only by the PMCs of supported DENTACs. Instruments containing precious metals will be issued to supported activities that are authorized such items.

(d) IMSAs will also issue controlled substances to Active and Reserve Component (RC) units that are authorized such items upon receipt by the IMSA of written approval signed by the unit commander.

(5) A local files check will be completed on vault custodian/alternates, warehouse personnel, and other personnel having access to controlled substances or medically sensitive items in accordance with AR 190–50.

3–57. Periodic inventories of controlled medical items

a. An inventory of all Note R and Q controlled items, except components of aviation survival kits on hand in aviation units, will be conducted monthly. Components of aviation survival kits will be inventoried at the same time the periodic inspection of the complete kit is conducted (every 120 days). The medical activity commander will appoint a disinterested officer to perform the duty. If officer personnel are limited or not available, a senior noncommissioned officer (sergeant first class or above) or civilian (GS–7 or above) may be appointed inventory officer.The actual inventory of controlled substance materiel held at the medical supply account level must be performed by an officer, senior noncommissioned officer (sergeant first class or above), or civilian (GS–7 or above).

(1) Commanders will—

(a) Change inventory officer assignments each month.

(b) Provide written instructions on inventory procedures based on current Army regulations.

(2) The chief of the logistics division may issue supplementary instructions when needed.

(3) The inventory officer for controlled substances in aviation survival kits will be the aviation life support equipment technician who conducts the periodic inspection of the complete kit.

b. Inventories will be conducted and corrective action taken as shown below.

(1) All stock balances recorded on accountable records at storage locations must agree with quantities on hand and must agree and be reconciled with the accountable stock record.

(2) The inventory officer will authenticate the balance on stock accounting records at storage locations for each line item inventoried. This will be done by a separate line entry on DA Form 1296, consisting of the date, the abbreviation "INV," quantity on hand, and legible payroll signature. The inventory officer will submit a report of the inventory to the medical activity commander and provide a copy to the IMSA.

(3) The commander will take appropriate action to correct all discrepancies prior to the next inventory. All irreconcilable shortages will be reported immediately to the local provost marshal for investigation to establish a basis for subsequent action.

3–58. Other items requiring control

MEDDAC and MEDCEN commanders will designate as controlled medical items those items that are expensive and known to be highly vulnerable to pilferage. The commander will determine which storage and handling precautions should be used.

3–59. Controlled medical items as components of medical equipment sets

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

a. When the operational readiness of TOE units requires that the controlled medical item components authorized in an MES be maintained in the unit, the unit commander will store the controlled items according to paragraph 3–56 to the maximum extent possible. If controlled item components cannot be extracted for special storage, the commander will ensure that chests containing items are handled or otherwise appropriately secured and that the entire MES is stored in the most secure manner possible.

b. A record of controlled medical items will be kept on DA Form 3862 (Controlled Substances Stock Record). DA Form 1296 will be used in units with a resupply mission. A monthly inventory and inspection of items will be accomplished by a disinterested officer appointed by the commander.

c. Where unit storage security is inadequate and operational readiness is not unduly compromised, controlled items should be stored at the lowest supply level having adequate storage facilities. They may also be stored by the supporting IMSA; however, using unit personnel will perform the required monthly inventories of their stocks.

(1) When stored at an IMSA commingled with IMSA stocks, controlled items will be accounted for as contingency stocks (and assigned a unique project code if applicable, to automated systems) and the IMSA has inventory responsibility. When stored at an IMSA in a container secured by the owning unit, the IMSA has no inventory accounting or surveillance responsibility for the contents; inventory responsibility remains with the owning unit.

(2) Plans to facilitate the issue of these items when they are required for mission accomplishment will be prepared and kept current.

3–60. Controlled medical items as components of aviation survival kits

Controlled medical items, Schedule V drugs, that are components of aviation survival kits will be issued with the complete kit to the requesting unit. At unit level, these kits will normally be in the possession of personnel authorized kits for aviation operations. Kits will be secured in the same manner as prescribed for other aviation life support equipment such as in a locked room, cage, or individual locker. Controlled items must be in the survival kits at all times to ensure availability for use by crew members in the event of emergency survival situations. Replacement of expired controlled items is authorized by supply officers who account for the kits.

Section X
Regulated Medical Items and Other Items Requiring Special Management Controls

3–61. Categories that require additional controls

Certain kinds of medical materiel require additional controls.These include regulated medical items, provisioned medical equipment items, reference book sets, durable medical materiel, disposable medical materiel, radioactive materiel, and possibly effective materiel. (See para 3–69.)

3–62. Regulated medical items

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

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

(2) The item is funded by a centrally (HQDA)managed funding program.

(3) Distribution and redistribution must be controlled due to critical supply availability.

(4) Distribution and redistribution must be controlled due to the unique physical properties of the item and/or its specialized use.

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

(1) PA funded capital investment medical equipment for TOE units.

(2) MES (all major MES and specified minor MES).(See table 3–2.)

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

c. Regulated medical items are assigned AAC A in the AMDF.

d. Certain medical items may receive a temporary regulated item designation due to special distribution requirements for the item. Temporary regulated item status will be announced by USAMMA messages and listed in the SB 8–75 series.

e. Basic requisitioning procedure for all regulated items is as follows:

(1) Requisitions will be prepared in accordance with procedures established in AR 725–50. The prescribed MILSTRIP format provided in AR 725–50 will also be described each year in one issue of the SB 8–75 series. This issue of the SB 8–75 series will also contain any current, updated information on requisitioning procedures for regulated items.

(2) The DIC for all requisitions will be AOE or AO5.

(3) The routing identifier code (RIC) for all requisitions will be B69 (USAMMA).

(4) The requesting unit's DODAAC will be perpetuated in the requisition's document number. If the supporting automated system requires the SSAs DODAAC in the document number, then the requesting unit will be identified in the supplementary address field. All requisitions will contain the original requester's complete document number in the exception data accompanying the requisition. The in-the-clear name of the unit will also be included in the exception data, for example: 41st MASH.

(5) The preferred method for transmission to USAMMA is by message with an information copy to the appropriate MACOM. Mail may be used as an alternative submission method. Requests for regulated items will not be submitted through DAAS.

(6) USAMMA will forward all requisitions to the DPSC.

f. Special requisition procedures for regulated items are as follows:

(1) Requisitions for Other Procurement, Army (OPA), funded capital investment TOE medical equipment will be submitted as follows:

(a) The code GA will be entered as the fund code for requisitions that are unfunded from the requester.

(b) A type requirement code (AR 725–50) will be entered in card columns 55–56 of the requisition.

(c) The MES that the item is a component of or related to (for example, item is used with an MES that comprises a unit's primary equipment authorization) will be identified in exception data accompanying the requisition.

(d) ARNG requisitions will be formatted and transmitted as specified in SB 8–75 series (SB 8–75–S10).

(2) Requisitions for MES will be submitted as follows:

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

(b) A type requirement code (AR 725–50) will be entered in card columns 55–56 of the requisition.

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

(d) The unit will furnish the following exception data with each requisition:Current authorization; unit identification code (UIC); and reason for shortage, initial issue, or replacement.

(3) Other medical regulated items will be requisitioned as follows:

(a) They will be funded from the requester, unless a USAMMA message or the SB 8–75 series identifies the item for a special, central funding program.

(b) Special exception data as may be required by USAMMA will be identified in a message or in the SB 8–75 series.

g. Routing of regulated medical item (AAC A)requisitions is as follows:

(1) For CONUS and OCONUS active duty units, the requester submits the request to the supporting IMSA, MEDLOG battalion, or SSA. The supporting activity sends the request to USAMMA with an information copy to the requester's MEDCOM. USAMMA validates the requirement with the appropriate MEDCOM as required.

(2) For USAR units, the requester submits a request to the U.S. Army Reserve Command (ARCOM) or U.S. Army Reserve General Officer Command (GOCOM) as appropriate. The ARCOM or GOCOM validates the requirement and assigns funds for Operation and Maintenance, Army Reserve (OMAR)-funded items. ARCOM or GOCOM forwards the request to the supporting IMSA. The IMSA sends the requisition to USAMMA with an information copy to U.S. Army Forces Command (FORSCOM). USAMMA validates the requirement with FORSCOM.

(3) For ARNG units, the requester submits a request to USPFO. USPFO assigns funds for Operations and Maintenance, National Guard(OMNG)-funded items and forwards the requisition with a letter of transmittal through HQDA (NGB–ARL–ME), 111 South George Mason Drive, Arlington, VA 22204–1382 to Commander, USAMMA, ATTN:SGMMA–RMA, Fort Detrick, Frederick, MD 21702–5001.

h. Status will be provided by the supplier in accordance with AR 725–50. Submit followups to USAMMA.

3–63. Provisioned medical equipment items

a. Medical equipment items designated for field use that require unique supportability and maintainability for each different manufacturer and model will be procured with the following provisioned items or data:

(1) Operator and maintenance manuals.
(2) Spare parts.
(3) Repair parts.
(4) Training materiel.
(5) Automated test program.
(6) Consumable and durable item list.

b. Provisioned medical equipment items will be assigned a generic NSN and an AAC of W for use in identifying the equipment items in appropriate authorization documents. Each generic NSN will have one or more related NSNs that identifies a specific item capable of satisfying the requirement and will be assigned an AAC of either J, D, A, or L.

c. Provisioned medical equipment items can be either OPA or OMA funded as determined by the appropriation and budget activity account code (ABA) of the MCSC in the AMDF.

d. OPA provisioned medical equipment items will be centrally funded by USAMMA. OMA provisioned medical equipment items will be funded by the MACOM.

e. Provisioned medical equipment items will be announced by USAMMA message and listed in the SB 8–75 series.

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

(1) Standard MILSTRIP requisitions will be prepared in accordance with AR 725–50, and forwarded through appropriate Class VIII supply channels to USAMMA for funding and requirement validation review.

(2) The DIC for all requisitions will be AOE or AO5.

(3) The RIC for all requisitions for all AAC W end items will be B69 (USAMMA).

(4) Requisitions should cite the appropriate AAC W NSN. Requisitions for AAC J NSNs will be canceled, unless accompanied by a valid sole source justification.

(5) The requesting unit's DODAAC will be perpetuated in the requisition's document number. If the supporting automated system requires the SSA's DODAAC in the document number, then the requesting unit will be identified in the supplementary address field. All requisitions will contain the original requester's complete document number in the exception data accompanying the requisition. The in-the-clear name of the unit will also be included in the exception data, for example: 41st MASH.

(6) The preferred method for submission to USAMMA is by message with an information copy to the appropriate MACOM. Mail may be used as an alternative submission method. Requests for PA provisioned medical equipment items will not be submitted through the DAAS.

(7) Units will furnish the following exception data with each requisition:

(a) Current authorization (MTOE and effective date).
(b) UIC.
(c) Reason for shortage (that is, initial issue or replacement).

(8) USAMMA will forward all validated and funded requisitions to the DPSC.

(9) The DPSC will convert the requester's AAC W NSN to a specific AAC J NSN provisioned item for subsequent processing and issue to the requester. A specific NSN will be assigned to each different manufacturer's make and model item that meets the generic essential characteristics of the NSN, AAC W item.

3–64. Reference book sets for medical TOE units

a. The AMEDDC&S is responsible for determining the components of book sets. Book sets are reviewed annually and revised component listings are published in SB 8–75 series (SB 8–75–S3). Book sets for medical TOE units are authorized by MTOE and other Army authorization documents.

b. Book sets will be requisitioned from the DPSC in the same manner as other items of medical materiel or ordered through a DBPA in accordance with instructions prescribed in the SB 8–75 series.

(1) Requisitions will satisfy the following requirements:

(a) Newly activated units. MSOs will requisition book sets listed in applicable TOE at the same time that requisitions are submitted for other authorized TOE medical materiel.

(b) Prepositioned assemblages. Book sets are not authorized for prepositioning as part of major assemblages or as separate TOE line item numbers (LINs). These book sets will be requisitioned by the unit and shipped as part of unit equipment when deployed.

(c) Army Security Assistance Program. USAMMA will coordinate the issue of book sets included in major assemblages with DPSC when these are destined for a recipient country under the Army Security Assistance Program.

(2) Book sets will be kept current on a yearly basis as revised component listings are published in the SB–8–75 series (SB 8–75–S3).

c. Individual reference books for book sets will be obtained through local purchase procedures. The current GSA FSS, Federal Supply Group 76, will be used. The PR will specify that the "latest edition" is required.

3–65. Review program for durable medical materiel

a. Commanders will establish a formal program for reviewing the consumption of durable medical items. This program is designed to improve supply discipline, emphasize economy, and focus attention on the prudent use of resources.

b. To manage the program, commanders will conduct quarterly consumption reviews of the 20 durable items the activity has spent the most money on during the last year. The items will be reviewed for potential savings and for increases in usage from quarter to quarter. Reviews may also be conducted on other durable 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 in *c* or *d* below. ARNG activities will conduct annual reviews.

c. Items selected for intensive management may be managed as turn-in and direct exchange items. If an unserviceable item is not available for exchange, a letter or form can be required by the IMSA justifying the items.

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. TOE units normally will not establish usage levels unless actively engaged in patient care.

f. Activities will dispose of uneconomically reparable durable items according to procedures in this chapter.

3–66. Disposable medical materiel

a. Disposable medical materiel is any one-time-use medical or dental item with a reusable item counterpart; for example, catheters, gloves, masks, needles, syringes, and drapes.

b. TOE units responsible for tactical support will not use disposable medical materiel unless specifically authorized in an MES or by the major MEDCOM or command surgeon. The general use of disposable medical materiel in combat situations is precluded by logistical problems, including—

(1) The resupply and storage of increased quantities of disposable materiel in comparison with reusable items.

(2) Disposal of used materiel.

3–67. Control of disposable syringes and needles

Activities will maintain adequate control of disposable syringes and

needles to prevent misuse or access by unauthorized persons. Disposable needles and syringes will be stored in accordance with AR 190–50.

3–68. Radioactive materiel

a. Commanders of medical activities using radioactive materiel will designate, in writing, a radiological protection officer (AR 40–14/DLAR 1000.28 and TB MED 525). This officer is responsible for—

(1) The control, receipt, issue, use, storage, and disposal of radioactive materiel.

(2) Compliance with Nuclear Regulatory Commission(NRC) licenses and Army authorizations.

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

b. Radioactive materiel will be acquired and controlled according to TB MED 525 and AR 385–11.

3–69. Ineffective, possibly effective, and probably effective drugs

The following guidance on the purchase, management, and therapeutic use of drugs applies to all AMEDD personnel. The drugs involved are classified by the FDA as ineffective, possibly effective, and probably effective. AMEDD activities will manage these drugs as described below.

a. Category 1, ineffective drugs, has two subcategories.

(1) Category 1A consists of items that have been withdrawn from the market as the result of a final FDA order. No further purchase or issue is authorized. Remaining stocks of standard and nonstandard items will be destroyed or other appropriate action taken as announced in the SB 8–75 series.

(2) Category 1B includes items awaiting final determination by the FDA. These items are not authorized for central or local purchase until final action is taken by the FDA. Drugs that the FDA determines should remain on the market pending long-term resolution are an exception to this policy.

(a) The DMSB, together with TSG, will determine whether centrally acquired stocks are to be suspended from issue. Standard drug items that are determined to be exceptions to the overall ineffective(1B) policy by DMSB will be announced by USAMMA.

(b) P&T committees will locally recommend to the commander which ineffective (1B) drug items should be approved for continued purchase and use.

b. Category 2, possibly effective, are those drugs of which final FDA determination of effectiveness may take a long time. Central and local purchase of Categories 1B and 2 drugs should be minimized since these items may be declared ineffective and ordered removed from the market. Also, pharmacists and P&T committees should review the prescriptions for Categories 1B and 2 drugs from the standpoint of whether more effective medications exist.

c. Category 3, probably effective, are those drugs that require no special action. Their purchase, however, should be minimized pending final determination by the FDA.

Section XI
Medical Materiel Complaints

3–70. Complaint policy

Complaints involving standard and nonstandard items of medical materiel found to be injurious or unsatisfactory will be reported on SF 380(Reporting and Processing Medical Materiel Complaints/ Quality Improvement Report) and, when necessary, reported in accordance with the implementation of NATO International Standardization Agreement (STANAG) 2907 and QSTAG 287.(See fig 3–1 for a completed sample of SF 380.) The items will be thoroughly evaluated by medical, supply, and maintenance personnel before submitting the complaint. Materiel that produces side effects to the individual patient as described on the item package insert will not be reported. In complaints involving blood grouping and blood reagents, the actual bottle or reagent involved and the cells and serum used with the reagent will be kept available for testing.

3–71. Types of materiel complaints

Complaints concerning defective or unsatisfactory medical materiel will be classified as follows:

a. Type I complaints.

(1) These complaints will be submitted on materiel, to include equipment, determined by use or test to be harmful or defective to the extent that its use has or may cause death, injury, or illness.

(2) Immediate action must be taken to report such items and suspend their issue and use.

(3) Only a medical or dental officer familiar with the details of the complaint can initially classify it as Type I. Because of the immediate worldwide notification required on Type I complaints, professional personnel should carefully ascertain and evaluate all pertinent facts to preclude unnecessary delay or undue alarm. Information disseminated must include all information required on SF 380. Furthermore, the person initiating the complaint should be available to respond to telephone inquiries on the complaint.

b. Type II complaints. These complaints will be used to report materiel other than equipment that is suspected of being harmful, defective, deteriorated, or otherwise unsuitable for use. Take expeditious action to report such items and to suspend their issue and use.

c. Type III complaints. These complaints relate to equipment which is determined to be unsatisfactory because of malfunction, design, defects (attributable to faulty materiel, workmanship, or quality inspection), or performance. A Type III complaint does not necessarily require suspension of the item.

3–72. Submitting materiel complaints

a. When submitting complaints on SF 380, the No.block is a mandatory field. (See fig 3–1.) The complaint number will be constructed as follows: DODAAC/julian date/serial number. The DODAAC is six positions and represents the activity submitting the complaint. The julian date is the day of the year (1–365 or 366) on which the SF 380 is prepared. The serial number, which represents the number of SFs 380 an activity has submitted for a calendar year, should begin with A001 and run consecutively through the year. Complaints on nonstandard items procured through DPSC will cite the purchase order number and document number. See the SB 8–75 series (SB 8–75–S1) for examples and additional information.

b. For Type I complaints, circumstances will be reported immediately to the DPSC (DPSC–MQ) by the quickest means; that is, by telephone or immediate message. Telephone calls will be documented immediately on SF 380. Written confirmation will be accomplished within 12 hours for Type I complaints. When a Type II or III complaint is determined appropriate, complaints will be submitted within 48 hours.

(1) During normal duty hours, call the DPSC quality control representative, DSN 444–2187/2188, or commercial (215)952–2187 or 2188.

(2) After duty hours, call the DPSC medical expeditor, DSN 444–2111 or commercial (215) 952–2111. If no answer, call the DPSC duty officer at DSN 444–2341, or commercial (215)952–2341.

c. Type III complaints will include photographs and drawings of equipment when they can help describe or substantiate the complaint. This information will be sent with the SF 380. Also, Type II complaints will include a specific statement on the storage conditions under which the materiel was stored; for example, controlled temperature warehouse or unheated warehouse. The statement will be entered on the SF 380.

d. Copies of the SF 380 will be forwarded as indicated below.

(1) Five copies to DPSC (DPSC–MQF) for the following categories of materiel:

(a) Standard materiel purchased by the DPSC.

(b) Nonstandard materiel purchased by the DPSC for OCONUS activities.

(c) Type I complaints on all locally purchased materiel.

(2) Appropriate local contracting activity for complaints on standard and nonstandard materiel purchased locally.

(3) GSA regional office for GSA catalog materiel.

(4) Information copies of all complaints to—

(a) Staff Director, DMSB, Fort Detrick, Frederick, MD 21702–5013.

(b) Commander, USAMMA, ATTN: SGMMA–O, Fort Detrick, Frederick, MD 21702–5001.

e. The medical materiel complaints submitted on SF 380 are exempted from information requirements control under AR 335–15.

f. The Code of Federal Regulations (21 CFR)prescribes requirements to report certain materiel/equipment conditions to the FDA under the Safe Medical Devices Act (SMDA). As part of the facility's broader Risk Management Program, logistics personnel should coordinate reporting with the risk manager.

g. Additional reports may be required under AR 385–40.

Section XII
Medical Support to Army Personnel Serving as Defense Attaches

3–73. Sources of attache medical supply support

a. Army personnel serving as Defense attaches will use local supply sources or U.S. military MTFs located within a reasonable distance.

b. Major OCONUS commanders will provide medical supply support upon request by Army personnel serving as Defense attaches if—

(1) They are stationed within the perimeter of the major OCONUS command.

(2) Communications and transportation, including State Department pouch, Army Post Office, or Embassy Post Office, permit.

c. Walter Reed Army Medical Center (WRAMC) will provide medical supply support where other supply sources are not available or where difficulties exist in communication. The Commander, WRAMC, will designate the U.S. Army Health Clinic, Pentagon, as a supply source for this medical support. Requests for medical supplies will be forwarded through the Assistant Chief of Staff for Intelligence, DA, to the U.S. Army Health Clinic, Pentagon, for supply action. Normally, this is limited to delivery by diplomatic pouch.

d. Prescription-type items will be dispensed from a pharmacy upon presentation of a doctor's prescription in accordance with AR 40–2.

3–74. Financing medical supplies for attaches

Medical supplies issued by an Army command pursuant to this section will be financed from medical funds available to the command unless different billing arrangements have been made.

Section XIII
Management of Medical Materiel by Reserve Components Assigned a Patient Care Mission

3–75. Management procedures

When RC units are assigned a mission of providing patient care to military personnel authorized such care by AR 40–3, controlled, shelf life refrigerated materiel may be requisitioned and used. During use, ARNG and USAR units will control and account for those items according to this chapter and AR 40–2. ARNG units will also comply with pharmaceutical management procedures published in the SB 8–75 series (SB 8–75–10).

3–76. Turn-in procedures

Upon completion of the patient care mission—

a. USAR units will coordinate turn-in of all unused stocks to the supporting IMSA.

b. ARNG units will—

(1) Turn in all controlled items under paragraph 3–52.

(2) Turn in, as directed by the USPFO, unit of issue quantities of all other items unlikely to be consumed prior to their expiration date. Turn-in will be accomplished within 60 days of the completion of the patient care mission.

(3) Turn in FSC 6505 items that are on the IMSA stockage list and unlikely to be consumed within 12 months.

(4) Manage remaining stocks as specified in applicable regulations and the SB 8–75 series (SB 8–75–10).

Table 3–2
Major medical assemblages (alphabetical listing)

LIN	Description	Supply catalog	NSN	Unit assembly code
F94613	DEN EQ SE AIRCRAFT BA	SC 6545–8–D10	6545008902191	2230
F95024	DENT EQ SE DEN HYG FL	SC 6545–8–D11	6545001428996	1717
F95093	DENT EQ SE PROST TEAM	SC 6545–8–T09	6545009596240	1711
F94819	DENTAL EQUIP COMMZ	SC 6545–8–L07	6545002998260	1707
F95298	DENTAL EQUIP SE GEN	SC 6545–8–D13	6545001428813	1710
	DES CEN DEN LAB CONUS	SC 6545–8–L05	6545009148900	1703
	DES CMP DEN LAB CONUS	SC 6545–8–L06	6545009148950	1709
	DES DEN CLINIC AUG	SC 6545–8–D38	6545002863782	1706
D39228	DES DENT HYGIEN FIELD	SC 6545–8–D18	6545011026789	1719
D95343	DES DENTAL SUPPORT	SC 6545–8–D42	6545011419478	1724
D39478	DES DENTAL X-RAY FLD	SC 6545–8–D08	6545011419472	1720
D95593	DES FIXED PROSTHETICS	SC 6545–8–D35	6545011419483	1722
D26151	DES GEN DENTISTRY FLD	SC 6545–8–D14	6545011045359	1712
Z21044	DES OPER FIELD LT INF	SC 6545–8–D43	6545011918973	1725
	DES OPH LAB CONUS TP1	SC 6545–8–P06	6545001050104	1320
	DES OPH LAB CONUS TP2	SC 6545–8–P06	6545001050123	1321
	DES OPH LAB CONUS TP3	SC 6545–8–P06	6545001050124	1322
	DES OPH LAB CONUS TP4	SC 6545–8–P06	6545001050140	1323
D95617	DES REMOV PROSTHETICS	SC 6545–8–D19	6545011419482	1721
D95867	DES TEAM HA	SC 6545–8–D41	6545011425590	1723
D43836	DMS COMMZ DENT HYGIEN		6545011823835	D476
D43700	DMS COMMZ HOS DENT AU		6545011823833	D470
D43950	DMS COMZ PROSTHODONTI		6545011823834	D473
D43632	DMS DENTAL SUPPORT		6545011823811	D375

Table 3–2
Major medical assemblages (alphabetical listing)—Continued

LIN	Description	Supply catalog	NSN	Unit assembly code
D43882	DMS DENTAL X-RAY		6515011823810	D374
	DMS HOSP DENT AFORCE		6545011823807	D371
D43768	DMS HOSP DENT CONSUMB		6545011823808	D372
D65926	DMS HOSPITAL DENTISTRY		6545011823806	D370
	DMS HOSPITL DENTISTRY		6545011139183	D232
	DMS PROSTHODONTICS		6545011823809	D373
	DRS OPERATORY FIELD	SC 6545–8–R23	6545012544122	1332
M27533	MED EQ EXPAN 20 BED	SC 6545–8–E23	6545007534726	0213
M29177	MED EQ MBL 60 BD	SC 6545–8–H18	6545009314850	2701
M22427	MED EQ SE ACFT BAT	SC 6545–8–S01	6545001105546	2231
M23149	MED EQ SE ARMY MED LA	SC 6545–8–L08	6545006640358	1206
M23012	MED EQ SE ARMY MED LA	SC 6545–8–L09	6545005434111	1205
M28915	MED EQ SE CLIN LAB ME	SC 6545–8–M04	6545009996448	1008
M24719	MED EQ SE EMERG TRMT	SC 6545–8–D12	6545009359884	0513
M24993	MED EQ SE EPIDEM SER	SC 6545–8–E09	6545009359882	1207
M28927	MED EQ SE FLD EMERG	SC 6545–8–M10	6545009996454	1014
M25204	MED EQ SE FLD HOS U	SC 6545–8–H19	6545005436730	1002
M25120	MED EQ SE FLD HOSP HQ	SC 6545–8–H14	6545009359883	1004
M28933	MED EQ SE FLD INT CAR	SC 6545–8–M12	6545008776995	1016
M28987	MED EQ SE FLD STER PR	SC 6545–8–M03	6545009996447	1007
M28999	MED EQ SE FLD SURG ME	SC 6545–8–M02	6545009996446	1005
M29011	MED EQ SE FLD WARD	SC 6545–8–M08	6545009996452	1012
M25615	MED EQ SE GAS CASULTY	SC 6545–8–T01	6545009596260	0505
M45477	MED EQ SE IMMUN-SEROL	SC 6545–8–L12	6545010333692	1210
M45545	MED EQ SE LAB VET AUG	SC 6545–8–L11	6545010333691	1209
M30317	MED EQ SE PATH LAB AU	SC 6545–8–L10	6545010333690	1208
M30153	MED EQ SE VET DET 100	SC 6545–8–V03	6545007826801	1919
M30136	MED EQ SE VET DET 50P	SC 6545–8–V02	6545002999489	1915
M30340	MED EQ SE VET SVC FLD	SC 6545–8–V06	6545009359881	1901
M23286	MED EQ SET BLD DETCH	SC 6545–8–D30	6545009112430	0502
M23423	MED EQ SET BLD PROCS	SC 6545–8–D31	6545009112450	0504
M22738	MED EQ SET CNVLSCNT	SC 6545–8–C01	6545009144295	0304
M29656	MED EQUIP SET R/E MET	SC 6545–8–D34	6545009261484	0503
M25067	MED EVAC 400 S–MOB	SC 6545–8–H15	6545009195800	0801
M25752	MED GEN DISP COMZ TY1	SC 6545–8–D40	6545009252700	0305
M25889	MED GEN DISP COMZ TY2	SC 6545–8–D44	6545009252800	0306
M26163	MED GEN HOS 1000 BED	SC 6545–8–H03	6545009253950	0203
M28081	MED HOSP EXP 100 BED	SC 6545–8–E21	6545009255330	0215
M26300	MED HOSP STA 100 BED	SC 6545–8–H07	6545009551830	0209
M26574	MED HOSP STA 500 BED	SC 6545–8–H05	6545009551880	0207
M26505	MED HOSP 300 BED	SC 6545–8–H11	6545009823739	0212
M28909	MED IND HYG SURV FLD	SC 6545–8–S02	6545009355881	1109
	MED INST SE BLD CONUS	SC 6545–8–C09	6545006826482	0514
M28218	MEDICAL EQ TRAIN NO 1	SC 6545–8–T10	6545009598600	2001
M28355	MEDICAL EQ TRAIN NO 2	SC 6545–8–T11	6545009598640	2002
M28492	MEDICAL EQ TRAIN NO 3	SC 6545–8–T12	6545009598680	2003
M28629	MEDICAL EQ TRAIN NO 4	SC 6545–8–T13	6545009598720	2004
M28766	MEDICAL EQ TRAIN NO 5	SC 6545–8–T14	6545009598750	2005
M28903	MEDICAL EQ TRAIN NO 6	SC 6545–8–T15	6545009598780	2006
M31506	MEDICAL INSTR PREVENT	SC 6545–8–D32	6545009494000	1106
M31369	MEDICAL INSTR PREVENT	SC 6545–8–D33	6545009494100	1108
	MEDICAL SUPPLY SET		6545012376087	0484
M29213	MES AIR AMBULANCE	SC 6545–8–M36	6545011419477	0257
M52274	MES BATTALION AID STA	SC 6545–8–D26	6545011001675	0311
M23218	MES BN AID STA	SC 6545–8–D27	6545004576858	0309
M23673	MES CHEM ACT PAT TR	SC 6545–8–M29	6545011419469	0249
M25865	MES CHEM AG PAT DECON	SC 6545–8–M38	6545011764612	0258
M23471	MES CLEARING STA	SC 6545–8–D28	6545004576859	0310
M52524	MES CLEARING STATION	SC 6545–8–D29	6545011026790	0312
E37001	MES CLIN PSYCHOL FLD	SC 6545–8–M32	6545011419487	0253
	MES CLINIC CONUS	SC 6545–8–D25	6545009259100	1609
	MES CLINIC CONUS 10BE	SC 6545–8–D24	6545009259060	1608
	MES CLINIC SPECIAL CR	SC 6545–8–T17	6545008901519	2119
	MES DEN CLIN CONUS1CH	SC 6545–8–D38	6545009146640	1705

Table 3–2
Major medical assemblages (alphabetical listing)—Continued

LIN	Description	Supply catalog	NSN	Unit assembly code
	MES DEN CLIN CONUS4CH	SC 6545–8–D38	6545009146630	1704
	MES DEN CLIN CONUS8CH	SC 6545–8–D38	6545009146620	1703
	MES DENCLIN CONUS12CH	SC 6545–8–D38	6545002929795	1714
	MES DENCLIN CONUS20CH	SC 6545–8–D38	6545006629974	1716
M24385	MES DERMATO FIELD	SC 6545–8–T20	6545001450410	2233
	MES DNTL CLIN 16CHAIR	SC 6545–8–D38	6545009146610	1702
M52774	MES EMER TR MED DETAC	SC 6545–8–M30	6545011419474	0250
	MES EMP HLTH CLINIC 1	SC 6545–8–D39	6545005511731	1618
	MES EMP HLTH CLINIC 2	SC 6545–8–D39	6545005511797	1619
	MES EMP HLTH CLINIC 3	SC 6545–8–D39	6545005511738	1620
	MES EMP HLTH CLINIC 4	SC 6545–8–D39	6545005511732	1621
	MES EMPL SERV STA	SC 6545–8–D23	6545005514819	1622
M24687	MES ENT TEAM FIELD	SC 6545–8–T19	6545001450409	2232
	MES ENT TREAT CTR	SC 6545–8–C08	6545008901725	0303
M28940	MES EYE EXAM EVAC HOS	SC 6545–8–M24	6545001817121	1021
M29024	MES FIELD X-RAY MUST	SC 6545–8–M05	6545009996449	1009
M28939	MES FLD ORAL SUR MUST	SC 6545–8–M06	6545009996450	1010
M28963	MES FLD PHARMACY MUST	SC 6545–8–M07	6545009996451	1011
M28975	MES FLD TR PATIENTMUS	SC 6545–8–M09	6545009996453	1013
M79412	MES GEN CLIN COMZ TY1	SC 6545–8–M31	6545011419485	0251
M79662	MES GEN CLIN COMZ TY2	SC 6545–8–M48	6545011419486	0252
	MES GEN CONUS 1750BED	SC 6545–8–H32	6545009254225	1501
	MES GENERAL CLINIC	SC 6545–8–D20	6545009252900	1602
M26413	MES GROUND AMBULANCE	SC 6545–8–M35	6545011419476	0256
	MES HOS CONUS 1000BED	SC 6545–8–H32	6545009254200	1502
	MES HOS EX CONUS 50BE	SC 6545–8–E22	6545009255510	1516
	MES HOSP CONUS 100BED	SC 6545–8–H32	6545009552060	1510
	MES HOSP CONUS 25BED	SC 6545–8–H32	6545009552030	1512
	MES HOSP CONUS 250BED	SC 6545–8–H32	6545009522000	1505
	MES HOSP CONUS 50BED	SC 6545–8–H32	6545009552040	1511
	MES HOSP CONUS 500BED	SC 6545–8–H32	6545009522010	1504
	MES HOSP CONUS 750 BD	SC 6545–8–H32	6545009522020	1503
	MES HOSP EXPAN 100BED	SC 6545–8–E22	6545009255530	1515
	MES HOSP EXPAN 25 BED	SC 6545–8–E22	6545009255500	1517
	MES HOSP EXPAN 250BED	SC 6545–8–E22	6545009255550	1514
	MES HOSP EXPAN 500BED	SC 6545–8–E22	6545009255570	1513
M29159	MES LAB FLD LIGHTWT	SC 6545–8–M43	6545011918970	0263
M28938	MES MED ENT EVAC HOSP	SC 6545–8–M25	6545001817122	1022
	MES MED LAB CONUS	SC 6545–8–L04	6545009259790	1103
M28936	MES MED SUP EVAC HOSP	SC 6545–8–M14	6545001164036	1018
M28937	MES MED SUP SURG HOSP	SC 6545–8–M13	6545001164035	1017
M29330	MES OPHT TEAM FIELD	SC 6545–8–T18	6545001450408	3010
M28945	MES ORTHO EVAC HOSP	SC 6545–8–M23	6545001817120	1020
M29633	MES PAT HOLD SQUAD LT	SC 6545–8–M41	6545011921900	0261
M29906	MES SICK CALL FLD (1)	SC 6545–8–M40	6545011918974	0260
M30156	MES SICK CALL FLD (2)	SC 6545–8–M47	6545012281886	0265
M28935	MES SUP CBT SUP HOSP	SC 6545–8–M26	6545000797146	1025
M45375	MES SURG SQUAD FLD LT	SC 6545–8–M45	6545012028078	0266
M30249	MES TRAU FLD (1)	SC 6545–8–M39	6545011918972	0259
M30499	MES TRAUMA FIELD (2)	SC 6545–8–M46	6545012281887	0264
M30067	MES VET LGE AN FLD	SC 6545–8–V08	6545001450095	1921
	MES VET POSTMORTEM FD	SC 6545–8–V07	6545001450094	1920
	MES VETHOSP CONUS 50P	SC 6545–8–V01	6545002999490	1916
M45613	MES X-RAY FLD LID	SC 6545–8–M42	6545011918971	0262
	MISS RESUPPLY SET NO1	SC 6545–8–R07	6545008646260	1308
	MISS RESUPPLY SET NO2	SC 6545–8–R07	6545008646261	1309
	MISS RESUPPLY SET NO3	SC 6545–8–R07	6545008646508	1310
	MISS RESUPPLY SET NO4	SC 6545–8–R07	6545011749884	1311
	MMS AF MAIN AUG		6545012400585	D322
	MMS AIR FORCE 500 BED		6545011823815	D384
Z43451	MMS ANATOM PATH/CYTOL		6545011823832	D435
	MMS ANATOM PATHOLGY\L	SC 6545–8–MK5	6545012995634	L435
Z43444	MMS ANGIOGRAPHY SPEC		6545011823830	D434
	MMS ANGIOGRPH SP AU\L	SC 6545–8–MK4	6545012995633	L434

Table 3–2
Major medical assemblages (alphabetical listing)—Continued

LIN	Description	Supply catalog	NSN	Unit assembly code
M71982	MMS CEN MAT COMMZ AUG		6545011823817	D402
	MMS CEN MAT DEPMEDS\K	SC 6545–8–MA2	6545012989803	K302
	MMS CEN MAT SPEC AUGM		6545011823831	D435
	MMS CENT MAT DEPMDS\L	SC 6545–8–MF1	6545013003523	L302
M08417	MMS CENTRAL MATERIAL		6545011823787	D302
	MMS CENTRL MAT SVC\L	SC 6545–8–MH9	6545012995621	L402
Z42600	MMS CMS SPEC AUG DEP		6545012484806	D342
	MMS CNT MAT SRV AUG\L	SC 6545–8–MH4	6545012994211	L342
	MMS CNTRL MAT SRVC\J	SC 6545–8–ML3	6545012995637	J302
	MMS DEN HSP DEPMEDS\L	SC 6545–8–DA6	6545012994213	L370
	MMS DENT XRAY DPMDS\K	SC 6545–8–DA2	6545012991704	K374
	MMS DENTAL X-RAY\L	SC 6545–8–DA7	6545012994214	L374
	MMS DENTL PROSTH AU\L	SC 6545–8–DA9	6545012995636	L473
	MMS DNTL HYGIENIST\L	SC 6545–8–DB1	6545012998077	L475
	MMS EENT AUG DEPMED\L	SC 6545–8–MG8	6545012994258	L320
	MMS EENT AUG DEP\K	SC 6545–8–MC1	6545012989819	K320
M47805	MMS EENT AUGMENTATION		6545011823804	D320
M08667	MMS EYE EXAM CLINIC		6545011823799	D315
	MMS EYE EXAM DEPMED\K	SC 6545–8–MB6	6545012989815	K315
	MMS EYE EXAM DEPMED\L	SC 6545–8–MG5	6545012994255	L315
	MMS HOSP DENT DPMDS\K	SC 6545–8–DA1	6545012991703	K370
	MMS HOSP DNTSTRY AU\L	SC 6545–8–DA8	6545012995635	L470
	MMS INT CARE WARD COM		6545011823821	D410
M08599	MMS INTER CARE WARD		6545011823794	D310
	MMS INTERM CARE DEP\L	SC 6545–8–MF9	6545012994224	L310
	MMS INTERMED DEPMED\K	SC 6545–8–MB1	6545012989810	K310
	MMS INTRMED CARE WD\J	SC 6545–8–ML6	6545012995640	J310
	MMS LAB (GEN) DEPMD\L	SC 6545–8–MF2	6545012994219	L303
	MMS LAB BB AUG DEPM\L	SC 6545–8–MJ2	6545012995623	L404
	MMS LAB BB AUG DEP\K	SC 6545–8–MC8	6545013003527	K404
	MMS LAB BB DEPMEDS\K	SC 6545–8–MA4	6545012989804	K304
	MMS LAB BB DEPMEDS\L	SC 6545–8–MF3	6545013003524	L304
M48737	MMS LAB BLOOD BANK		6545011823789	D304
	MMS LAB GEN DEPMEDS\K	SC 6545–8–MA3	6545012998085	K303
M72232	MMS LAB (BLD BNK) COMMZ		6545011823818	D404
	MMS LAB (GEN) AUG DEP\L	SC 6545–8–MJ1	6545012995622	L403
M08724	MMS LAB (GEN) COMMZ AUG		6545011841241	D403
	MMS LAB (GEN) DEPMEDS\J	SC 6545–8–ML4	6545012995638	J303
M72482	MMS LABORATORY GEN		6545011823788	D303
	MMS MD FLD HSP HQ\K	SC 6545–8–ME5	6545012994200	K487
	MMS MD FLD HSP 100B\K	SC 6545–8–ME6	6545012994201	K483
	MMS MD HOS 100B DEP\L	SC 6545–8–MK9	6545012998081	L483
	MMS MD MAT AU ARM\L	SC 6545–8–MH1	6545012994260	L324
	MMS MD MNT AUG ARMY\K	SC 6545–8–MC3	6545012998086	K324
	MMS MD SP FLD DPMDS\L	SC 6545–8–MK7	6545012998079	L487
	MMS MD STA HOS 300B\L	SC 6545–8–MK8	6545012998080	L489
	MMS MD STA HSP 500B\K	SC 6545–8–ME8	6545012994207	K490
	MMS MD SUP CSH DEP/K	SC 6545–8–MC5	6545012991706	K381
	MMS MD SUP EVAC HSP\L	SC 6545–8–MH8	6545012994217	L382
	MMS MD SUP MASH DEP/K	SC 6545–8–MC4	6545012991705	K380
	MMS MD SUP MASH\L	SC 6545–8–MH6	6545012994215	L380
M09349	MMS MED MAIN AUG ARMY		6545012414336	D324
	MMS MED MAINTEN DEP\K	SC 6545–8–MC2	6545012991702	K321
	MMS MED MAINTEN DEP\L	SC 6545–8–MG9	6545012994259	L321
M47987	MMS MED MAINTENANCE		6545011823805	D321
	MMS MED SER CLN DEP\K	SC 6545–8–MB4	6545012989813	K313
	MMS MED SUP CSH\L	SC 6545–8–MH7	6545012994216	L381
M72928	MMS MED SUP EVAC ARMY		6545011823814	D382
	MMS MED SUP FLD HOSP		6545012281476	D488
M72360	MMS MED SUP GEN HISP		6545011823836	D483
	MMS MED SUP GEN HSP\L	SC 6545–8–MK6	6545012998078	L483
Z64302	MMS MED SUP STA HOSP		6545012299093	D489
Z43872	MMS MED SUP 500 BD HO		6545012400584	D490
M72678	MMS MED SUPPLY CSH		6545011823813	D381

Table 3–2
Major medical assemblages (alphabetical listing)—Continued

LIN	Description	Supply catalog	NSN	Unit assembly code
M72610	MMS MED SUPPLY MASH		6545011823812	D380
M09099	MMS MED SVC CLIN AUG		6545011823823	D413
	MMS MED SVC CLIN AU\L	SC 6545–8–MJ6	6545012995627	L413
	MMS MED SVC CLINIC	SC 6545–8–H50	6545011139187	D236
	MMS MED SVC CLN DEP\L	SC 6545–8–MG3	6545012998083	L313
M72428	MMS MEDICAL SVCS CLIN		6545011823797	D313
	MMS MIN CARE DEPMED\K	SC 6545–8–MB2	6545012989811	K311
M48055	MMS MINIMAL CARE WARD		6545011823795	D311
	MMS MINIML CARE DEP\L	SC 6545–8–MG1	6545012995619	L311
	MMS NAVY FL HOS 250BD		6545011823838	D385
	MMS NAVY FL HOS 500BD		6545011823840	D386
M72860	MMS NEURO COMMZ AUG		6545011823826	D430
	MMS NEUROLOGICL AUG\L	SC 6545–8–MK1	6545013003528	L430
	MMS NEUROSR AUG DEP\K	SC 6545–8–MB8	6545012989817	K318
	MMS NEUROSR AUG DEP\L	SC 6545–8–MG7	6545012994257	L318
Z43415	MMS NEUROSUR SPEC AUG		6545011823824	D418
M48305	MMS NEUROSURGERY AUG		6545011823802	D318
	MMS NUROSGRY SPC AU\L	SC 6545–8–MJ8	6545012995629	L418
M31824	MMS OB/GYN CLINIC		6545011823800	D316
	MMS OB/GYN CLIN DEP\L	SC 6545–8–MG6	6545012994256	L316
	MMS OB/GYN CLNC DEP\K	SC 6545–8–MB7	6545012989816	L316
	MMS OPER RM COMZ AUG		6545011823816	D401
	MMS OPER RM DEPMEDS\J	SC 6545–8–ML2	6545012998084	J301
	MMS OPER RM DEPMEDS\K	SC 6545–8–MA1	6545012989802	K301
	MMS OPER RM DEPMEDS\L	SC 6545–8–ME9	6545012994218	L301
M72936	MMS OPERATING ROOM		6545011823786	D301
Z43422	MMS OPHTH SUR SPEC AU		6545011823825	D419
	MMS OPHTHAL AJG DEP\K	SC 6545–8–MB9	6545012989818	K319
	MMS OPHTHAL AUG DEP\L	SC 6545–8–MH5	6545012994212	L319
M47737	MMS OPHTHALMOLOGY AUG		6545011823803	D319
	MMS OPTHL SU SP AUG\L	SC 6545–8–MJ9	6545012995630	L419
M72868	MMS ORTHO CAST CLINIC		6545011823798	D314
	MMS ORTHO CAST DEP\K	SC 6545–8–MB5	6545012989814	K314
	MMS ORTHO CAST DEP\L	SC 6545–8–MG4	6545012994208	L314
	MMS ORTHOPDC SUR AU\L	SC 6545–8–MJ7	6545012995628	L412
M32074	MMS ORTHOPED SUR AUG		6545011823801	D317
M09678	MMS PHARM COMMZ AUGMN		6545011834866	D406
	MMS PHARMACY DEPMED\K	SC 6545–8–MA6	6545012989806	K306
	MMS PHARMACY DEPMED\L	SC 6545–8–MF5	6545012994221	L306
M73118	MMS PHARMACY DEPMEDS		6545011823790	D306
	MMS PHARMCY AUG DEP\L	SC 6545–8–MJ3	6545012995624	L406
M72800	MMS PHYS THER COMMZ A		6545011823822	D412
	MMS PHYS THR AU DEP\L	SC 6545–8–MJ5	6545012995626	L412
	MMS PHYSCL THER DEP\L	SC 6545–8–MG2	6545012995620	L312
M72050	MMS PHYSICAL THERAPY		6545011823796	D312
Z43659	MMS PORT L CAP X-RAY		6545012484804	D334
M09576	MMS POST-OP/ICU WARD		6545011823793	D309
	MMS POSTOP ICU DEP\L	SC 6545–8–MF8	6545012994223	L309
	MMS POSTOP/ICU DEP\K	SC 6545–8–MA9	6545012989809	K309
	MMS PRT LOWCAP XRAY\L	SC 6545–8–MH3	6545012994210	L334
	MMS PT DEPMEDS\K	SC 6545–8–MB3	6545012989812	K312
Z43439	MMS RAD COMPUT TOMOGR		6545011823828	D432
	MMS RADIO CT SPC AU\L	SC 6545–8–MK3	6545012995632	L432
	MMS SUP STA HOS DEP\L	SC 6545–8–ML1	6545012998082	L490
	MMS SUP STA HSP300B\K	SC 6545–8–ME7	6545012994206	K489
	MMS T/E/P COMMZ AUGMN		6545011823820	D408
	MMS TRIAG/E/PRE DEP\L	SC 6545–8–MF7	6545012994222	L308
	MMS TRIAGE/E/P DEP\K	SC 6545–8–MA8	6545012989808	K308
M73050	MMS TRIAGE/EMER/PREOP		6545011823792	D308
	MMS VITRE SUR SP AU\L	SC 6545–8–MK2	6545012995631	L431
Z43432	MMS VITREOUS SUR SPEC		6545011823827	D431
M72300	MMS X-RAY		6545011823791	D307
M48487	MMS X-RAY COMMZ AUGMN		6545011823819	D407
Z65537	MMS X-RAY MOB DEP		6545012484803	D333

Table 3–2
Major medical assemblages (alphabetical listing)—Continued

LIN	Description	Supply catalog	NSN	Unit assembly code
	MMS X-RAY MOBILE\K	SC 6545–8–MH2	6545012994209	L333
Z65469	MMS X-RAY RAD DEP		6545012484802	D305
	MMS X-RAY (NOT ISO) AUG		6545011823829	D433
	MMS X-RAY AUG DEPMED\L	SC 6545–8–MJ4	6545012995625	L407
	MMS X-RAY DEPMED (J307)	SC 6545–8–ML5	6545012995639	J307
	MMS X-RAY DEPMEDS\K	SC 6545–8–MA7	6545012989807	K307
	MMS X-RAY DEPMEDS\L	SC 6545–8–MF6	6545012998087	L307
	MMS X-RAY RAD DEPMED\K	SC 6545–8–MA5	6545012989805	K305
	MMS X-RAY RAD DEPMED\L	SC 6545–8–MF4	6545012994220	L305
	MRS LAB FLD LTW PREPG	SC 6545–8–R22	6545012544128	1331
	MRS MFTF SURGERY	SC 6545–8–H48	6545011139185	0234
	MRS PAT FLD LTW PREPG	SC 6545–8–R20	6545012544125	1329
	MRS SICAL FLD PREPG 1	SC 6545–8–R17	6545012544120	1326
	MRS SICAL FLD PREPG 2	SC 6545–8–R19	6545012544129	1328
	MRS TRAU FLD PREPG(1)	SC 6545–8–R16	6545012544119	1325
	MRS TRAU FLD PREPG(2)	SC 6545–8–R18	6545012544124	1327
	MRS X-RAY FLD LWT	SC 6545–8–R21	6545012544121	1330
	MSPM #1	SC 6545–8–R10	6545012154097	1312
	MSPM #2	SC 6545–8–R11	6545012154098	1313
	MSPM #3	SC 6545–8–R12	6545012154099	1314
	MSPM #4	SC 6545–8–R13	6545012161789	1315
	MSPM #5	SC 6545–8–R14	6545012154096	1316
	MSPM #6 EXPEDITNARY	SC 6545–8–R15	6545012211514	1317
	MSS CIVIL AFFAIR TP 1	SC 6545–8–R09	6545001049035	1624
	MSS CIVIL AFFAIR TP 2	SC 6545–8–R09	6545001049036	1625
	MSS CIVIL AFFAIR TP 3	SC 6545–8–R09	6545001049169	1626
	MSS CIVIL AFFAIR TP 4	SC 6545–8–R09	6545001049177	1627
N22210	OPTIC FAB UNIT FLD 1	SC 6545–8–P01	6545002929683	3004
N22347	OPTIC FAB UNIT FLD 2	SC 6545–8–P02	6545002929696	3005
N22073	OPTIC FAB UNIT PORTFL	SC 6545–8–P03	6545009315130	3003
	OPTICAL RESUP SET NO1	SC 6545–8–R08	6545008902201	3008
	OPTICAL RESUP SET NO2	SC 6545–8–R08	6545007826505	3009
N23712	OPTOMETRY EQ SE (R–1)	SC 6545–8–P07	6545011312633	1324
	SPEC REP SET FIELD	SC 6545–8–P05	6545004540309	3002
U65480	SUR INSTR&SUP SE INDI	SC 6545–8–M37	6545011419470	0245
U66987	SURG INSTR ORTH TM	SC 6545–8–T05	6545009596330	0509
U66165	SURG SE GEN SURG TM	SC 6545–8–T02	6545009596270	0506
U66439	SURG SE MAXILLO TM	SC 6545–8–T03	6545009596290	0507
U66850	SURG SE NEUROSURG TM	SC 6545–8–T04	6545009596310	0508
U67261	SURG SE SHOCK TM	SC 6545–8–T06	6545009596350	0510
U67398	SURG SE THORACIC TM	SC 6545–8–T07	6545009596370	0511
Y91908	X-RAY APP X-RAY TEAM	SC 6545–8–T08	6545009596390	0512

Notes:

1. All Z LIN sets in this table are still under development. The Z LIN will eventually be replaced by a standard LIN;however, the other information should be unchanged. Z LIN sets should not be requisitioned.

2. Some assemblages do not reflect LINs.

3. Some assemblages do not reflect supply catalog numbers.

STANDARD FORM 380 (12–81)
Prescribed by VA and DOD
VAPR 6–14.50 and MP–2, 108–26;
DLAR 4155.28

REPORTING AND PROCESSING MEDICAL MATERIEL COMPLAINTS/ QUALITY IMPROVEMENT REPORT

DATE: 12 Aug 92
NO. RIC AZZ WK4F244301-A001

TO: Defense Personnel Support Center ATTN: DPSC-MOS-CCP 2800 S. 20th Street Philadelphia, PA 19101-8419	FROM: MEDDAC ATTN: HSXJ-OC Fort Jones, MD 22134-0001

TYPE OF COMPLAINT ▶ 1A. FOR DOD USE: ☐ I ☒ II ☐ III
1B. FOR VA USE: ☐ QUALITY COMPLAINT ☐ NEW ITEM ☐ SIMILAR ITEM

2. NATIONAL STOCK NO.	3. ITEM DESCRIPTION
6515-00-000-0000	Complete nomenclature

4. NAME AND ADDRESS OF MANUFACTURER	5. NAME OF CONTRACTOR (If other than the manufacturer)
Smith Biological Corporation 123 1st Street Smithville, NJ 00123-0001	If applicable
	6. CONTRACT NO. OR PURCHASE ORDER NO.: DLA 120-89-C-1234

7A. VA DEPOT VOUCHER NO.	7B. DOD REQUISITION NO	8. LOT NO.
If applicable	WK4F2443010001	4210
9. CONTROL NO.	10. MANUFACTURER'S SERIAL NO.	11. MODEL NO.
	If applicable	If applicable
12. DATE MANUFACTURED	13. DATE PACKED	14. EXPIRATION DATE
12/89	2/90	12/92
15. SOURCE (Name of Depot)	16. QUANTITY ON HAND	17. QUANTITY SUSPENDED
Defense Depot Tracy, CA	15	10

COMPLETE ITEM 18A THROUGH 18F FOR DOD TYPE I COMPLAINTS ONLY

18A. TOTAL NO. PATIENTS INVOLVED	18B. TOTAL NO. REACTIONS	18C. SEVERE OR UNUSUAL REACTIONS
18D. REACTIONS REQUIRING HOSPITALIZATION	18E. LENGTH OF HOSPITALIZATION	18F. VACCINE: ☐ INITIAL ☐ BOOSTER INTERVAL _____

19. CAUSE OF COMPLAINT (Explanation of unsatisfactory condition, deficiency, or description of reaction. Complete 19 through 22 for ALL complaints.)

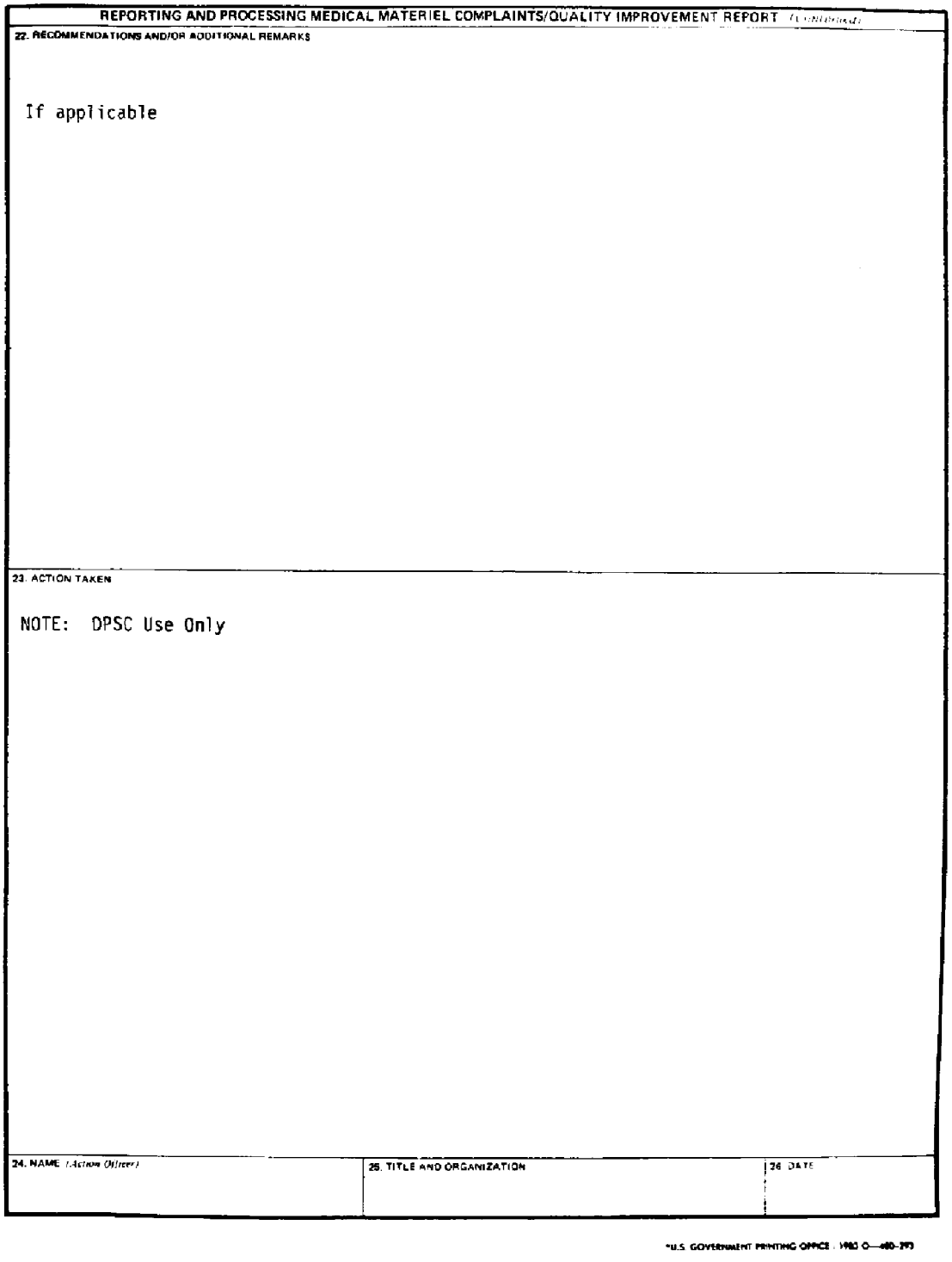
NOTE: Give a complete but concise description of cause of complaint.

SAMPLE

20A. TYPED NAME OF INITIATOR (For Type I MC/DC/INC)	20B. AUTOVON/FTS TELEPHONE NO.	20C. COMMERCIAL TELEPHONE NO.
COL Davis	DSN 412-0000	(211) 210-0000
21A. TYPED NAME OF SUPPLY OFFICER	21B. SIGNATURE OF SUPPLY OFFICER	21C. DATE
Mary Jones	Mary Jones	12 Aug 92
21D. AUTOVON/FTS TELEPHONE NO.	21E. COMMERCIAL TELEPHONE NO.	
DSN 412-0001	AREA CODE (211) 210-0001	

380-101 NSN 7540-01-127-0790

Figure 3-1. Sample entries on SF 380


REPORTING AND PROCESSING MEDICAL MATERIEL COMPLAINTS/QUALITY IMPROVEMENT REPORT (Continued)

22. RECOMMENDATIONS AND/OR ADDITIONAL REMARKS

If applicable

23. ACTION TAKEN

NOTE: DPSC Use Only

24. NAME (Action Officer)	25. TITLE AND ORGANIZATION	26. DATE

*U.S. GOVERNMENT PRINTING OFFICE : 1980 O—680-293

Figure 3-1. Sample entries on SF 380—Continued

Chapter 4
Equipment Management

Section I
Procedures for Equipment Acquisition and Management

4–1. Equipment acquisition policy

a. Commanders of TDA health care activities will establish equipment requirements. Requirements will be in accordance with major MEDCOM or command surgeon policies.

(1) TDA medical facilities will cite this regulation as authority for medical equipment, excluding Army adopted medical items. (See SB 700–20.) Army adopted medical items will be authorized in accordance with AR 71–13.

(2) Nonmedical equipment will be authorized according to AR 71–13.Common tables of allowances (CTA) cited in AR 71–13 will also be used as authorization documents.

(3) Equipment allowances for medical materiel mobilization programs will be as stated in chapter 9, section II.

b. Equipment will be procured in the following priorities:

(1) To meet medical emergencies.

(2) To support AMEDD health care programs.

(3) To support approved construction projects.

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

c. The following conditions will be met prior to equipment acquisition:

(1) Equipment will not be replaced solely because of age.

(2) Replacement equipment will be identified to the specific item being replaced. Full consideration will be given to the actual need for the item in terms of—

(a) Specific improvements in health care.

(b) Effects on operating costs (personnel, repair parts, consumable supplies), maintenance capabilities, and workload.

(c) Availability of similar equipment on hand, on excess lists, or available by lease, rental, or purchase that would produce the desired result at lesser cost.

(3) Arrangements for installation (funding, building modification, power and utility needs) must be complete prior to equipment delivery to prevent delay in using the equipment after receipt.

(4) Medical equipment intended for use in air ambulances will not be acquired or used until its suitability for such use has been determined.Suitability determinations will be obtained from the AMEDDC&S, in accordance with provisions in chapters 2 and 3 of this regulation.

d. Furnishings required for use in patient contact areas (such as waiting areas, clinician offices, reception areas, patient lounges, solariums, and so forth) will be of such design as to provide an aesthetic, pleasant atmosphere and are not limited by the provisions of CTA 50–909. Furnishings for patient contact areas may therefore be acquired as necessary in accordance with the appropriate MEDCASE or capital expense equipment approval procedures and availability of funds. Furnishings required for use in administrative areas not involved with direct patient contact will conform to the provisions of CTA 50–909.

4–2. Equipment acquisition in AMEDD TDA organizations

a. Medical care support investment equipment will be financed within Other Procurement, Defense (OPD), Defense Health Program (DHP) procurement limitations.

b. Nonexpendable equipment required to initially equip major medical military construction projects will be funded with either OPD or DOD MILCON according to the logistical category (LOGCAT) established by MIL–STD–1691. Nonexpendable equipment and medical systems not included in the scope of work approved by Congress on DD Form 1391 (FY, Military Construction Project Data) will be funded with OPD.

c. Items funded by OPD will not be processed through the Army Stock Fund unless items are physically available in the local stock fund inventory.

d. Equipment not eligible for OPD or DOD MILCON financing will be funded by Operation and Maintenance, Defense (OMD), DHP operation and maintenance limitation.

e. Equipment identified in the AMDF and supply catalogs and bulletins as centrally funded through nonmedical programs must be acquired through those funding channels.

f. Other equipment will be acquired through existing authorization and funding procedures. Photographic, audiovisual, and television systems will be requested under AR 25–1.

4–3. Equipment acquisition and management in medical TOE units

a. This paragraph applies specifically to medical equipment. Acquisition and management of nonmedical equipment will be conducted in accordance with the applicable Army regulation and funding procedures. Medical TOE units are required to have on hand or on order those items of medical and nonmedical equipment authorized by their MTOE.

b. The type of funding used to acquire medical equipment will determine specific procedures for requesting and managing items. Medical equipment authorized for TOE units is obtained through one of the following funding programs:

(1) OPA funded capital investment equipment (items with an MCSC of CQ (AR 710–1, chap 5)).

(2) OMA funded MESs.

(3) OMA funded expense equipment (items with an MCSC of C2).

c. OPA funded capital investment equipment is acquired and managed as follows:

(1) Central programming of capital investment equipment requirements is based on fielding plans for newly introduced equipment items, data from the Continuing Balance System—Expanded (CBS-X) and the Total Army Equipment Distribution Plan (TAEDP), PARMS plans, and identification of projected replacement requirements. MACOMs are encouraged to have units provide, through command channels, reports (in letter format) of anticipated requirements due to obsolescence or condition of present equipment. This information should be submitted to USAMMA (SGMMA–R) not later than 31 March preceding the fiscal year in which funding is desired.

(2) The associated support items of equipment(ASIOE) support medical assemblages. ASIOE components in supply catalogs reflecting LINs are for information purposes only. This does not constitute a separate authorization.The unit assemblage (UA) listing may provide interim authorization for OPA funded items pending LIN assignment and migration from the MES to the unit's MTOE.

(3) All OPA funded capital investment medical equipment for TOE units will be identified as regulated medical items, AAC A or provisioned medical equipment items, AAC W. Unfunded requisitions for OPA funded items will be submitted to USAMMA (SGMMA–RMA) in accordance with procedures outlined in chapter 3.

(4) Procurement of OPA funded capital investment equipment will be performed by the DPSC or another appropriate procurement agency as determined by USAMMA. Priorities for acquisition will be established by HQDA(DASG–LO) upon coordination with the MEDCOMs.

(5) OPA funded nonmedical equipment will be programmed by the appropriate HQDA central manager. Identification of requirements and submission of requisitions will be coordinated with the appropriate organizational or installation SSA.

d. Unless otherwise indicated, medical equipment sets is used as a generic term to describe medical SKOs and includes medical equipment sets (MES), dental equipment sets (DES), medical materiel sets (MMS), and dental materiel sets (DMS). MES will be managed as follows:

(1) MES component listings will contain capital expense equipment items, consumables and durables, and will identify the ASIOE required to support the set. ASIOE may be either OMA or OPA funded and will be authorized separately on the MTOE. MES may provide interim authorization for ASIOE items pending LIN application to MTOEs by MACOMs.

(2) Acquisition of MES will be OMA funded.

(3) Major MES (listed in table 3–2) and specified minor MES will be identified as regulated medical items, AAC A.

(4) HQDA (DASG–LO) will perform central programming and obtain funding for MES that—

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

(b) Constitute a major modernization of an existing MES as determined by HQDA (DASG–LO).

(c) Constitute an initial issue of an existing MES to a newly activated unit.

(5) Requisitions can be initiated by the newly activated unit, by USAMMA, or according to instructions in the materiel fielding plan (MFP) for MES described in (4) above.

(6) Acquisition of all MES that are not centrally programmed and funded must be purchased with MACOM OMA funds. Funded requisitions for these MES will be submitted in accordance with the procedures in chapter 3.

(7) Individual item replacement for the MES capital expense

equipment and supply components will be OMA funded by the MACOM.

(8) Accounting for MES components will be performed in accordance with chapter 5 of this regulation.

e. Capital expense equipment items may be either components of MES or separate line items on the unit's MTOE. MACOMs will provide OMA funds for replacement of capital expense components of MES and separate line items.Capital expense components of centrally funded MES identified in *d*(4) above will be funded by HQDA. Replacement of these components will be MACOM funded. Medical items will be requisitioned through the medical SSA for appropriate supply action. Nonmedical items will be requisitioned through the appropriate organizational or installation SSA for appropriate supply action.

f. The command surgeon of an OCONUS MACOM may authorize nonstandard, nontype classified equipment in place of TOE medical equipment.

g. Modernization and fielding of newly standardized equipment items will be accomplished in accordance with AR 40–60.

h. Property management for equipment on hand in medical TOE units will be conducted in accordance with AR 710–2, DA PAM 710–2–1, and this regulation.

i. Medical TOE units that operate TMCs or dispensaries as an element of garrison or installation level health services will obtain equipment for the TMC from the MEDDAC or MEDCEN responsible for supporting the installation.Personnel from the medical TOE unit staffing the TMCs will be assigned property responsibility for the equipment used in the TMCs using hand-receipt procedures. TMCs on ARNG training sites will be partially or fully equipped by the ARNG training site.

4–4. Substitution policy

a. USAMMA will only issue medical items that are authorized to the requesting unit. If the authorized item is not available, a substitute LIN may be issued to maintain unit readiness if—

(1) The substitute item is included in the approved DA Class VII/VIII substitute list.

(2) A new requisition has been submitted for the authorized item, to be held on back order, pending availability of the authorized item.

b. Units of the Active Army, ARNG, and USAR are equipped with medical equipment identified by LIN in the authorization document, unless otherwise directed by HQDA. These units are equipped in DA master priority list (DAMPL)sequence. Out-of-DAMPL issues to meet urgent requirements must be approved by DA, Deputy Chief of Staff for Operations (DCSOPS).

c. The use of substitute items does not relieve the unit from having the authorized item on hand or on order (AR 310–49).

d. USAMMA will develop a list of substitute LINs for publication in SB 700–20, appendix H, as the HQDA Class VII/VIII LIN substitute list.

e. Substitute LINs that are used instead of authorized LINs must appear in the HQDA-approved list to qualify for readiness reporting purposes per AR 220–1.

f. Substitute LINs are reported as assets on hand and are included in equipment totals for unit status reporting purposes.

g. Only items with standard LINs are included in the DA–approved substitute list.

h. The requirement determination process for the authorized LIN is unaffected by this substitution policy since units are required to have the authorized LIN on order.

i. When the substitute LIN is replaced with the authorized LIN, the substitute item is either redistributed per AR 710–2, MACOM guidance, or reported to USAMMA for disposition instructions.

j. USAMMA will maintain the approved substitute list to provide the next best item that allows the unit/organization to accomplish its mission.Substitute items must meet the following conditions:

(1) Be compatible with the ASIOE.

(2) Perform the same function and purpose as the authorized LIN.

(3) Be maintenance supportable by personnel authorized in the unit MTOE/TDA.

(4) Be supply supportable (repair parts, tools and test, measurement, and diagnostic equipment (TMDE)).

k. Medical equipment used as substitutes are reflected in the CBS-X and TAEDP.

4–5. Equipment authorization procedures for ARNG physical examination facilities

a. States desiring to establish a physical examination facility will submit a letter request to HQDA (NGB–ARP–H). The request must—

(1) State the desired facility location and unit to man it.

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

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

(4) State projected cost savings.

b. Upon approval of the facility by HQDA(NGB–ARP–H), States may request equipment authorization by submitting a request letter to HQDA(NGB–ARL–ME). The equipment authorization request will include the State Area Command (STARC) paragraph to which the authorization should be added.

c. A suggested list of physical examination facility equipment is published in the SB 8–75 series (SB 8–75–S10).

d. Equipment authorization will be made in the form of a letter of authorization (LOA) issued by the ARNG (HQDA (NGB–ARL–ME)).

(1) The National Guard Bureau (NGB) will assign NGB LINs to nontype classified equipment.

(2) The LOA will be an interim authorization document. Authorizations will be added to the STARC TDA on the next revision cycle and the LOA will expire at that time.

(3) LOA issued for a 3-year period without mention of inclusion on the STARC TDA must, 6 months prior to expiration, be resubmitted to NGB–ARL–ME with a request for inclusion on the STARC TDA.

4–6. Equipment authorization procedures for troop medical clinics at ARNG training sites

a. Requests for authorization of medical equipment will be submitted in letter form, fully justified, to HQDA (NGB–ARL–ME), 111 South George Mason Drive, Arlington, VA 22204–1382 for approval.

b. For approved items, HQDA(NGB–ARL–ME) will assign NGB LINs, when required, and issue a LOA valid until the next revision of the TDA, at which time the items will automatically be added to the applicable TDA.

c. Each ARNG training site with an approved TDA and operating a TMC is authorized nontype classified medical and dental furniture, in FSCs 6520 and 6530 only, on an "as required" basis for use only in that facility. The installation property book serves as the authorization document for this property. (See AR 71–13 and AR 310–49.)

d. In addition, ARNG training sites with a valid NGB authorization for medical equipment may substitute nontype classified items in the same quantity for FSCs 6515, 6520, and 6530 items authorized by the authorization document.

e. USPFOs retain authority to disapprove specific proposed acquisitions otherwise authorized in *c* and *d* above.

Section II
Medical Care Support Equipment Program (MEDCASE)

4–7. Program description

a. The MEDCASE Program is the AMEDD program for the acquisition of capital investment equipment for TDA health care facilities and the initial outfitting of expanded or newly constructed health care facilities. The MEDCASE Program is divided into six

categories, each designated by a specific budget line item code (BLIC), to support various AMEDD missions. The six MEDCASE BLICs are as follows:

(1) BLIC CF, Clinical Investigation, supports the AMEDD's Clinical Investigation Program conducted at specified MEDCENs and Office of The Surgeon General (OTSG) designated hospitals.

(2) BLIC DA, Drug Abuse and Control, supports the AMEDD's Drug Abuse Prevention and Control Program conducted at OTSG designated MEDCENs, MEDDACs, and medical laboratories.

(3) BLIC NF supports Expansion and/or New Installation by providing OPD funded nonexpendable equipment for initial equipage of a major medical DOD MILCON project. Equipment is designated by LOGCAT in accordance with MIL–STD–1691. The LOGCAT may be changed with the approval authority of the U.S. Army Health Facilities Planning Agency (USAHFPA) and OTSG.

(4) BLIC MB supports DOD MILCON funded nonexpendable equipment designated by MIL–STD–1691. Equipment is initially identified in the Equipment Requirements Planning Guide prepared to support DD Form 1391 and submitted in accordance with SB 8–75–MEDCASE procedures for approval.

(5) BLIC PC, Pollution Control, supports the AMEDD's Pollution Control Program.

(6) BLIC UR, Replacement and Modernization, supports the acquisition of equipment intended to modernize and upgrade medical equipment used in AMEDD facilities and to replace obsolete or noneconomically repairable equipment.

b. The MEDCASE Program is managed by TSG and executed by USAMMA in coordination with Army MEDCOMs and command surgeons. Procedures are prescribed in the SB 8–75–MEDCASE.

c. MEDCASE Program data sources are as follows:

(1) The MEDCASE Report (RCS MED–250) is used for annual reporting of health care activity assets and requirements data. See appendix C and SB 8–75–MEDCASE for guidance on preparing the report.

(2) The asset visibility file (AVF) is a major file of AMEDDPAS. The file contains all items of equipment with a unit price of $1,000 or more that are on AMEDD property records. It also contains maintenance data on equipment.The file is managed by USAMMA and queried for information pertinent to the MEDCASE Program.

(3) The AMEDDPAS is used to manage MEDCASE Program development at the activity level. Activities using AMEDDPAS will use the equipment planning module to prepare requirements transactions for submission through command channels.

(4) The MEDCASE Requirements and Execution (MRE)System is an automated information system operated at USAMMA that provides management data and execution of the MEDCASE Program above the station level. The MRE System provides detailed information on station requirements, execution and status of requirements, and MEDCASE financial functions. A detailed description of the system is contained is SB 8–75–MEDCASE.

d. USAMMA will periodically provide file data and reports from the AVF and MRE System to OTSG, MEDCOMs, and health care activities. MEDCASE data will be maintained on an individual item basis (not line item). USAMMA has functional proponency for the maintenance of the AVF and MRE System. As such, USAMMA will routinely take action to keep these systems current consistent with program policies established by OTSG. Above the local level, management information about the MEDCASE Program will only be generated from the AVF and MRE System; no other automated systems will be developed to accomplish this task without HQDA (DASG–LO) approval.

4–8. Equipment eligibility criteria

a. Equipment is eligible for the MEDCASE Program when it is—

(1) Required to support the AMEDD health care mission. This includes medical equipment with direct patient-care application and nonmedical equipment used in administrative, maintenance, technical, or another type of direct support of a health care mission.

(2) A nonexpendable end item or a nonexpendable component or accessory to an end item that will be accounted for on the activity's property book.

(3) Classified as capital investment-type equipment, a nonexpendable end item, or a furnishings package required for a major medical DOD MILCON project.

(4) Not centrally managed and funded through another DA-level program.

(5) Not required solely to accomplish a base operations support function(except for installations commanded by USAMEDCOM).

(6) Not required to back up existing equipment.

b. Certain types of nonmedical equipment are eligible for funding by the MEDCASE Program but require processing and approval in accordance with additional Army regulations. (For example, Information Mission Area equipment must be approved under the provisions of AR 25–1.)

c. Nonmedical equipment acquired through the MEDCASE Program will be documented in the AMEDD TDA or in the appropriate CTA in accordance with AR 71–13 or AR 310–49. All Army authorization requirements must be met, including those other than MEDCASE, before acquisition of an item can begin.

d. Detailed guidance on equipment eligibility is in SB 8–75–MEDCASE.

e. Questions concerning the MEDCASE Program eligibility of a specific item should be sent through command channels to HQDA (DASG–LO), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

4–9. MEDCASE funding policy

a. Funding types. Equipment acquired through the MEDCASE Program will be funded by either DHP OPD/OMD or DOD MILCON funds. All BLIC categories except BLIC MB are funded by the OPD. BLIC MB is funded by the DOD MILCON appropriation. Medical equipment with an AAC "A," ABA"Q,"and unit cost less than $15,000 required to support TDA missions will be purchased with MACOM OMD funds. The requiring activity should submit a funded requisition to DPSC for procurement.

b. Managing funds.

(1) OTSG releases OPD funds by funded ceiling amounts for MEDCOMs, field operating agencies (FOAs), miscellaneous individual activities, or projects.

(2) USAMMA will account for and distribute MEDCASE Program funds in accordance with OTSG instructions. Funds will not be released without proper requirements documentation in the MRE System. The Standard Army Financial System (STANFINS) is the official accounting system for the MEDCASE Program.All fiscal monitoring and reporting (for example, commitment and obligation execution rates) utilizes STANFINS and MRE data.

(3) MEDCOMs will determine an annual funding ceiling amount for each of their subordinate activities within the total dollar amount established by OTSG. MEDCOMs may reserve an amount of their total funding ceiling amount to finance approved High Dollar Value (HDV) requirements and contingencies.

(4) Health care activity commanders are responsible for the judicious management and use of MEDCASE funds. Activity commanders are authorized to determine which approved requirements will be purchased, and in what sequence, using the bulk OPD funds ceiling established by the parent command.Commanders will use the Program Budget and Advisory Committee (PBAC) process to help set local priorities. Commanders will schedule a PBAC process during March and September of each fiscal year. The equipment funding priority results of the PBAC must be available by the last working day of March and September.

(5) USAMMA, MEDCOMs, and AMEDD activities will monitor, provide liaison, and coordinate all funding actions. They will ensure that—

(a) MEDCASE fiscal data are current.

(b) Locally established obligations are liquidated promptly in accordance with prompt payment procedures and obligation documents (such as contracts, delivery orders, and amendments) are promptly forwarded to USAMMA for posting.

(c) Total obligations do not exceed the obligation authority.

c. Withdrawal of funding. OTSG will automatically revise all MEDCASE Programs during the third quarter of the fiscal year in the first year of funds availability. All uncommitted/unobligated MEDCASE funds will be withdrawn from all MEDCASE Program participants. Uncommitted/unobligated funds will be withdrawn for central management by OTSG and used to fund high priority, unfinanced requirements.

4–10. MEDCASE approval policy

a. Activity commanders, MEDCOMs, and OTSG will approve or disapprove candidate requirements. All BLIC NF and BLIC MB requirements must be approved by the USAHFPA or their on-site representative before final MEDCASE approval processes. Each level of review will disapprove candidate requirements—

(1) If the justification is inadequate.

(2) If the item is not eligible for the MEDCASE Program.

(3) When the item is not appropriate considering mission, assigned personnel, density of similar equipment, or other factors from the requester.

b. MEDCOMs with functional medical specialty consultants have approval authority for items with a unit cost of $25,000 or more but less than$100,000. Activity commanders have approval authority for items with a unit cost of less than $25,000. The OTSG, as the MEDCASE Program Manager, or the parent command, as appropriate, may question and override approval action on an exception basis.

c. BLIC MB requirements must be forwarded through command channels to OTSG for final approval, regardless of dollar value.

d. Both the MEDCOMs and OTSG must approve a requirement costing $100,000 or more.

e. OTSG is the approval authority for OTSG FOAs.OTSG will approve or disapprove all FOA requirements with a unit cost of $25, 000 or more.

f. Diagnostic imaging and radiotherapy equipment requirements with a unit cost of $200,000 or more will be reviewed for propriety of need by the OTSG Diagnostic Imaging and Radiotherapy Board.

g. Medical equipment requirements costing$1,000,000 or more (regardless of BLIC) will be staffed and approved according to AR 40–65/NAVMEDCOMINST 6700.4/AFR 167–13 and SB 8–75–MEDCASE.

4–11. Submission of requirements

All MEDCASE requirements will be submitted on DA Form 5027–R(TEST)(MEDCASE Program Requirements). DA Form 5027–R (TEST) will be forwarded to the command with DA Form 5028–R (TEST) (MEDCASE Support and Transmittal Form). MEDCASE submissions will be assembled with supporting documents as prescribed by SB 8–75–MEDCASE. All necessary local review and coordination will be accomplished prior to submission. Once approved by the activity commander, complete requirements will be submitted to the parent command/OTSG in accordance with OTSG policy and command procedures.

4–12. Utilization of excess equipment

Prior to submission of DA Form 5027–R (TEST), or initiation of procurement action for an approved item, current excess lists will be reviewed to determine if an advertised excess item will meet the activity's requirement. The certification by the chief of the logistics division on the DA Form 5028–R (TEST) indicates that consideration has been given to the availability of excess assets at the time of DA Form 5027–R (TEST) submission and that none are available to meet the requirement.

4–13. Equipment replacement policy

a. MEDCASE Program participants will ensure that data and justification provided on the DA Form 5027–R (TEST) are factual and fully support a requirement to replace existing equipment. The fact that an item is approaching or is beyond its life expectancy is not, of itself, sufficient cause to replace the item. Life expectancy is a guideline used in the planning and managing of the medical equipment program. Factors that can justify replacement include—

(1) Excessive maintenance expense, supported by maintenance records.

(2) High frequency of repair, supported by maintenance records.

(3) Unreliability of the equipment, supported by maintenance records and narrative justification.

(4) Obsolescence that inhibits standard medical practice, clarified in the justification.

(5) Requirement for and availability of new technology, clarified in the justification.

(6) Cost reductions through conservation of manpower, supplies, and/or utilities justified and supported with objective data.

(7) Equipment that cannot be engineered to meet existing Federal safety inspection codes.

b. For new facility construction/renovation projects, existing equipment assets will be considered as the first source of supply. All assets in the old facility will be transferred to the new facility unless a valid reason for not doing so is provided and approved. Justification for new equipment required in new facilities will indicate that existing assets have been considered and found to be unacceptable. Criteria to be used for planning equipment requirements for new facility projects are contained in SB 8–75–MEDCASE.

4–14. Competitive acquisition of equipment

DOD policy requires that acquisitions be made on a competitive basis to the maximum extent possible. MEDCASE acquisitions must adhere to this policy by ensuring that minimum essential specifications are identified for competitive purchase of the item. If the activity's evaluation of the equipment requirements reveals a genuine need for sole source purchase, supporting documentation must be provided to the contracting officer clearly substantiating that only the sole source item meets the Government's minimum needs. This determination must be made by the user of the item.

4–15. Physical examination and troop medical clinic equipment for the Reserve Components

Selected USAR centers, ARNG STARCs, ARNG medical units, and ARNG training sites may be authorized to provide physical examination and/or health clinic support to RC personnel. Health clinic operations may be required to support AT periods. Equipment to perform this TDA-type mission may not be available from the activity's authorized MTOE equipment. Investment equipment authorized to provide this support will therefore be obtained through the MEDCASE funding program.

a. Requests from USAR centers to initiate a physical examination program or establish a health clinic operation will be approved by FORSCOM in accordance with AR 40–501. Requests from ARNG activities will be approved by the NGB in accordance with the appropriate NGB directive.

b. FORSCOM and the NGB will establish criteria to determine when equipment is required to provide physical examination and/or health clinic support.Criteria will be concurred with by HQDA (DASG–PSZ). Initial approval of the physical examination or health clinic mission does not, in itself, authorize equipment. Authorization for specific equipment will be based on availability of examination/health care resources at other Federal health care facilities and cost comparisons with civilian sources.

c. FORSCOM and the NGB will maintain a list of recommended equipment items for use in the clinic physical examination program or health clinic operation. The list will be reviewed annually by HQDA (DASG–PSZ). The list of equipment recommended for ARNG physical examination station use and detailed procedures for securing authorization of physical examination and TMC equipment are published in the SB 8–75 series (SB 8–75–S10).

d. The requesting USAR center or ARNG activity will prepare a list of the equipment required to support the mission and forward it to their parent command.

e. Equipment for the USAR will be accounted for on the ARCOMs or GOCOMs USAR center TDA or USAR technicians group

TDA and property records. Equipment for the ARNG will be accounted for on the ARNG STARC or ARNG training site TDA and property records.

f. Requisition or procurement support for approved items will be obtained from the MEDDAC or MEDCEN providing medical logistics support to the USAR or ARNG activity or other approved support activity.

4–16. Acquiring diagnostic imaging equipment

USAMMA will—

a. Receive and process all requisitions and PRs for approved diagnostic imaging systems and major components.

b. Monitor and provide assistance during the development, requisitioning, contracting, and acceptance stages of the acquisition.

c. Approve or disapprove requests for local acquisition of major imaging systems.

4–17. Furniture and furnishings for new health care facilities

a. Furniture and furnishings acquired for new health care facilities will—

(1) Create a functional environment with a pleasing appearance conducive to patient care. This includes all areas where patients are present.

(2) Maintain efficient use of space.

(3) Create an environment that reduces stress on patients and increases efficiency of employees.

b. See SB 8–75–MEDCASE for detailed guidelines.

Section III
Property Management

4–18. Property accountability

a. MEDCOMs and command surgeons will establish installation property books at all AMEDD activities operating under a TDA. The Army Medical Department Property Accounting System (AMEDDPAS) will be used. See the AMEDDPAS users manual, ADSM 18–HL3–RPB–IBM–UM, for specific procedures on this system. (See the glossary, sec II, for definitions and dollar thresholds for expendable, durable, and nonexpendable materiel.)

b. All nonexpendable equipment on hand or in use at the activity will be accounted for in accordance with AR 710–2, DA PAM 710–2–1, and this regulation. All Class VIII nonexpendable equipment (medical items valued at $500 or more that retain their original identity and are not consumed in use and nonmaintenance significant medical furniture (FSCs 6520,6525, 6530) items valued over $1,000) will be accounted for in accordance with this regulation.

c. Items coded expendable, regardless of price, will not be accounted for using property book procedures except in cases where other characteristics of the item clearly indicate that this level of control is required (for example, negotiable media—credit cards).

d. Expendable and durable maintenance significant items of TDA activities will be accounted for in accordance with AMEDDPAS.

e. Reportable items will be accounted for using property book procedures.

f. AMEDD activities will account for automated data processing equipment(ADPE) to include tier III equipment in accordance with AMEDDPAS.

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

h. All items on AMEDDPAS property books will be identified by bar code labels to improve inventory accuracy.

4–19. Loan of medical equipment

a. The commander of the MTF may temporarily lend medical equipment when needed for the treatment of specific disease or injury. Approved loans will normally not exceed 1 year in duration. Requirements for equipment expected to exceed 1 year in duration should be coordinated with the local adviser for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)to determine whether the equipment should be lent, leased, or the patient referred to the CHAMPUS program, depending upon which alternative represents the least cost to the Government.

(1) Property lent will be identified as Military Medical Benefits Property(MMBP).

(2) Such loans are restricted to persons who are authorized care under AR 40–3 and DOD 6010.8–R.

(3) MMBP equipment is equipment that is medically required for treating illness or injury. It improves the function of a malformed body member or retards further deterioration of a patient's physical condition. MMBP equipment is not useful to any person in the absence of illness or injury and is primarily and customarily used to serve a medical purpose rather than primarily for transportation, comfort, or convenience. The equipment can withstand repeated use; provides the medically appropriate level of performance and quality for the medical condition present (that is, nonluxury, nondeluxe); and consists of other than eyeglasses, spectacles or other lenses, optical devices, hearing aids, or communication devices.

b. MMBP for loan to eligible patients receiving care at an AMEDD facility may be obtained from property book equipment on hand, requisition, local purchase, or rental. Medical facility commanders will consider all resources available to them before issuing a DD Form 2161 (Referral for Civilian Medical Care) for cooperative care. These resources include excess items, assets on hand, lateral transfer, leases, and purchases.

c. MMBP for loan to eligible retirees or dependents receiving care from civilian sources is authorized.

d. Stock fund owned assets will not be lent as MMBP; they must first be purchased through the property account using consumer funds.

e. Loans will be made to eligible patients upon presentation of a written prescription or letter. It must be signed by a licensed physician, dentist, or other person authorized by regulations to prescribe treatment.Prescriptions or letters signed by prescribers not assigned to the MTF must be reviewed and countersigned by an appropriate staff member. Procedures for filling such requests will be established locally by the MTF commander. These procedures should specify an expiration or review date of the prescription or letter.

f. MMBP loan procedures are as follows:

(1) Activities on version 9.5 of AMEDDPAS will use the automated hand receipt for issue of MMBP equipment. Manual procedures, described below, will only be used if an activity is not on version 9.5 of AMEDDPAS or during times when the system is not functioning.

(2) MMBP 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 (SSN) of the borrower.

(b) DA Form 3161 will have, in addition to a listing of the equipment lent, the suggested statement shown in figure 4-1 at the end of this chapter.

(c) DA Form 3161 will be prepared in duplicate and signed by the patient or sponsor accepting the loan. The original copy of the form, with the written prescription or letter, will be kept by the MMBP manager, who will review the loan at least once each year. The second copy will be given to the borrower.

g. A DA Form 2409 (Equipment Maintenance Log(Consolidated)) or AMEDDPAS equivalent will be established for medical equipment requiring preventive maintenance or repairs. The log will be retained by the supporting medical maintenance activity. It is used to determine parts support, man-hour costs, and future replacement of the MMBP item.

h. Recovery of MMBP is handled as follows:

(1) MMBP that has been lent will be turned in to the property book officer(PBO) or MMBP manager when no longer needed. Commanders will establish local procedures for these actions.

(2) When MMBP is returned in a damaged or unserviceable condition, through causes other than fair wear and tear, action will be taken according to AR 735–5.

(3) If all efforts to regain physical or constructive control of lent

MMBP fail, relief from property accountability and responsibility will be obtained through procedures contained in AR 735–5.

i. Health care activity commanders may authorize the transfer of MMBP on loan to patients, when continuous use during the move and/or continued use at the new duty station is professionally indicated. The losing MMBP PBO is responsible for coordinating and effecting the transfer of loaned MMBP to the treatment facility assuming responsibility for care and treatment. DA Form 3161 will be prepared for this type of transfer and maintained on file by the MMBP PBO. Lateral transfers of this type will not be posted to a stock record account or reflected as a stock fund transaction.

j. MMBP reconciliations are handled as follows:

(1) The physical inventory of MMBP on loan is not required. However, equipment will be reconciled each year to verify the accuracy of property book and hand-receipt balances.

(2) The MMBP manager will do the reconciliation.The following procedures apply:

(a) Send DA Form 3321 (Request for Acknowledgement of Loaned Durable Medical Equipment), or AMEDDPAS Automated Hand Receipt with a memo by mail to the borrower, to acknowledge possession of MMBP on loan.

(b) Complete all items on the form except Condition of Equipment, Date Borrower Signs, and Telephone Number of Borrower.

(c) Furnish penalty window envelope for reply.

(d) Upon receipt of acknowledgement, file DA Form 3321 behind the appropriate DA Form 3161 as evidence of annual reconciliation.

(3) Reconciliations not received from eligible borrowers within 30 days following the mailing date will be repeated by certified mail. If no response is received from the second letter, action will be initiated to drop accountability in accordance with AR 735–5.

4–20. 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.

b. Medical supply OMA 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 in sufficient detail to meet audit requirements and notification of the patient in the event 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, SSN, manufacturer, make, model, and serial number of the device, requisition number, and date implanted.

d. The reporting and tracking requirements of the SMDA contained in 21 CFR apply.

4–21. Retention of medical materiel by military patients after separation

a. Military patients, upon separation from the Armed Forces, may retain medical equipment or appliances, if required for their comfort and safety.

b. Issue procedures will be established by the health care activity commander. Requests for issue will be submitted to the responsible PBO.

(1) The PBO will prepare DA Form 3161, listing equipment being issued.Block 2 will show the complete name, grade, SSN, and home of record of the recipient of the property. The medical circumstances necessitating the issue will be noted after the last item issued in block 12.

(2) The DA Form 3161, signed by the patient acknowledging receipt of the property, will be used as a voucher to drop the equipment from the property book record.

c. When equipment issued according to this paragraph requires shipment, it will be shipped by Government bill of lading at no cost to the recipient.

4–22. Medical equipment on loan between U.S. Army organizations and other activities

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

b. Emergency loans of medical equipment to other local government or civilian health care facilities may be made as determined by the commander of the MTF and as described in AR 700–131. The loan may not exceed 15 days without parent command approval.

c. Borrowing equipment from aviation organizations is not authorized unless specifically approved by HQDA (DASG–LO).

d. See AR 700–131 for other policies on lending medical equipment.

4–23. Loan of Defense Logistics Agency stock fund nonexpendable medical materiel

a. DLA materiel may be lent to the Army to meet contingencies listed in AR 37–1.

b. USAMMA is designated as the Army activity to approve and process requests for loan of this materiel. Processing procedures are outlined in AR 700–49/DLAR 4140.27/AFR 400–52/MCO 4443.10.

4–24. Transfer of specialized equipment with specialists

a. The AMEDD mission calls for many highly specialized personnel. These specialists require specific equipment to perform their duties. Health care activity commanders may authorize the transfer of this equipment to the specialist's new duty station if the gaining unit has a need for the equipment and the specialist will be performing services using the equipment at the new duty station. Supplies and repair parts peculiar to the specialty equipment may be transferred with the basic equipment. This authority is intended to reduce excesses at the losing activity and avoid funding unnecessary equipment acquisition at the gaining activity.

b. If requested, the PBO will ship this equipment.These items will not be formally turned in to the IMSA or posted to the stock record account.Transfers will be posted to the appropriate property books in accordance with lateral transfer procedures contained in AR 710–2 and DA PAM 710–2–1. Supplies on hand in the IMSA that will no longer be required to support the transferred equipment will be transferred to the gaining IMSA. Use normal stock record accounting procedures in DA PAM 710–2–2 for this transaction.

c. This transfer authorization applies only to intra-Army transfers. Interservice transfers or transfers to civilian agencies must be done in accordance with DOD 4160.21–M.

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

e. Prescription surgical loupes will be transferred with the individual for whom prescribed, and accounted for as outlined for special measurement clothing and footwear in AR 700–84. Upon departure from the Service, the individual may purchase them at cost minus depreciation.

4–25. Managing excess medical materiel on property books

Excess medical materiel on property books will be reported according to the procedures in chapter 3. Additionally, the following procedures apply:

a. The PBO will have equipment inspected by the supporting medical maintenance activity. Qualified medical maintenance personnel will condition code equipment according to DOD 4160.21–M and AR 725–50.

(1) Unserviceable items that are not economically reparable will be disposed of in accordance with chapter 3, section VIII.

(2) Serviceable or economically reparable items will be screened for possible use within the activity.

(a) If an item can be used, issue it on hand receipt to the requesting activity. When such issue satisfies a MEDCASE Program requirement, delete the requirement from the MEDCASE Program.

(b) If an item cannot be used, report it for excess action according to chapter 3, section VII.

(3) Condition coding of excess ARNG medical materiel by qualified medical maintenance personnel is required only if that materiel is excess to State requirements and is to be reported to the NGB. If qualified medical maintenance personnel are unavailable within the State, support may be requested from the USAMEDCOM activity with area support responsibility. (Also see para 3–42.)

b. Transactions will not be posted to the stock record account or reflected as FIA or stock fund transactions. The property manager will coordinate transfers of investment equipment with USAMMA to ensure an update of the MEDCASE Program.

4–26. Reporting unsatisfactory equipment

Equipment reported to the property management officer as unsatisfactory will be processed through the supporting medical maintenance activity. If the condition is not remedied, details will be reported to the IMSA for medical materiel complaint processing according to chapter 3, section XI.

4–27. Exemption of medical equipment from requirements of AR 700–43/DLAM 4215.1/NAVSUP PUB 5009/AFM 78–9

Equipment in use in fixed health care facilities and the U.S. Army Environmental Hygiene Agency is not considered industrial plant equipment. It will not be reported nor accounted for under AR 700–43/DLAM 4215.1/NAVSUP PUB 5009/AFM 78–9.

4–28. Equipment management during medical evacuation

a. Peacetime procedures.

(1) *Originating (source) medical facility.* When required to provide nonexpendable equipment for nursing care during evacuation, the facility medical evacuation coordinating officer will notify the PBO to prepare the necessary property accountability documents.

(a) The hand-receipt holder will request that the PBO prepare a DA Form 3161 under DA PAM 710–2–1 for temporary hand receipting of property. The following statement will be included on the form:

> The property described above is to accompany *(patient name and SSN)* during medical evacuation from *(name of facility)* to *(name of facility)*. Property is to be returned to *(name and address of facility, include DODAAC)*upon arrival at destination. Authority for this action is AR 40–538/BUMEDINST 6700.2B/AFR 167–5 and AR 40–61.

(b) The PBO will provide the facility medical evacuation coordinating officer with a minimum of three copies of the DA Form 3161 to accompany the patient.

(c) The PBO will update the appropriate hand-receipt records, establish a suspense copy of the transaction, provide a copy of the form to the IMSA as advance notification of the return shipment, and mail a copy of the form to the destination medical facility PBO. The destination medical facility PBO may be notified by message if the originating medical facility requires expeditious return of the equipment.

(d) Upon receipt of the equipment, the PBO will withdraw the suspense copy and make the appropriate postings to hand receipts.

(2) *Destination medical facility.* Upon arrival at the destination medical facility, the equipment accompanying the patient will be turned in to the IMSA with the DA Form 3161 for return shipment to the originating medical facility. The turn-in will not be posted to the accountable supply records; however, a record of turn-ins and shipments will be maintained.

b. Contingency, humanitarian, and peacekeeping operations procedures.

(1) *General.* Critical, nonexpendable AE equipment requires special management as it accompanies seriously ill patients through medical evacuation channels and then through logistics channels, where it is serviced and returned to the user. Supervisory responsibility as outlined in AR 735–5 applies to every person involved in managing AE equipment.

(2) *AE equipment system.* The flow(loop) for AE equipment begins at the originating MTF in the AO, continues to the final destination MTF, proceeds to the AE equipment collection point (CP), and returns the AE assets to the originating MTF in the AO.

(3) *AE equipment management.* Continuous visibility of these assets ensures their timely return to the user.

(a) Within the AO. In country, the MEDLOG battalions, MTFs, evacuation units, or other users of AE equipment issue these assets from stock records or from the PBO releasing the patient. The issuer of AE equipment will prepare a DA Form 3161 identifying AE equipment transferring with the patient. A copy of the DA Form 3161 will be placed in the patient's medical records. Another copy will be forwarded to the losing unit's accountable officer. In addition, the losing activity's accountable officer will make the following entry in a locally maintained log or document register: "Issued for Medical Evacuation." This log provides a record for audit purposes.

(b) Medical regulating offices. The medical regulating system provides visibility for the next stage of the AE equipment system. The medical regulating office that influences the final destination of patients codes the AE equipment as a data element, transmits this information via medical regulating office communication channels, and notifies the patient administration division office (PAD) at the final destination MTF that patients with AE equipment are inbound.

(c) Final destination MTF. The PAD notifies the medical logistics office that AE equipment is expected or has arrived. The medical logistics office takes possession of the AE equipment and reports and ships the assets to the AE equipment CPs.

(d) CONUS/OCONUS AE equipment CPs. USAMMAs Medical Maintenance Operations Division, Tobyhanna Army Depot, is the CONUS CP(East). USAMMAs Medical Maintenance Operations Division, Defense Distribution Region West—Tracy, CA, is the CONUS CP (West). The U.S. Army Medical Materiel Center, Europe (USAMMCE) is the CP for Europe. The CPs, in coordination with USAMMA, track and give disposition instructions for AE assets that arrive at MTFs; mark, store, and maintain AE equipment in their possession; and return AE equipment to the AO.

c. Wartime procedures.

(1) *Implementation.* Implementation of this procedure is effective upon direction by the Secretary of the Army to implement the wartime accountability procedure in AR 710–2.

(2) *Originating medical facility.*

(a) The facility medical evacuation coordinating officer will notify the PBO when nonexpendable equipment is required for patient evacuation.

(b) The PBO will prepare a DA Form 3161 to document the posting of the property book for all equipment transferred with patients. A copy of the admission and disposition sheet showing the patients evacuated will be attached as the authority for the action.

(c) Replacement equipment will be acquired by submission of a routine supply request to the supporting medical supply activity.

(3) *Destination medical facility.* Nonexpendable equipment will be turned in to the accountable supply officer as excess air evacuation property. The accountable MSO will process this excess in accordance with instructions in chapter 3 for air evacuation items.

4–29. Property accountability in TOE units

a. Accountability for organizational and CTA authorized equipment in TOE units will be in accordance with this regulation, AR 710–2, and DA PAM 710–2–1.

b. Separate property books will be maintained down to parent UIC level.Medical brigades, medical groups, etc., may collocate property books as long as separate books are maintained by the parent UIC. Parent UICs end in"AA."It is necessary to maintain this level of unit integrity to support individual unit deployments, separate from the medical brigade or group.

c. Property responsibility will be assigned down to the level of use. For example, in hospital units, property will be hand receipted from the PBO to the first line supervisor, or end user, as the primary hand-receipt holder.It is improper to hand receipt all unit property to one person, such as the company commander.

I hereby acknowledge acceptance of the above listed Government-owned equipment received in good working order and repair, for temporary use during the period ***(date)*** to ***(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 required to be performed ***(frequency).*** Service is required ***(dates)***. When feasible, it is my responsibility to transport the equipment to ***(MTF)*** to obtain the required services. Prior arrangements for services should be made by telephoning ***(number)***. If I relocate to another area and will receive medical care from another Federal health care facility, I must notify ***(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 ***(MTF name).***

(Signature of patient or sponsor)

Figure 4-1. Statement acknowledging receipt of MMBP equipment

Chapter 5
Managing Medical Assemblages

Section I
Medical Assemblages Management Guidance

5–1. Overview
This chapter prescribes policy and provides procedures for the issue, turn-in, accounting, storage, and reporting of medical assemblages. AR 40–60 delineates specific responsibilities and procedures for the development and revision of medical assemblages.

5–2. Operational controls
a. The AMEDDC&S will design, develop, update, and recommend the composition of medical assemblages except medical resupply sets (MRSs), medical supply planning modules (MSPMs), and optical resupply sets (ORSs) that are developed by USAMMA. Actions relative to DEPMEDS MMS or DMS will be accomplished by the DMSB.

b. USAMMA coordinates requirements with the DPSC.USAMMA performs staff management actions as directed by TSG and as delineated in AR 40–60.USAMMA, as the mission assignee agency, will develop requirements; OTSG will coordinate for programming and budgeting from the proper appropriation (OMA, OMAR, OMNG, OPA, or Stock Fund) for procurement of newly developed or significantly revised medical assemblages and for ASIOE.

c. MACOMs (in addition to ARCOM and the NGB) are responsible for requisitioning, storing, and maintaining those medical assemblages and equipment authorized to be on hand in TOE units or TDA activities. MACOMs will use consumer funds for programming and budgeting for replacement of consumable and expense equipment components and for minor changes to medical assemblages on hand at TOE units.

Section II
Medical Equipment Sets

5–3. Identifying medical equipment sets
There are two categories of MES: Service-unique and multiservice.

a. Service-unique MES. This set consists of a grouping of medical and nonmedical items under a single stock number that is managed by AMEDD and used primarily by the Army. These assemblages are identified by a four-character numeric UA number.

b. Multiservice MES. This set consists of a grouping of medical and nonmedical items under a single stock number that is monitored by the DMSB and used by multiple Services. These assemblages are identified by a four-character numeric UA number. The first character for these specific sets will always be "7."

5–4. Composition of medical equipment sets
a. Components of Service-unique MES, to include ASIOE, are determined by the AMEDDC&S and are approved by TSG. Component authorizations are published in MES computer listings/floppy disks available from USAMMA and in the appropriate supply catalogs (SC 6545–8 series). Revisions to components are published annually in the SB 8–75 series and are reflected in current year computer listings/floppy disks with ASIOE provided for information only. Publication of component authorization changes in the SB 8–75 series and/or a current year MES computer listing/floppy disk constitutes authority for updating assemblages by respective units and serves as the authorization document of assemblage components. Commanders will request a current MES listing/floppy disk annually by writing a letter to USAMMA (SGMMA–OCU). The request should identify the activity's UIC and UA number, nomenclature, and LIN or NSN for each MES required. This original USAMMA disk must be copied to the unit's hard drive and the USAMMA disk be retained as the official record.

b. The responsibility for resupply set development is determined by the following criteria:

(1) The AMEDDC&S will develop resupply sets for Service-unique SKOs. These sets will normally be called Prepackaged Resupply Sets (PRSs) and are intended to resupply the SKOs from which they were developed (that is, PRS, Trauma (2) would resupply the Trauma (2) SKO).

(2) USAMMA will develop resupply sets for a given force type such as division, armored cavalry regiment, or brigade. These sets will normally be called Recommended Stockage Lists (RSLs), which are used for contingency planning. In order to provide mission specific support, the activity/MACOM is authorized to add or delete items and to adjust the allowances for existing items in the

RSL. Under current policy, these RSLs will *not*have a LIN number assigned and thus will *not* be authorized by TOE/MTOE. In addition, since these are planning SKOs and not authorizations, supply catalogs will not be published for RSLs.

c. Components of multiservice MES are monitored by the DMSB and approved by multiservice concurrence. Changes to these sets are published annually in the SB 8–75 series.

d. Activities may recommend changes to components of MES. Recommendations with justification for changes to Service-unique sets will be submitted through channels to the AMEDDC&S (HSMC–FCO–S). Recommendations for multiservice sets will be submitted, with justification, to the DMSB, Fort Detrick, Frederick, MD 21702–5013. Recommendations for changes to MRSs and ORSs will be sent to USAMMA (SGMMA–R).

e. The stated number of days of supply listed in the supply catalog or a UA listing for an SKO constitutes the minimum basic load to sustain that SKO.

5–5. Requisition, issue, and turn-in of medical equipment sets

a. Authorized Service regulated MES will be requisitioned according to chapter 3. These MES will be billed at the standard price of the components packed, plus the cost of the actual labor and materials associated with packing the MES. Medical equipment items listed individually on MTOE and assigned a LIN (OPA funded capital investment equipment) will also be requisitioned according to chapter 3.

b. Authorized MES that are not Service regulated will be requisitioned through the supporting IMSA (USPFO for the ARNG) or MEDLOG battalion SSA to the wholesale supply system. Multiservice medical sets and kits that are not Service regulated will be billed at the standard unit price for the set. The standard unit price for the set is the standard unit price of all authorized components plus 15 percent for estimated cost of labor and materials to pack the set.

c. If components of Service regulated sets are not available at the time of initial shipment, DPSC will provide the requisitioner with a list of shortages by stock number and quantity. USAMMA will provide initial shortage package within 12 months. Remaining shortages must be requisitioned and funded by the requesting unit.

d. The issue of Service-unique medical sets to Active Army units is as follows:

(1) Equipment and MES listed in the authorized column of Active Army TOE or MTOE units will be either on hand or on requisition according to AR 310–49 and AR 710–2.

(2) MTOE units equipped below Level 1 will be issued a new MTOE authorization when notified of deployment. A new MTOE authorization up to Level 1 will enable the unit to immediately requisition equipment and supplies required to attain Level 1 readiness.

e. The issue of MES to ARNG and USAR will be as follows:

(1) The appropriate MACOM will control the authorization and issue of medical equipment and MES to ARNG and USAR MTOE units.

(2) Equipment for training will be issued to ARNG and USAR MTOE units organized at reduced authorized level of organization (ALO) or those not capable of storing and maintaining medical equipment. Whenever possible, equipment for training will be that portion of TOE equipment that the unit can store and maintain and that is needed for training.

(3) Specific authorization policy for ARNG and USAR MTOE medical units is contained in AR 310–49.

(4) When MTOE authorized equipment is issued, units will dispose of medical training sets and equipment either under AR 220–10 or as directed by the MACOM.

(5) Controlled medical items (that is, scheduled drugs), shelf life items, and refrigerated items will not be issued with a Service regulated MES to ARNG and USAR units until those units are designated as Active Army units.Nonservice regulated MES may be issued by DLA with controlled or deleted items. When received locally, these items will be withdrawn and turned in.

f. The turn-in of medical sets is as follows:

(1) Sets will be turned in when excess. MES shortages will be listed and attached to the turn-in document. Components will not be requisitioned to fill shortages in an excess MES. The commander authorizing turn-in will enter in any available space the statement shown in figure 5–1:

Action required by AR 735–5 was initiated, where necessary. This materiel has been released by the appropriate authority.

(Commander's signature and date)

Figure 5-1. Excess medical set turn-in statement

(2) IMSAs will report excess Service regulated MES to USAMMA. USAMMA will provide disposition instructions on a timely basis. Nonservice regulated MES that are serviceable will be reported to the DPSC for disposition (chap 3).

5–6. Accounting for components of medical equipment sets

a. Commanders of TOE units will establish and maintain records as follows:

(1) Units utilizing manual property accounting procedures will establish property account records on each authorized nonexpendable item in accordance with DA PAM 710–2–1, paragraph 4–29.

(2) Those expendable or durable (accounting requirements code (ARC) X or D)medical items in hand-receipt supply catalogs (SC 6545–8–CL–HR series) or part of USAMMA assembly listings need not be accounted for under the inventory provisions of AR 710–2, chapter 2, and DA PAM 710–2–1, chapter 6. These items are listed in the supply catalog or assembly listings for the purpose of identifying authorized component quantities. SKO components will be inventoried against the current assemblage configuration at least every 6 months (12 months in RCs) to assure readiness and maintain informal accountability. This inventory may be performed in conjunction with other required inventories as long as the inventory meets the requirements stated above and is recorded as indicated in the following subparagraphs. A viable quality control program for all dated items will also be established as discussed in chapter 2.

(a) Manual procedures using SC 6545–8–CL–HR series. For assemblages with published hand-receipt supply catalogs(SC 6545–8–CL–HR series), units will use the preprinted hand-receipt lists provided to record the results of inventories and maintain accountability. The items listed in Section III of the SC 6545–8–CL–HR series, beginning with Page III–03, are ASIOE end items dedicated to the operation and/or maintenance of the medical assemblage. The ASIOE are separately documented on TOE/MTOE/TDA and are not to be considered components of the medical assemblage. They are listed in Section III for information purposes only and do not constitute an additional authorization. Total authorization is reflected on the unit's MTOE. The ***2 indicators will still be reflected in the Remarks column of the Section III report noting these items will appear in Section II of the UA List. The items on this report with ***2 indicators will no longer appear in the Section II hand-receipt portion of the supply catalog. A DA Form 4996–R will be prepared and maintained for shelf life items.

(b) Manual procedures using DA Form 4998–R. Units will prepare a DA Form 4998–R (Quality Control and Surveillance Record for TOE Medical Assemblage) for each expendable and durable item in the medical assemblage. The quantity on hand column will reflect the results of the most recent inventory and the Date Last Inspection column will reflect the date of the inventory. Units will also use the DA Form 4998–R to record and manage quality control

information. DA Form 4998–R will be reproduced locally on 8- by 5-inch card stock. A copy for reproduction is located at the back of this regulation.

(c) Automated procedures. DA approved automated medical materiel management systems that provide assemblage management and quality control capabilities will be used in lieu of DA Form 1296 and DA Form 4996–R.

(3) Elements of MTOE hospitals and DMSOs will accomplish the following for ASL items in anticipation of their resupply mission. (See para 3–7*b* for determining ASL.)

(a) Establish a DA Form 1296 for each item for which demands are expected.Use the component listing of authorized MES and CTA 8–100 as a guide.Detailed instructions for using stock accounting records are in DA PAM 710–2–2. These forms, with support records, will be used to informally manage supply activities upon mobilization. Advance preparation will enhance operational readiness upon mobilization or deployment.

(b) Establish a DA Form 4998–R for each medical item that has a shelf life and for which demands are expected. This form will help in managing quality control actions required by chapter 2.

(c) DA approved automated medical materiel management systems providing inventory management and quality control capabilities will be used in lieu of DA Form 1296 and DA Form 4996–R.

b. TOE units authorized to operate a formal stock record account (for example, SSAs) will maintain accountable records in accordance with AR 710–2. DA approved automated medical materiel management systems that provide inventory management and quality control capabilities will be used to manage the accountability and quality control functions.

Section III
Medical Materiel Sets

5–7. Identifying medical materiel sets

a. An MMS consists of a grouping of medical and non-medical items under a single stock number monitored by the DMSB and used to compose the DEPMEDS.

b. These assemblages are identified by a four-character UA number. The first character for these specific sets is an alpha character. The alpha character determines the specific UA fielded to a unit.

5–8. Composition of medical materiel sets

a. DEPMEDS is a multiservice managed system with components monitored by the DMSB and approved by multiservice concurrence. Component authorizations are published in MMS computer listings available from USAMMA and in the appropriate supply catalogs (SC 6545–8 series). Revisions to components are published annually in the SB 8–75 series and are reflected in current year computer listings.

b. Commanders of DEPMEDS units will continue to utilize the UA list initially fielded with the unit until authorized for update by USAMMA. This may result in the use of several UA listings with different dates for different assemblages until a single current-year update is provided by USAMMA.

c. The DMSB will develop DEPMEDS Medical Supply Sets to support MMS configured to level 3 and 4 hospitals. The patient stream/load that determines the hospital supply sets will be provided to the DMSB by the AMEDDC&S.

5–9. Requisition, issue, and turn-in of medical materiel sets

a. All MMS and DMS are Service regulated.

b. Requisition and issue of DEPMEDS units is accomplished under the Army's total package fielding (TPF) method. Procedures are outlined in paragraph 5–11.

c. Units will report excess MMS and DMS to USAMMA(SGMMA–R). USAMMA will provide disposition instructions. MACOMs will not cross-level medical equipment components of excess sets.

5–10. Accounting for components of medical materiel sets

a. Commanders of DEPMEDS units will establish and maintain records according to paragraph 5–6.

b. DEPMEDS equipped units will be inventoried against the UA list fielded with the unit until authorized by USAMMA to use the current assemblage configuration.

5–11. Total package fielding

a. TPF is the Army's method of fielding in which the system or end item and all required support materiel is identified, consolidated into a single package, funded, and deprocessed by the fielding command responsible for fielding medical systems or end items under total package concepts. AR 700–142 and DA PAM 700–142 explain the policies and procedures required for TPF.

b. USAMMA is the OTSG agency responsible for the fielding of medical materiel systems.

(1) USAMMA will requisition all major medical end items, medical ASIOE, and some nonmedical ASIOE required for the TPF of the medical systems.Organizational support equipment will be requisitioned by the gaining unit/MACOM.

(2) USAMMA will provide shortages recorded during the hand-off/fielding process. The shortages are normally in two categories:

(a) Category 1 is major items of OPA funded medical ASIOE and some nonmedical ASIOE.

(b) Category 2 is other expendables, durables, and nonexpendables that are components of MMS and MES.

(3) USAMMA will provide both category 1 and 2 shortages either under the ship-short program or another alternative method as determined by the Commander, USAMMA.

c. Materiel fielding teams (MFTs) are teams established by the fielding command, USAMMA, to accomplish specified tasks in conjunction with fielding of the medical system or end item using TPF techniques as outlined in DA PAM 700–142. The MFT will deprocess, conduct joint inventories, and complete customer documentation packages to name a few of the functions outlined in DA PAM 700–142. By no means will the MFT perform gaining command functions, but instead will help to ensure an efficient and effective fielding operation.

d. Customer documentation packages are those documents required by the gaining unit and support activities to post receipts or due-ins and to update SSA accountable records, property books, and financial records. The MFT, as directed by USAMMA, will prepare and provide documentation to the gaining unit/MACOM for each item of materiel to be handed off.

e. USAMMA will continue to support the fielded unit after the initial fielding. Updated status for all due-ins after the fielding of the medical system or end item will be provided to the unit/MACOM by USAMMA.

Section IV
Maintenance and Management of Medical Assemblages

5–12. Maintenance of medical assemblages

a. General. TOE unit commanders authorized MES are responsible for maintaining the component equipment and supplies of such sets.

b. Supply maintenance. USAMMA will, on request, furnish up-to-date medical assemblage listings to unit commanders. These listings reflect current medical assemblage configurations and authorizations approved by TSG. Commanders will requisition newly authorized components of medical assemblages while taking into consideration authorized substitutions.Consumable and expendable equipment will be funded locally. Newly authorized medical assemblages, and capital investment equipment identified by a"Q"in the second digit of the MCSC in the AMDF, are funded centrally by USAMMA.

c. Equipment maintenance. Commanders are also responsible for appropriate maintenance checks, services, and tests on MES component equipment items as specified in applicable technical manuals or manufacturer's operating instructions. Selected medical equipment

items are reportable under Unit Status Report (USR) procedures. These items of medical equipment are not necessarily components of medical assemblages. AR 700–138 identifies all such reportable equipment.

5–13. Equipment on hand readiness computation requirements

a. General. This policy applies to all equipment readiness code (ERC) P (pacing) and A medical assemblages designated as either an SKO, MES, MMS, DMS, or DES. The computation procedures that follow are intended to ascertain whether a medical assemblage is sufficiently complete to be used for its intended purpose according to AR 220–1 and if the assemblage should therefore be counted as on hand.

b. Applicability.

(1) For purposes of monthly USR equipment on hand(EOH) computations, all echelon one and two medical units and those echelon three medical units that are forward-deployed or belong to Support Package one or two of the Contingency Force Pool (CFP) will base their medical assemblage EOH computations on 100 percent of the authorized components of reportable sets, including potency and dated (P&D) items.

(2) All other echelon three and four medical units, including Caretaker and RC Hospitals, are authorized to exclude P&Ds from monthly EOH computations.

c. P&D materiel.

(1) In order to minimize the loss of shelf life items, commanders of CFP Support Package one and two units will arrange for rotation and storage of P&Ds with the IMSA. TOE units are required to budget for projected losses of consumable materiel that cannot be rotated.

(2) The IMSA will rotate and store these items for Support Package one and two units within existing capabilities. MEDDAC commanders, P&T committees, and MSCs will be involved to assure maximum MEDDAC use of items authorized in supported units' medical assemblages. Commanders will review actions of their P&T committees, focusing on the aggressive use of D-Day Significant items.USAMMA will periodically publish updated lists of D-Day Significant items in the SB 8–75 series.

5–14. Equipment on hand readiness computation policies

a. The EOH readiness computation procedures for medical assemblages outlined in appendix E will be used by commanders to determine if authorized medical assemblages are sufficiently complete to perform their intended missions.These computations will be performed each month as part of unit-level USR EOH computations.

b. Although EOH readiness computations for unit medical assemblages can be done by both manual and automated methods, manual computations are only feasible in nonhospital units. All hospital units are programmed to receive TAMMIS hardware and Medical Assemblage Management (MEDASM) software. Due to the complexity of hospital medical assemblages, hospital units will not be required to implement these computations until TAMMIS hardware and MEDASM software are fielded to the unit and are functional. Nonhospital units without TAMMIS may automate some of their computations by modifying Unit Level Logistics System S-4.

c. The EOH computations specified in this chapter do not replace the requirement for other accountability inventories outlined in AR 710–2.However, other periodic inventories may be used to support monthly EOH readiness computations. Such periodic inventories may include post field training inventories, change of command or hand-receipt holder inventories, or routine quality control actions.

d. Commands will not apply this policy to medical assemblages in prepositioned materiel configured to unit sets (POMCUS) or RC decrement stocks until these programs include reports with detailed component listings below the LIN level of detail. All other CONUS or OCONUS units authorized medical assemblages that remain under the owning unit's control will compute and report assemblage readiness according to this policy.

e. MACOMs are responsible for ensuring that units manage medical materiel according to this policy. This includes budgeting for consumable and P&D stocks necessary to maintain medical assemblages sufficiently complete for their intended purposes, as specified above.

f. Implementation of these EOH readiness computations is required within 6 months of the effective date of this regulation or, in the case of hospital units, within 6 months of completed TAMMIS and MEDASM fielding.

g. Because most MES components are nonexpendable or durable, and quality control activities closely monitor the expendable items, most MES readiness computations will change only slightly each month. Use of standardized worksheets will expedite and simplify these computations. (See app E.)

5–15. Loan of DEPMEDS equipment in support of projects at medical treatment facilities

a. This paragraph pertains to requests for HQDA owned/controlled DEPMEDS assets. It does not apply to USAR and NGB controlled assets. The equipment loaned under this program comes from stock funded AR stocks. Therefore, HQDA policy concerning the use of stock fund assets must be considered prior to fielding and use of required equipment. MACOMs are not required to obtain approval to use their own assets to meet peacetime mission requirements.

b. All requests will be submitted through command channels to the Logistics Directorate (DASG–LO), OTSG, the primary coordinating office. The requesting activity will—

(1) Ensure requests for loan of DEPMEDS equipment are submitted through command channels for MACOM approval normally 12 months in advance of need.The request will include quantity and type of equipment, length of time equipment is needed (normally not to exceed 10 months), any support requirements, and proposed site layout of the equipment. Local coordination and approval of the Director of Engineering and Housing is necessary to determine the best location and availability of utilities.

(2) Ensure that an economic analysis considering alternatives to resolve the impacts of construction accompanies the request. Alternatives should include relocation of services to existing buildings, lease of space or relocatable buildings, curtailment of services, use of other Federal facilities (other Services or Department of Veterans Affairs), and the use of DEPMEDS equipment.

(3) Ensure the request has been reviewed by the requesting activity's Quality Improvement Coordinator/Risk Management Committee and indicate patients will sign consent forms for any surgical procedures performed in DEPMEDS facilities. Coordination with the installation preventive medicine office will be made to assess water, solid, liquid, and hazardous waste management, sanitation, and radiation protection issues.

(4) Ensure the request states that local unit DEPMEDS equipment is not available. If local equipment is available, the requesting activity's MACOM will coordinate with the DEPMEDS unit's MACOM for permission to use the equipment. A concept plan will accompany the request. This concept will address issues concerned with the return of equipment to the providing unit to include maintenance and method of recovery. In addition, a plan will be developed in concert with the providing unit to meet contingency timeframes as required by AR 220–1, paragraph 3–7*b*(7).

(5) Ensure an estimate of site preparation and installation costs is included with the request and that funds are available to support the request. This is necessary to avoid delays once the use of DEPMEDS equipment is approved. The requirement for use of DEPMEDS equipment must be identified and programmed early in the budget cycle to ensure funding availability.

(6) Ensure standards for fire, safety, and operations, acceptable to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are considered in the final design layout.

c. MACOMs will—

(1) Coordinate and validate information on the requests to ensure a complete package with all required enclosures.

(2) Ensure funding is available.

(3) Recommend approval and forward to DASG–LO.

d. The Logistics Directorate (DASG–LO)will—

(1) Staff all proposed requests with the DEPMEDS Project Manager Office(DASG–HCP) and the USAHFPA (SGFP–ZA) to obtain concurrence.

(2) Resolve conflicts between offices.

(3) Provide final approval/disapproval.

e. SGFP–ZA will—

(1) Assist the activity in development of phasing plans and requirements for temporary facilities during the design and development process.

(2) Provide technical assistance on medically related space and utilities.

(3) Upon MACOM approval, review the proposal to confirm that it effectively supports the MILCON project.

(4) Recommend approval/disapproval.

f. DASG–HCP will—

(1) Review the requests to determine whether the equipment is available and that the action will not impact fieldings of DEPMEDS equipment to TOE units.

(2) Provide technical assistance to the requesting activity as required.

(3) Recommend approval/disapproval.

g. After the request is approved, USAMMA(SGMMA–R) will—

(1) Conduct the fielding in the same manner as a normal DEPMEDS fielding, to include prebrief, hand-off, and displacement.

(2) Prepare a loan agreement according to AR 700–131 between the gaining activity/MACOM before handoff of the equipment. The agreement will state that all DEPMEDS equipment will be maintained by the requesting activity's personnel and returned in serviceable condition.

(3) Provide disposition instructions to return the materiel to DEPMEDS project manager/USAMMA control upon completion of the project. Transportation and temporary duty funds will be provided by the requesting activity.

h. A complete loan request package consists of a covering memorandum and enclosures.

(1) *Memorandum.* The covering memorandum should address issues discussed in paragraph 5–15*b*(1), i.e., quantity and type of equipment required, duration of loan, support requirements, and local availability of equipment. Other information not defined as an enclosure in paras (2)(*a*) through (*e*) below may be placed in the memorandum.

(2) *Enclosures.*

(a) Enclosure 1: coordination with Quality Improvement Coordinator/Risk Management Committee (para 5–15*b*(3)).

(b) Enclosure 2: coordination with Preventive Medicine Office (para 5–15*b*(3)).

(c) Enclosure 3: economic analysis (paras 5–15*b*(2)and 5–15*b*(5)).

(d) Enclosure 4: concept plan (para 5–15*b*(4)).

(e) Enclosure 5: site layout package (paras 5–15*b*(1), 5–15*b*(5), and 5–15*b*(6)).

5–16. Newly developed medical assemblages

a. Newly developed or significantly revised medical assemblages will be issued to units in accordance with MFPs developed by USAMMA and coordinated with gaining MACOMs.

b. Turn-in procedures for assemblages becoming excess as a result of newly issued sets may be modified on a case-by-case basis by the individual assemblage's MFP.

c. Costs to gaining units will be dictated by the provisions in the MFP.

Chapter 6
Medical Equipment Maintenance

Section I
Maintenance Concepts

6–1. Maintenance elements

This chapter provides concepts and policies for the maintenance of medical materiel. It includes maintenance engineering and maintenance operations.

6–2. Maintenance policy

a. Materiel maintenance is a command responsibility. Each commander will provide for the maintenance of materiel issued to or under the responsibility of his or her activity to include the efficiency of programs established for this purpose. This includes medical equipment.

b. The medical maintenance function is limited to maintenance activities tasked by TSG, Army MEDCOMs, and command surgeons to support the AMEDD mission.

(1) Medical maintenance activities (such as MEDDACs, MEDCENs, MEDLOG battalions, and Regional Training Sites—Medical (RTS–MED)) will publish their external maintenance support procedures for use by customers.

(2) MEDLOG battalions will establish a support agreement with supported unit commanders. This agreement will define requirements of both the supported unit and the supporting activity for administration of a proactive medical equipment maintenance program.

(3) There will be only one TDA medical activity assigned a medical maintenance function on an installation except for installations where RTS–MED are located with other medical activities. Other exceptions must be approved by HQDA (DASG–LO).

c. Maximum coordination of medical equipment maintenance resources utilization will be accomplished between MACOMs possessing such capabilities.Formal agreements will be established with primary emphasis directed toward the achievement of a high state of unit readiness and attainment of maximum managerial and technical training of personnel.

d. Routine use of contract maintenance to perform unit through direct and general support maintenance is prohibited for materiel fielded under TOE. Use of RTS–MED is authorized as Government owned-contractor operated activities.

e. Scheduled periodic maintenance services take precedence over all but emergency repair requirements.

f. Maintenance services will be performed by the lowest level of maintenance with the capability, capacity, and authority to perform the service.Equipment overhaul will not be accomplished at unit level except as approved by Army MEDCOMs or command surgeons.

g. Maintenance engineering will be employed throughout the life cycle of medical materiel to ensure adequate logistics support. (See AR 700–127.)

h. Medical materiel acquisition policies and procedures will be employed to minimize logistics support requirements. (See AR 40–60.)

i. Each piece of medical equipment will be tested prior to initial use and at least annually thereafter. The testing will be documented.

j. Medical equipment in storage, including ARs and OPs, will be tested in accordance with TB MED 1. Medical equipment in TOE units, although temporarily stored (for example, between field training exercises) will be considered as equipment in use for scheduled periodic services. Procedures for equipment in use are stated in section II of this chapter. Equipment in use includes Medical Standby Equipment Program (MEDSTEP) and other equipment retained by the commander for discretionary use.

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

(1) TB 38–750–2 prescribes procedures for the preparation and management of forms and records by units without automation.

(2) The Army Medical Department Property Accounting System

(AMEDDPAS), ADSM 18–HL3–RPB–IBM–UM, is the automated maintenance management system for retail TDA activities.

(3) The Theater Army Medical Management Information System (TAMMIS), AISM 25–HKH–RZT–HPC–UM, is the automated maintenance management system for MTOE units.

l. ARNG specific maintenance policy is as follows:

(1) State maintenance officers are responsible for the coordination of medical maintenance support.

(2) Medical maintenance requirements beyond unit capabilities may be supported from the following resources, listed in priority sequence:

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

(b) USAMEDCOM organizations with area support responsibility (reimbursable basis). (See AR 5–9.)

(c) USAMMA maintenance divisions (reimbursable basis).

(3) Additional ARNG-specific medical equipment maintenance guidance is found in the SB 8–75 series.

6–3. Levels of maintenance

a. The AMEDD Maintenance System.

(1) Maintenance operations will be primarily based upon the policies contained in AR 750–1, AR 750–2, and this regulation. The levels for medical materiel are as follows:

(a) Unit.

(b) Direct support.

(c) General support.

(d) Depot.

(2) Specific objectives of the AMEDD Maintenance System are to—

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

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

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

(d) Optimize a philosophy of repair by replacement forward of the corps rear boundary.

(e) Integrate the forward support maintenance concept to maximize equipment in-service time.

(f) Establish equipment design criteria that emphasizes modular design of end items that will promote the following maintenance priorities: first, discard; second, repair forward; and third, evacuate and replace with MEDSTEP assets if available.

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

(1) *User or operator personnel.* Maintenance services performed by these personnel will consist of routine cleaning, preventive maintenance checks and services (PMCS) at specified intervals, and replacement of operator level parts. Technical manuals, manufacturer's literature, and local SOPs will be used as guides for operator/user level maintenance services. Replacement of parts will not require—

(a) Extensive disassembly of the item.

(b) Critical alignment or adjustment after replacement.

(c) Special tools.

(d) Maintaining stocks and records for demand supported parts.

(2) *Medical equipment repairers.* Maintenance services and functions performed by these personnel include—

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

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

(c) Performing unscheduled maintenance functions with emphasis on replacement of components and modules when available. As maintenance allocation charts (MACs) are published they will be used to determine specific actions at each echelon.

(d) Operating a repair parts program to include stockage of medical repair parts as well as other commodity class materiel and parts for medical equipment.

(e) Maintaining a file of technical manuals, technical bulletins, supply bulletins (SB 8–75 series), manufacturers' maintenance manuals, and parts listings for all equipment items maintained.

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

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

c. Direct support and general support.

(1) *Direct support.* This mission is characterized by—

(a) Providing all authorized maintenance functions that exceed the authority, capability, or capacity of unit maintenance.

(b) Providing unit maintenance to medical units within the combat zone(CZ) without an organic capability.

(c) Repairing direct support level components and/or modules.

(d) Providing onsite support to CZ medical units by means of mobile support teams (MSTs).

(e) Providing technical assistance to supported units.

(f) Fabricating minor repair parts when required to meet operational readiness requirements.

(g) Notifying the next higher maintenance level of requirements and/or evacuation of unserviceable equipment or higher maintenance level components and/or modules.

(2) *General support.* This mission is characterized by—

(a) Providing all authorized repair functions that exceed the authority, capability, or capacity of direct support units.

(b) Providing unit maintenance to medical units within the communications zone (COMMZ) without an organic capability.

(c) Repairing general support level components and/or modules.

(d) Providing onsite support to COMMZ units by means of MSTs.

(e) Providing technical assistance to supported units.

(f) Fabricating repair parts when required.

(g) Notifying the next higher maintenance support level of requirements and/or evacuating unserviceable equipment or higher maintenance level components and/or modules.

d. Depot. This mission is characterized by—

(1) Providing overhaul and rebuild of end items and components in support of the wholesale supply system and as "repair and return"actions.

(2) Performing special inspections, tests, and modification program actions.

(3) Performing maintenance services and functions for the wholesale supply system.

(4) Manufacturing items and parts when required.

(5) Providing end items, components, and repair parts through established programs in support of both TOE and TDA medical units.

(6) Providing onsite MSTs on an "as-required"basis.

e. TDA maintenance operations. The mission of these operations encompasses both unit and direct support levels and is characterized by fixed facilities located in conjunction with AMEDD health care facilities and research and development activities. Services and functions are provided for organic medical equipment within these facilities in addition to area support missions and/or ISSA missions as directed by the commands.

Section II
Primary Equipment Maintenance Services

6–4. Preventive maintenance checks and services

a. PMCS is the systematic care, servicing, and inspection of equipment. The purpose of PMCS is to maintain equipment in a serviceable condition and detect minor faults before they become

major defects. PMCS also provides a standard method of determining the status of medical equipment reported in accordance with AR 220–1 and AR 700–138.

b. Unit commanders will oversee PMCS programs.When applicable (primarily TOE units), the commander will report the status of selected medical items of equipment in accordance with AR 220–1 and AR 700–138.

c. PMCS will be performed by user or operator personnel and unit medical equipment repairers at specified intervals in accordance with published maintenance doctrine and applicable DOD and DA equipment publications or manufacturer's manuals when provided in place of DOD and DA equipment publications. TM 8–6500–001–10–PMCS or equipment-specific technical manuals contain the PMCS procedures for medical equipment that must be reported in accordance with AR 220–1 and AR 700–138. Current lists of published technical manuals for specific equipment items can be found in the SB 8–75 series.

(1) Operator PMCS consists of checks and services before, during, and after use and includes the care and cleaning of exterior surfaces, components, and accessories, and replacement of bulbs and tubing or similar items. These actions do not require the use of special tools or disassembly of equipment or result in maintenance level adjustment or alignment. Services that are not a part of operating the equipment are referred by the user or operator personnel to qualified maintenance personnel.

(2) Maintenance personnel perform PMCS that consists of scheduling, performing, and documenting applicable procedures. Repairs that exceed 10 percent of the scheduled PMCS time or require other than bench stock parts will be documented as a repair action. Maintenance personnel will perform remedial maintenance when minor faults or major defects are detected. This may be done during a scheduled visit or at some later date in accordance with a priority system. Local procedures will detail the unit's method of medical maintenance operations.

6–5. Electrical safety inspections and tests

a. MTFs must provide a safe environment to prevent electrical shock hazards attendant with the use of electricity in patient care areas.

(1) The safety officer will designate in writing those areas in the MTF that are considered to be critical care, wet locations, and anesthetizing locations as defined in NFPA Standard 99. This designation will be made annually and submitted to the safety committee for review and to the MTF commander for approval.

(2) Patient care-related electrical appliances will be tested on a scheduled basis to ensure compliance with the standards established by the JCAHO and the standards established in NFPA Standard 99.

(3) The testing, inspection, and documentation of all nonmedical electrical equipment will be ensured by the MTF safety officer. Inspections must be conducted to ensure compliance with the standards established in NFPA Standard 99 and by the JCAHO.

b. Entry on AMEDDPAS maintenance records denoting that a safety test was performed is sufficient to document the test (required of TDA activities only). Use DA Form 5621–R (General Leakage Current Measurements) and DA Form 5622–R (EKG Leakage Current Measurements) only if equipment fails the test. See TB 38–750–2 for instructions on completing these forms.

c. Line isolation monitors shall be tested in accordance with NFPA Standard 99. Test results for each line isolation monitor will be documented as a scheduled service (action code ST) for activities using AMEDDPAS. Other activities will initiate a DA Form 2407 (Maintenance Request) and maintain a DA Form 2409 for each line isolation monitor.

d. To the maximum extent possible, OCONUS fixed facilities will comply with the referenced standards. If unique electrical or grounding problems exist due to variations in facilities, primary concern will be given to patient and operator safety. Action will be taken at the earliest possible time to correct identifiable electrical safety hazards that exist in health care facilities.

e. While commanders of TOE field medical units are not mandated to comply directly with all requirements of the standards listed in NFPA Standard 99, every effort will be taken to prevent electrical shock hazards and establish an electrically safe environment. Proper grounding of medical equipment in use and power generators is essential to safety. Medical equipment and power distribution systems must be inspected frequently for frayed cords, exposed wiring, and defective connectors, with corrective action made as necessary.At a minimum, all electrically operated medical equipment will be tested annually for current leakage and ground resistance in accordance with limits specified in NFPA Standard 99 and upon completion of any electrical repairs.During prolonged exercises or missions involving patient treatment, scheduled testing of electrically operated medical equipment designated for use in critical care areas will be performed semiannually.

6–6. Calibration, verification, and certification services on medical equipment

a. Perform CVC services on medical equipment in accordance with Federal requirements, manufacturer's recommendations, and other applicable guidance.

b. Perform CVC services on organic medical equipment, except that restricted to designated units, as unit maintenance.

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

d. Maintenance and calibration of medical equipment producing ionizing radiation will be performed by a qualified medical equipment repairer.Services shall be conducted to verify that equipment meets performance requirements outlined in 21 CFR, the manufacturer's written recommendations, or JCAHO standards, whichever is the most stringent.

(1) The Federal requirement to provide CVC and repair services to components of medical equipment producing ionizing radiation originates in Subchapter J, 21 CFR 1020. This regulation requires manufacturers of medical equipment producing ionizing radiation to meet specific performance criteria as described in Subchapter J, 21 CFR 1021.31; 1020.32; and 1020.33. The manufacturers will then provide the necessary written maintenance instructions and maintenance interval schedules that, in the manufacturers'opinion, will keep their equipment in compliance with all specific performance criteria.

(2) All medical equipment producing ionizing radiation used in Army MTFs(fixed or mobile) will be calibrated at least once every 360 days (plus or minus 30 days).

(3) Medical equipment producing ionizing radiation that undergoes a repair service and requires an exchange of parts or certified components that could affect the overall calibration integrity will be recalibrated prior to further use.

e. Thoroughly evaluate and test defibrillators semiannually using a defibrillator analyzer. Record the results of the evaluation on DA Form 5624–R (DC Defibrillator Inspection Record). A DA Label 175(Defibrillator Energy Output Certification) (label) should be affixed as close as possible to the control panel; see TB 38–750–2 for instructions.

f. Perform scheduled CVC services in field medical units at least annually.Portions of CVC requirements, affected by replacement of components or repairs to assemblies, will be performed upon completion of the service(s).CVC services will be performed at the appropriate maintenance level as designated in the applicable MAC or, where not specified, at the first level authorized and assigned capabilities and TMDE.

6–7. Calibration of audiometers

a. Calibrate audiometers in accordance with TB 8–6515–001–35. Calibration services will be provided by designated AMEDD activities either at their facilities or onsite.

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

(1) Initially installed.

(2) The test environment is disassembled or reassembled.
(3) Deterioration of the test environment is suspected.

6–8. Remedial maintenance (repair)

Repair of medical equipment is authorized at all levels of maintenance.Repairs will be performed only by or under the direct supervision of a health services maintenance technician (military occupational specialty (MOS) 670A), a medical equipment repairer (MOS 35G or 35U), or the civilian equivalent.The repair function consists of a technical inspection (TI), verification inspection (VI), classification, testing, servicing, and all actions necessary to return an item to a fully mission capable status. It includes those CVC services incidental to a repair action. TIs and VIs will be performed prior to repair or evacuation of unserviceable equipment according to TB MED 7.

6–9. Overhaul

a. The overhaul function consists of restoring an item of standard medical equipment to a completely serviceable or operational condition as prescribed by maintenance standards.

b. Overhaul of medical equipment by commercial firms under contract is authorized in accordance with AR 750–1.

c. In field medical units, overhaul of medical equipment will be performed by designated MEDLOG battalions and maintenance detachments.

d. Adjustments to medical equipment life expectancies will be accomplished as specified in TB MED 7.

e. Overhaul may be performed by MEDDACs or MEDCENs when approved by the parent command. Requests for approval of an overhaul must be submitted in writing and include the number of years that the life expectancy will be adjusted upon completion of the overhaul.

f. Overhaul may be performed at RTS–MED when approved by the MACOM.

6–10. Rebuild

a. The rebuild of end items or components of standard medical equipment will be restricted to either AMEDD general support MEDLOG battalions or USAMMA maintenance divisions and commercial firms under contract as approved by HQDA(DASG–LO).

b. X-ray tube unit assemblies that are certified in accordance with 21 CFR will be rebuilt (remanufactured) only by USAMMA maintenance divisions, HQDA approved general support MEDLOG battalions, or by commercial firms when cost effective.

c. The life expectancy of rebuilt equipment will be adjusted as specified in TB MED 7.

6–11. Ancillary services

a. Medical maintenance elements perform ancillary services within AMEDD fixed facilities. Such services include, but are not limited to—

(1) Providing review of MEDCASE program requirements for medical equipment.

(2) Participating with other logistical support personnel in the surveillance of stored medical materiel as outlined in TB MED 1.

(3) Assisting with specification data for acquiring new equipment.

(4) Conducting on-the-job electrical safety training for operators and newly assigned personnel and when new equipment is introduced into the facility.

b. Since these services vary significantly in scope and complexity, conventional work units do not apply. The recording and reporting of ancillary services will be prescribed by MEDCOMs.

Section III
Support Maintenance

6–12. Maintenance services

a. The wide range in size, complexity, location, and organization of field medical units, fixed medical activities, and other users of medical equipment requires flexibility in support maintenance and depot-level maintenance missions. The performance of maintenance services requiring a trained medical equipment repairer at units and activities without such personnel may be directed.

b. MACOMs will coordinate and effect support for units.

6–13. Direct and general support maintenance

a. Medical equipment in field medical units will be provided support maintenance by designated MEDLOG battalions, maintenance detachments, or MEDDACs and MEDCENs on an area support basis. These support activities may provide onsite maintenance services when resources permit. Items that require service beyond the capability or authority of the supporting activity will be evacuated to the appropriate USAMMA maintenance division.

b. Medical equipment at fixed medical facilities will be provided maintenance by their organic maintenance activity.

c. Where an ISSA is in effect, support maintenance will be provided to units by designated activities.

6–14. Depot maintenance

a. Depot-level maintenance will be provided by the USAMMA maintenance divisions or by designated MEDLOG battalions as necessary when directed by the appropriate commander.

b. Services will be on a nonreimbursable basis to consumer (OMA) funded Active Army units. When provided to other than consumer funded Active Army units and to ARNG, USAR, and other eligible DOD or Government agencies, the services will be reimbursable.

c. Services may be requested by using units if the item is eligible for support maintenance based upon the cost estimating procedures and expenditure limits in TB MED 7 and paragraph 6–16 of this regulation or based upon a waiver approved by the medical facility commander.

d. OCONUS activities with medical equipment requiring evacuation for maintenance services not available in theater will use USAMMA maintenance divisions for support or the designated support maintenance activity cited in the SB 8–75 series. In a command not supported by a designated activity, the command surgeon may direct the return of an item to a USAMMA maintenance division when the item meets the criteria in *c*above. All equipment being returned for warranty service by OCONUS activities will be sent according to paragraph 6–28.

e. Requests for onsite maintenance support will be submitted through appropriate command channels to the Commander, USAMMA, ATTN: SGMMA–M, Fort Detrick, Frederick, MD 21702–5001. Requests should include the following:

(1) Name and location of the requesting unit and work site.
(2) Specific requirement to include estimated man-hours.
(3) Recommendation and priority (commands).

f. Prior to shipping nonstandard equipment for return services, the applicable USAMMA maintenance division will be contacted by CONUS activities to ascertain capability to service the item. The availability of maintenance services for specific items of equipment will be periodically published in the SB 8–75 series.

Section IV
Maintenance Operations

6–15. Contract maintenance

a. The objective of medical maintenance operations is to support the health care mission. To support this objective, an AMEDD capability for the performance of maintenance operations will be established and maintained.This will include a capability for individual and unit training and a rotation base to assure readiness for mobilization or peacetime surge.

b. Contract maintenance support for equipment in TOE field medical units will be authorized only by HQDA (DASG–LO).

c. Contract maintenance support for TDA activities will be based upon the following criteria and supported by periodic economic analyses:

(1) Cost effectiveness of organic versus contractual support to include consideration of joint organic/contractor ventures.

(2) Requirement for wartime support of the specific item(s) in a theater of operations.

(3) Timeliness and effectiveness of alternatives compared to the impact upon clinical services, e.g., item availability rates.

(4) MEDCOM review and approval.

d. Contracts for commercial services will require a contractor to furnish the MEDDAC or MEDCEN with an itemized list of costs for labor and parts for each service. When applicable, the contractor will prepare an FDA Form 2579(Report of Assembly of a Diagnostic X-Ray System).

e. Contracts for commercial services will require the contractor to prepare and submit forms required by Federal law to the appropriate Federal agency with a copy provided to the MTF.

6–16. Repair and overhaul costs

a. Elements of cost to be identified to job orders and for use in estimating the cost of repair are—

(1) Direct labor (military and civilian).

(2) Direct materiels.

(3) Indirect or overhead costs.

(4) Contractual services.

(5) Shipping and transportation costs.

(6) Travel and per diem expenses (including regular labor hours in travel)incurred and attributable solely to unscheduled maintenance (that is, repair). Expenses will be prorated based on the related direct labor should multiple repair services be performed during a trip.

b. Maximum one-time repair and overhaul cost and man-hour estimates will be determined in accordance with AR 750–1 and TB MED 7. These allowances apply to each repair and overhaul accomplished on an item of medical equipment. Labor rates will be computed locally in accordance with AR 37–1, AR 750–1, and MACOM/MEDCOM guidance.

c. Medical equipment must operate effectively and its appearance must reinforce and support standards for patient care. If the appearance of a medical item has an adverse effect on patients, it must be considered for refinishing. Costs associated with any required refinishing will be included in the repair and overall cost estimate for the item.

d. When equipment is reported to the SICC and the USAMMA National Maintenance Point (NMP) for disposition instructions based on cost estimates, the NMP will compare the labor rate used by field personnel with the labor rate of the maintenance facility selected to accomplish the maintenance required. The cost estimate should be adjusted to reflect the labor rate of the performing activity before making a decision concerning the disposition of the unserviceable asset.

e. Published maximum expenditure limits for medical materiel (TB MED 7) may be exceeded when the MTF commander having overall responsibility for the MEDCASE Program determines that an urgent need for the item exists to save lives or prevent suffering and distress and a replacement item will not be available in time to satisfy the clinical requirement.

f. Items of medical equipment evacuated to support maintenance activities that are subsequently determined not to be economically repairable should be processed as follows:

(1) Notify the using unit by letter of the required repair expenditure and the determination of economical repairability. The letter should also request either a properly executed waiver of repair limitations or a document number and confirmation of proper identification data to allow disposal by the supporting maintenance activity.

(2) Screen the equipment for reporting requirements or transfer to a cannibalization point prior to DRMO disposal action.

6–17. Test, measurement, and diagnostic equipment

a. Test, measurement, and diagnostic equipment(TMDE) devices measure, generate, gauge, test, inspect, diagnose, or otherwise examine equipment.They are used to identify or isolate actual or potential malfunctions or determine compliance with specifications established in technical documents.Medical special purpose TMDE (TMDE–SP) is medical materiel used specifically for the test, calibration, and repair of medical equipment. TMDE does not include items used to diagnose or treat patients.

b. Activities will requisition TMDE only after the following conditions are met:

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

(2) OMA or OPA funding has been approved.

(3) Acquisition authority has been received from the central TMDE activity.

c. General purpose TMDE (TMDE–GP) support will be accomplished as follows:

(1) All TMDE–GP owners or users will perform unit-level maintenance.

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

d. Type classified medical TMDE–SP support will be accomplished as follows:

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

(2) TMDE–SP repair and calibration support will be obtained from the USAMMA Medical Equipment Maintenance Division, Defense Depot Tracy, California. TMDE–SP requiring maintenance services must be accompanied by a DA Form 2407 completed in accordance with TB 38–750–2.

(3) TMDE–SP calibration intervals are specified in TB 43–180 except for the following:

(a) TMDE–SP used in support of minimum essential equipment for training shall have a 3-year interval as long as the use of the medical equipment is limited to training purposes (no patient care).

(b) TMDE–SP used in school training courses need not be calibrated unless the owner school determines that uncalibrated TMDE would adversely affect safety, training efficiency, or cause damage to the equipment.

(4) Calibration services will be documented by DD Form 2163. (See para 6–6.)

e. Nontype classified medical TMDE–SP support will be accomplished as follows:

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

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

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

6–18. Cannibalization and controlled exchange

a. Cannibalization.

(1) Cannibalization of medical equipment by using units in a peacetime environment is not authorized unless approved by the MACOM/MEDCOM or USAMMA(SGMMA–MP).

(2) Normally, approval for cannibalization will be limited to the following:

(a) Removal of serviceable parts, components, and assemblies from unserviceable, uneconomically repairable end items leading to their immediate reuse in restoring one or more like items to a serviceable condition.

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

(3) Additional guidance is in AR 750–1 and AR 710–2.

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

6–19. Technical assistance

a. The objective of technical assistance is to ensure that medical maintenance policies and procedures are interpreted properly and applied uniformly to improve operations.

b. Technical assistance to field medical units and fixed medical facilities is available in accordance with the following:

(1) The AMEDD Maintenance Support Program (AR 740–1). This program is normally restricted to advice and assistance on technical problems through day-to-day contact or liaison visits. It does not include onsite maintenance covered by other paragraphs of this regulation.

(2) Medical Logistics Assistance Program (LAP) (AR 700–4). This program is available through command channels to both using and supporting units.

6–20. Modification and alteration of medical equipment

Approved modifications of Army medical equipment will be designated as mandatory modifications or quality assurance, minor, and other alterations as shown below. Modifications and alterations will be recorded in maintenance records in accordance with TB 38–750–2 or user procedures for DA standard ADPE systems. It should be recognized that minor alteration or special purpose alterations, without manufacturer consent, may negate any further manufacturer product liability.

a. A mandatory modification includes all changes to standard equipment. That is, all equipment that is assigned an NSN regardless of the method of acquisition. These configuration changes will be made in accordance with AR 70–1 and AR 750–10. A DA modification work order is the authority for the application of a mandatory modification.

b. A quality assurance alteration is a change required to correct hazards or faults in standard and nonstandard medical equipment. Changes will be announced by USAMMA MMQC messages.

c. A minor alteration is any necessary change to medical equipment that will enhance or improve its safe operation without altering its basic characteristics. These alterations may be performed only when the medical maintenance element has the capability to do so and they are approved by the health facility commander.

d. An alteration designated as "other"is a change made to equipment by a using organization. These alterations may be authorized by the health facility commander for a special purpose or for component modernization as described below.

(1) *Special purpose.* A temporary alteration required for medical purposes that does not permanently affect the internal configuration of the equipment. The item will be restored to its original condition after the requirement is over.

(2) *Component modernization.* The upgrade of equipment by manufacturer authorized changes. It is done only by qualified medical maintenance personnel according to manufacturer specifications.

6–21. Medical Standby Equipment Program

a. MEDSTEP assets include end items, components, or assemblies used to provide supported activities with serviceable items for unserviceable, economically repairable items. These assets were formerly called operational readiness float.

b. MEDSTEP assets will be used to maintain a high availability rate for critical patient care equipment.

c. MEDSTEP assets will not be used to fill equipment shortages, replace uneconomically repairable items, expand operational missions, or satisfy temporary loan requirements. Exceptions may be authorized only under emergency conditions by the appropriate commander.

d. MEDSTEP assets are established or authorized as follows:

(1) USAMMA will establish MEDSTEP assets at maintenance divisions to support AMEDD activities and other DOD customers.

(2) CONUS MEDCOMs may establish additional MEDSTEP assets at TDA health care facilities and medical research units. Additional assets for MEDLOG battalions may be approved by their MACOMs. Items and quantities will be based on the criticality of an item to the mission and the availability of the items from support units.

(3) OCONUS MEDCOMs will establish MEDSTEP assets at MEDDACs/MEDCENs and MEDLOG battalions to support both field medical units and fixed treatment facilities.

e. MEDSTEP procedures are as follows:

(1) MEDSTEP assets will be accounted for on property books in accordance with AR 710–2, DA PAM 710–2–1, and this regulation, except for support maintenance activities (MEDLOG battalion SSAs) that will account for assets on a stock record account.

(2) MEDSTEP assets may be exchanged or loaned to supported activities as shown below.

(a) Normally, assemblies will be exchanged in their entirety.

(b) Components will not be exchanged except when justified by activity requests or when the component is an x-ray tube requirement. X-ray tube considerations include certification, physical configuration, and color.

(c) End items normally will not be exchanged except for TDA equipment if they are not replaced with identical model, condition, age (within 10 percent), and color.

(3) MEDSTEP assets will be physically located in the maintenance activity in accordance with established hand-receipt procedures.

(4) Loans of MEDSTEP assets will be in accordance with local procedures, AR 710–2, and DA PAM 710–2–1. Reconciliation actions for loaned assets will be performed quarterly.

f. Local procedures will provide for recording the use of MEDSTEP assets and requests for assets not in stock or available when requested.

g. Each year, MEDDACs, MEDCENs, and MEDLOG battalions will prepare a list of their MEDSTEP assets and forward it to the appropriate MACOM or MEDCOM for review and approval. The approved list will be sent to USAMMA(SGMMA–MP) not later than 30 November.

6–22. Maintenance performance measures and reports

MEDCOMs or command surgeons will establish performance measures and reports to determine the effectiveness of maintenance operations.

6–23. Repair parts procedures

Repair parts for medical materiel will be managed in accordance with this regulation, AR 710–2, and DA PAM 710–2–1.

a. Repair parts for medical equipment encompass those components, supplies, and other materials necessary to facilitate unit and higher category maintenance support of medical equipment. These parts, though normally Class VIII or IX items, can be inclusive of all supply classes where such parts or materials are applicable to the above described services. Medical repair parts will be excluded from unit computations for the total prescribed load list (PLL) 300-line limit, as referenced in DA PAM 710–2–1.Initial stockage qualifications are three demands in 360 days. Retention stockage qualification is one demand in 360 days.

b. PLL stocks and records for medical equipment will be located with the medical equipment repair section.

c. Medical equipment MPL are developed by the AMEDD NMP for selected medical equipment items authorized to TOE medical units as designated on applicable UA component listings. MPL will be published annually in the SB 8–75 series. Active Army and RC medical TOE units may request MPL consideration for authorized medical equipment not listed in SB 8–75 series from Commander, USAMMA, ATTN: SGMMA–M, Fort Detrick, Frederick, MD 21702–5001. Requests will include the requesting unit's identification, mailing address, and the following information on each item of medical equipment for which an MPL is requested:

(1) End item NSN.

(2) Nomenclature.

(3) Manufacturer, model, and serial number.

(4) Quantity on hand and authorized.

d. Unit-level medical maintenance PLL will be managed under the procedures in DA PAM 710–2–1 and this regulation. Consumed PLL items will be replaced by requisitioning through the SSA and may be filled from items in the ASL.

e. Direct support and general support level medical maintenance

shops within MEDLOG battalions are authorized to stock maintenance-related supplies as PLL(includes MPL) for medical equipment organic to supported units. PLL will be managed as in *d* above.

f. TDA maintenance activities encompass aspects of both unit and direct support maintenance operations and as such will manage organic repair parts in accordance with AR 710–2, DA PAM 710–2–2, and supplemental policies and procedures as set by the respective MACOM and this regulation. Three types of maintenance related supplies are authorized. These supplies are shop stock, bench stock, and mission essential repair parts.

(1) Shop stock (demand supported repair parts) will require three demands in 360 days for initial stockage, and one demand in 360 days for retention.

(2) Bench stock is defined in DA PAM 710–2–2 and will not exceed a 30-day supply.

(3) Mission essential repair parts must—

(a) Ensure the functioning of lifesaving equipment.

(b) Support equipment for which the manufacturers will no longer supply parts.

(c) Support new equipment until demand data can be established.

(4) Commanders will keep a list of mission essential repair parts. This list will cite, as a minimum, end item application, stock number, descriptive data, and quantity. The listing must be approved by the activity commander.

(5) Accountability for mission essential repair parts will be the same as for shop stock.

g. ARNG units with qualified medical equipment repairers may be issued repair parts on a reimbursable basis. Such issues are normally made by the supporting IMSA.

Section V
Anesthetizing Locations in Army Health Care Facilities

6–24. Anesthetizing locations policy

a. The NFPA Standard for the use of inhalation anesthetics (NFPA Standard 99) and the JCAHO Standards establish requirements for specific types of flooring in anesthetizing locations. These standards require conductive flooring in all areas where flammable anesthetics are used.

b. The use of explosive or flammable anesthetics is prohibited in AMEDD facilities.

c. Conductive flooring currently in anesthetizing locations will not be replaced with nonconductive floor covering until normal deterioration dictates replacements.

d. Signs will be posted at the entrances to all anesthetizing locations in AMEDD facilities in accordance with NFPA Standard 99, chapter 3, paragraph 4.Signs will be worded: RESTRICTED TO NONFLAMMABLE INHALATION ANESTHETIC AGENTS.

e. Electrostatic safeguard standards established in NFPA Standard 99 do not apply for nonflammable anesthetizing locations. Testing of furniture for conductivity and antistatic clothing is not required.

6–25. Conductive flooring policy

Conductive flooring in fixed medical facilities shall be tested in accordance with NFPA Standard 99. Initial test results will be documented as an unscheduled service for activities using AMEDDPAS. Subsequent test results, when required, may be documented as a scheduled service. Activities using manual procedures for documentation will use DA Form 2407 and retain the appropriate copy as required.

Section VI
Army Warranty Program

6–26. Warranty Program overview

a. The overall policies and procedures for the Army Warranty Program are contained in AR 700–139, which requires that items for Army use should be acquired with warranties only when a warranty is in the Army's best interest. The decision must be made on a case-by-case basis.

b. Commercial off-the-shelf medical equipment is usually furnished with warranties typically provided to all customers. Warranty terms may vary between manufacturers and suppliers, facility locations, and acquiring activities. Additional information is furnished in SB 8–75–MEDCASE for centrally purchased radiology equipment.

c. In warranty applications, unit readiness and mission effectiveness will take priority. If the maintenance activity is not able to get an effective response through the warranty process, the activity should repair first and settle later through the acquisition support activity.

6–27. Warranty implementation

In addition to the procedures for administering warranties in accordance with AR 700–139, acquiring commands or activities will establish local warranty implementation procedures.

6–28. Warranty claim actions

Warranty claim actions for other than AAC L and nonstandard medical equipment will be reported to USAMMA (SGMMA–MPM) on DA Form 2407 with all pertinent information. Reporting activities will also provide a copy of any maintenance record or history in addition to copies of contract and receiving documents. Warranty claim actions for locally acquired medical equipment may also be forwarded for information or assistance by DA representatives to resolve warranty disputes.

Chapter 7
Measuring Medical Supply Performance

7–1. Performance guidance

This chapter establishes medical supply performance standards (in addition to those outlined in AR 710–2) and measures for use by medical logistics officers and commanders in evaluating, reporting, and monitoring medical supply performance at the IMSA level.

7–2. Performance measures

a. When directed by TSG, USAMMA is responsible for acquiring, maintaining, analyzing, and reporting pertinent supply performance data concerning DLA Class VIII wholesale supply support to the Army.

b. MEDCOMs, command surgeons, and commanders operating an IMSA will develop, maintain, and evaluate supply effectiveness data, both on support received and support rendered.

c. Commanders and managers at all levels will use performance measures to improve the management of medical materiel and conserve available resources.Refer to the glossary for an explanation of the terms "management level," "management objective," and"performance measures."

7–3. Measures of customer support

The following measures are used to evaluate quality of support to customers:

a. Demand accommodation (not applicable for items obtained through prime vendor contracts).

(1) Demand accommodation indicates the IMSA's success at stocking items demanded by customers and response to changing customer demand patterns.

(2) It must be used with caution since some IMSAs support research activities and specialty treatment centers whose demands are nonrecurring or materiel that should not be stocked because of rapid obsolescence or short shelf life.

(3) Demand accommodation will show the percentage of total valid demands(total demands minus rejected demands) received that are for items stocked by the IMSA. It may be computed as shown below.

(a) Formula. Divide the number of demands for stocked items by the total number of demands received, and multiply the resulting number by 100.

(b) Example. 6,700 demands for stocked items are received out of the 10,000 total demands received: 6,700 ÷ 10,000 × 100 = 67%.

(4) Performance measures are as follows:

(a) Management objective: 75 percent.

(b) Management level: 65 to 85 percent.

b. Demand satisfaction.

(1) Demand satisfaction is the percentage of demands for stocked lines satisfied by 100 percent of the total quantity demanded. Use the formula shown below to compute this figure.

(a) Formula. Divide the valid demands for stocked items 100-percent filled by the total valid demands for stocked items received, and multiply the resulting number by 100.

(b) Example. 6,378 of 6,700 total demands for stocked items were 100-percent filled: 6,378 ÷ 6,700 × 100 = 95%.

(2) Performance measures are as follows:

(a) Management objective: 95 percent.

(b) Management level: 90 to 98 percent.

(3) Demand satisfaction indicates the adequacy of RO levels; that is, whether stockage quantities are sufficient considering OST and fluctuating demands.

(4) An extremely high demand satisfaction percentage may indicate that stock levels are too high. If demand satisfaction is low, examine the zero balance rate, receipt processing time, and the validity of OST quantities based on recent experience.

7–4. Measures of processing time

a. Request processing time.

(1) This measure reflects the processing time of a supply request.

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

(b) For nonstocked lines, it is the number of days from the date a user request is received at the IMSA to the date the request is passed to the supply source or to the supporting contracting activity.

(2) Perform periodic samples of user requests received at the IMSA to obtain required data. The date received is not counted; however, the date passed to the supply source or supporting procurement activity is counted, as is the date of delivery or date of notification to the customer.

(3) Performance measures are as follows:

(a) Management objective: 2 days.

(b) Management level: 1 to 3 days.

(4) This measure indicates the efficiency of the IMSA in processing requests for both stocked and nonstocked lines. Longer processing times may indicate system deficiencies, inadequate staffing, training shortfalls, or a combination of these factors.

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.

(3) Performance measures are as follows:

(a) Management objective: 3 days.

(b) Management level: 1 to 4 days.

(4) Receipt processing time measures the efficiency of materiel receipt and posting systems. Longer processing times may indicate inadequate receiving or posting procedures, training needs, or staffing level problems.

7–5. Measures of inventory management

a. Assets to RO requirements indicators.

(1) These indicators reflect the percentage of total stockage item assets(on hand or on order) compared to total stockage item requirements (RO plus any RO dues-out). Use the formula below to compute this percentage.

(a) Formula. Divide the dollar value of serviceable RO inventory on hand and RO stock on order by the dollar value of RO and dues-out, and multiply the resulting number by 100.

(b) Example. If stockage assets equal$562,562 ($347,415 on hand and $215,147 on order) and stockage requirements equal $758,927 ($699,813 RO and $59,114 dues-out): $562,562 ÷ $758,927 × 100 = 74%.

(2) Performance measures are as follows:

(a) Management objective: none.

(b) Management level: 60 to 80 percent.

(3) This measure indicates the adequacy of assets compared to requirements.Too high an indicator may imply that inventories are maintained at too high a level resulting in excessive inventory carrying costs. Too low an indicator may reflect a breakdown in the replenishment requisitioning process or indicate that OSTs used to compute ROs are not valid. These indicators require judicious use because some factors that may directly affect them are beyond the control of the IMSA (for example, insufficient storage space).

(4) Assets to RO requirement indicators also help identify when OSTs have improved dramatically and are directly affected by increased or reduced missions.

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

(1) The zero balance rate shows the percentage of stocked lines that are at zero balance. Use the formula below to compute this rate.

(a) Formula. Divide the number of stocked lines at zero balance with an established due out by the number of stocked lines, and multiply the resulting number by 100.

(b) Example. If there are 70 stocked lines at zero balance out of a total of 1,578 stocked lines: 70 ÷ 1,578 × 100 = 4%.

(2) Performance measures are as follows:

(a) Management objective: less than 5 percent.

(b) Management level: 2 to 8 percent.

(3) This measure is an indicator of inventory management effectiveness and is usually related to demand satisfaction. Its value is that it can show inventory management problems earlier than other measures. It gives a rapid general picture of inventory status for RO (demand supported) stocked lines at a given point in time. Potential problems highlighted by this indicator may not have shown themselves in 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 and the assets-to-requirements indicator. Conversely, too low a zero balance index may reflect significant improvements in the wholesale resupply or transportation support to the IMSA or a significant downturn in customer demands.

c. Uniform materiel movement and issue priority high priority request/requisition rates. (See AR 710–2, para 1–19 and table 1–2.)

(1) These rates show the percentage of all requisitions placed upon a supply source (either local procurement or the wholesale system) that have an issue priority designator (IPD) of 01–08. (Exclude life or death IPD 03 requisitions from all calculations.) Use the formula below for computing these rates.

(a) Formula. Divide IPD 01–08 requests/requisitions by total requests or requisitions, and multiply the resulting number by 100.

(b) Example. If there are 17 IPD 01–08 requests/requisitions out of 189 total requests or requisitions submitted: 17 ÷ 189 × 100 = 9%.

(2) Performance measures are as follows:

(a) Management objective: less than 20 percent.

(b) Management level: none.

(3) 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 01–08 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 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.

d. Obligations to demand ratio (O/D ratio).

(1) The O/D ratio gives the ratio of funds obligated to support each dollar of demand placed on the IMSA by its customers over a specified period of time. It is a quick indicator for early detection of future inventory buildup or drawdown.

(a) Formula. Divide total obligations by the dollar value of demands (cumulative gross issues plus-or-minus net change in dues-out).

(b) Example. If, over a specified period of time, total obligations were $1,847,000 and the dollar value of customer demands was $1,793,000, the computation is as follows: $1,847,000 ÷ $1,793,000 = 1.03. The 1.03 ratio shows that, for each dollar of customer demands, this IMSA is obligating $1.03.

(2) Performance measures are as follows:

(a) Management objective: 1.00.

(b) Management level: 0.95 to 1.05.

(3) This measure should be used with care because it is affected by demands placed on the IMSA during a preceding fiscal year that did not result in obligations. As a result, this statistic can be skewed in 2 successive fiscal years. Demands that do not generate an obligation cause a reduction in the O/D ratio, while obligations resulting from prior fiscal year demands generate an increase to the O/D ratio for the fiscal year in which the obligation is incurred. Normally, when viewed against total obligations for the fiscal year, these aberrations are insignificant.

(4) Obligations not used to satisfy customer demands also affect this measure. These may include obligations used to replace—

(a) Materiel transferred to property disposal.

(b) Materiel that is determined unsuitable for use.

(c) Lost, damaged, or destroyed materiel.

7–6. Measures of storage management

a. Materiel release denial rate (warehouse denials).

(1) This rate shows the percentage of materiel release orders (MROs) denied by storage.

(a) Formula. Divide the number of MRO denials by the total MROs, and multiply the resulting number by 100.

(b) Example. If there are 28 MRO denials out of 3,253 total MROs: 28 ÷ 3,253 × 100 = 0.9%.

(2) Performance measures are as follows:

(a) Management objective: less than 2 percent.

(b) Management level: none.

(3) This measure can indicate a variety of potential problems. Examples are erroneous inventories, locator inaccuracies, stocks released to customers without the transaction being posted to accountable records, inaccurate selection of materiel for shipment or delivery, erroneous quantities verified on receipt documents, erroneous posting or receipt documents, or misappropriation.

b. Location accuracy.

(1) This measure is a comparison of locator records with the 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's 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 location without a supporting location record.

(3) 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 rewarehousing and stock depletion. Use the formula below to compute accuracy.

(a) Formula. Divide the total correct inventory locations by the total inventory locations surveyed, and multiply the resulting number by 100.

(b) Example. If out of 150 locations surveyed, 146 were correct: 146 ÷ 150 × 100 = 97%.

(4) Performance measures are as follows:

(a) Management objective: 97 percent.

(b) Management level: 95 to 100 percent.

Chapter 8
Medical Logistics Services Management in Health Care Facilities

Section I
Medical Logistics Services/Programs

8–1. Types of services

a. In health care facilities, medical logistics functions can include the following:

(1) The acquisition, receipt, storage, issue, movement, maintenance, repair, and accountability of materiel.

(2) Hospital housekeeping.

(3) Real property repair and maintenance.

(4) Interior decoration.

(5) Construction.

(6) Linen and laundry support.

(7) Waste collection and disposal.

(8) Transportation.

(9) Communications (in conjunction with the information management officer and the plans and operations staff).

(10) Equipment installation and site preparation.

(11) Equipment calibration and certification.

(12) Optical fabrication.

b. The logistics division will provide these services or coordinate their delivery with the appropriate installation-level support activity. Whether the chief of the logistics division has operational or staff responsibility is based on the mission of the facility, the parent command, and Army policy. MEDDAC and MEDCEN procedures will provide for the accomplishment of logistics functions. Local procedures will inform supported activities of how to obtain logistics service.

8–2. Logistics services management programs

The chief of the logistics division is responsible for all logistics operations in the facility and satellite activities to the extent authorized by MEDCOMs and command surgeons.

Section II
Materiel Distribution and Collection Systems

8–3. System concept

a. Materiel Distribution and Collection Systems(MATDACS) are internal hospital systems designed to increase efficiency and cost effectiveness in the provision of medical logistics services. New hospital facilities will be designed with MATDACS. In existing facilities, MATDACS will be established by activity commanders when review and analysis clearly indicates that efficiency and cost effectiveness can be enhanced. MATDACS will operate on a schedule tailored to the needs of supported activities. MATDACS may be applicable to other types of health care activities such as dental clinics, TMCs, laboratories, and other activities not located within a hospital facility.

b. At activities with automated MATDACS, both procedures and equipment will be able to adapt to future improvements. Provisions will be made for backup modes of operation in the event automated support is interrupted due to equipment breakdown or power failure.

8–4. MATDACS objectives

The objectives of MATDACS are to—

a. Provide medical logistics services in the most efficient and cost-effective manner possible.

b. Enhance patient care by improving the timely availability and delivery of items required to support health care services.

c. Improve utilization of personnel, relieving medical and nursing staffs from performance of nonpatient care duties.

d. Reduce operating costs and supply inventories at the user level.

e. Improve the flow of materiel through—

(1) Centralized management.

(2) Automatic resupply of routine-use items.

(3) Direct contact between logistics personnel and users.

(4) Direct delivery to the user level.

f. Provide safe and efficient delivery and recovery of equipment.

8–5. Items eligible for MATDACS

a. The following items are eligible for a MATDACS under the management and control of the logistics division:

(1) Medical supplies.

(2) Nonmedical supplies.

(3) Linen.

(4) Waste (contaminated and noncontaminated).

b. Other MATDACS may be in operation in the hospital, under the management and control of divisions other than the logistics division. For example, a separate MATDACS may exist for food, operated by the food service division.The following items may also be delivered and collected by an internal hospital system:

(1) Sterile supplies from the central materiel service.

(2) Mail.

(3) Medical records.

(4) Administrative forms.

(5) Flowers.

c. The items in *b* above may be processed by a logistics division MATDACS if deemed appropriate by the hospital commander. If items are assigned to a logistics division MATDACS, there must be strict adherence to the handling procedures, security measures, and/or environmental control required for all items.

d. The determination of which items will be managed with a MATDACS may be based on—

(1) Cost impact at the logistics division and at user levels.

(2) Physical plant factors supporting the use of a MATDACS.

(3) Utilization and staffing of personnel.

(4) Storage and handling capability at the user level.

8–6. Materiel distribution service

a. Unless otherwise directed by the MACOM, a materiel distribution service(MDS) may be established by the MEDDAC or MEDCEN. Such service will operate under the control of the chief, logistics division. It will perform resupply functions as approved by the chief, logistics division. These activities may use the Central Processing Distribution (CPD) system, TAMMIS-MEDSUP, or other approved automated systems to manage and control stock inventory. Other stockroom supply activities that provide supply support to other organizational elements, such as the bulk pharmacy, may also use CPD to manage and control stock inventory.

b. If an MDS has not been established, the customer reorder list will be used to assist in the management and control of inventories using the "par level" inventory method. To use the par level method, the activity counts (inventories) the quantity of stock on hand at periodic intervals, compares the on-hand quantity to the stockage level minus any dues-in, and reorders the quantity necessary to replenish the on-hand quantity to the stockage level.

Section III
Environmental Services Management (Linen Operations)

8–7. Concept of operations

a. The commander of the medical activity has overall responsibility for the management of hospital linen. This includes providing local policies and procedures.

b. The chief of the logistics division has staff responsibility for linen management.

c. A linen management officer, appointed by the commander, will perform the day-to-day functions involved with linen management.

d. A linen management committee will be established at each MTF. The committee recommends linen management policy and reviews program performance.It will consist of the executive officer, chief of the logistics division, chief of nursing services, infection control officer, and others as required.These members are appointed by the commander of the medical activity.

e. Refer to the glossary for definitions of hospital linen management terms.

8–8. Linen Management Program

This program will provide for—

a. Establishing economic stock levels at using locations.

b. Reviewing linen use and correcting inappropriate patterns of use.

c. Reducing or preventing the theft and misuse of linen.

d. Providing MATDACS procedures and equipment for responsive and safe linen support.

e. Complying with the MEDDAC or MEDCEN infection control program.

f. Providing linen repair and special fabrication procedures.

g. Implementing standards of the JCAHO.

h. Providing a documented continuing training program for linen service personnel.

8–9. Accounting for linen

The linen management officer will informally account for hospital linen on DA Form 1296 or an automated system. DA Form 2064 (or equivalent automated form)and voucher files will be used to support all entries. See AR 710–2 and DA PAM 710–2–2 for the use of these forms. Hold these informal records for 2 years after the last posting date, then destroy.

8–10. Handling linen

a. Clean linen will be handled and stored in such a way as to minimize contact and airborne contamination. Clean linen will be stored in a separate location from soiled linen.

b. Soiled linen will be handled and stored in such a way as to avoid the scattering of microbes into the environment. Care will be taken to protect personnel and equipment from contact with soiled linen. Collection (bagging)and processing of soiled linen will be in accordance with OSHA Standard 29 CFR 1910.1030, Occupational Exposure to Bloodborne Pathogens.

c. Separate carts will be used to transport clean and soiled linen. Separate vehicles will also be used if available. When they are not available, adequate controls and physical precautions will be used to prevent cross-contamination.

d. Provisions will be made for the cleaning and decontamination of soiled linen transporters and sorting locations. Procedures and cleaning products will be locally recommended to the commander by both the linen and infection control committees and will comply with JCAHO standards.

8–11. Using marked or dyed hospital linen

a. Standard white hospital sheets and pillowcases are distinctively marked with the name of the MTF, e.g., WRAMC. Their use is authorized only in patient care areas of MTFs. Additional markings may be added locally to facilitate control.

b. Standard green linen will be used only in surgery areas. White linen furnished as a substitute for green linen may be dyed locally.

c. Medical white linen may be dyed other colors when necessary for control.Colors may be used to identify the medical facility, the size, or a specific service or department.

d. Infant linen will not be dyed.

8–12. Disposal of linens

a. Linen that cannot be repaired or reconditioned economically will be classified as salvage. Items designated for salvage will be

listed on DA Form 3161 by stock number, nomenclature, and quantity. Salvaged linen may be disposed of as follows:

(1) By turn-in to the supporting property account or IMSA. The DA Form 3161, signed by an authorized representative of the accountable officer, will be used as a voucher to adjust the informal record.

(2) By conversion of salvaged linen to rags. Each item will be listed on DA Form 3161. The form will be marked to show that the items were converted to rags. It will be certified by a disinterested officer appointed on MEDDAC or MEDCEN orders. Rags will be dyed or marked so they are easy to distinguish from serviceable linen. The preferred method is to use brown dye. Other methods may be approved by the MACOM or command surgeon. Rags are marked or dyed to prevent their use as serviceable linen.

b. Persons authorized to classify linen as not economically repairable or reconditionable will be designated by duty title in local directives or by supplements to this regulation at the parent command level.

8–13. Linen inventories

Inventories will be conducted at least annually. Activity commanders will determine the frequency of inventories. The results of inventories are used to evaluate the effectiveness of the linen program and determine the amount of unexplained losses. Results will be reported through the linen management committee to the commander for appropriate action. DA Form 444 or automated equivalent will be used to document inventory actions and adjust informal accounting records. Results of the inventory will be approved by the activity commander.

Section IV
Environmental Services Management (Housekeeping Operations)

8–14. Management policy

Medical facilities will manage the delivery of housekeeping services.Housekeeping functions will be performed by a hospital housekeeping branch or by a qualified housekeeping service.

8–15. Program administration

a. The medical facility commander will maintain a qualified hospital housekeeping officer on his or her staff to manage the housekeeping program.In those facilities with a contract housekeeping service, this individual will monitor the effectiveness and quality of housekeeping services performed by the contractor.

b. The hospital housekeeping officer will—

(1) Manage daily housekeeping operations.

(2) Establish a random sample inspection system for evaluating the quality of services delivered.

(3) Integrate the hospital housekeeping services program into the facility's infection control program.

(4) Obtain approval of the commander, as head of the local infection control committee, for cleaning procedures and cleaning supplies. To the maximum extent practicable, choose the least hazardous cleaning supplies for housekeeping operations.

(5) Ensure that all MSDS for cleaning supplies are maintained so that they are accessible to all housekeeping employees at all times. If transferring cleaning supplies from the original containers, ensure that new containers meet all labeling requirements under 29 CFR 1910.1200.

(6) Operate or monitor a training program for housekeepers. At a minimum, document the description and amount of training and who was trained.

(7) Manage the collection, storage, transportation, and disposal of RMW within the MTF in accordance with AR 40–5.

(8) Comply with the standards of the JCAHO Accreditation Manual for Hospitals.

(9) Comply with OSHA Standard 29 CFR 1910.1030, Occupational Exposure to Bloodborne Pathogens.

8–16. Contract housekeeping

At those facilities with a contract housekeeping service—

a. The requirements of paragraph 8–15*b*will be included in the contract.

b. The hospital housekeeping officer will be designated as the contracting officer's representative to ensure compliance with the housekeeping contract.

c. The hospital housekeeping officer will establish a separate system, independent of the contractor's, to evaluate quality and assure that services are performed in accordance with the contract.

Section V
Standardization of Supplies and Equipment

8–17. Goals of standardization

Technology has created an immense range of materiel required for modern medicine. Materiel standardization should not be an isolated process but should be incorporated in the processes and decision-making functions associated with medical equipment and expendable/durable item procurements.An effective MSP will simplify management and reduce operating, maintenance, and materiel costs. These cost savings can be directly applied to improving patient care.

8–18. Policy

a. Each medical activity will establish and implement an MSP in accordance with the objectives stated in paragraph 8–20*b*. The MSP will be conducted under the direction of the chief of logistics.

b. Each medical activity will establish a materiel standardization committee(MSC) to recommend items for use in the treatment facility. (See para 8–20.)

c. The MEDDAC or MEDCEN commander is the approval authority for MSP actions, except that dental issues will be concurrently approved by the commander of the DENTAC.

8–19. Materiel criteria

All medical materiel used by more than one activity within the health care facility is subject to this section, with the following exceptions:

a. Drugs (AR 40–2), biological reagents, antitoxins, and laboratory media.

b. Books, periodicals, and journals.

c. Medical gases.

d. Repair parts.

e. Hearing aids, prosthetic devices, and implants.

f. Materiel for supported medical research and development.

g. Food supplements.

8–20. Materiel Standardization Committee

a. The committee chairperson will be appointed by the activity commander.The committee will meet at least quarterly. As required, the MSC will perform a competition advocacy function in preliminary evaluation of sole source recommendations for nonstandard materiel prior to forwarding requests to an acquisition source. This review will be in accordance with guidelines contained in the FAR.

b. The objectives of the committee are to—

(1) Improve patient care through the standardization of supplies and equipment used by more than one activity, ward, clinic, or service within health care activities. Consistent use of the same supplies, equipment, and associated training throughout MTFs will ultimately improve the quality of care rendered to patients.

(2) Reduce operating, maintenance, and procurement costs. To achieve this objective, particular attention should be devoted to those nonstandard items for which the hospital is spending the most money.

(3) Optimize the variety of items, processes, and practices required for acquisition and logistics support by ensuring the use of standard wholesale stocked items to the maximum extent possible.

(4) Improve the operational readiness in accordance with activity missions.

(5) Enhance interchangeability, reliability, and maintainability of supplies and equipment.

(6) Ensure that products of requisite quality and minimum essential need are specified and obtained.

(7) Assure that specifications and standards imposed in the acquisition programs are tailored to reflect only particular needs consistent with mission requirements.

c. The goal of the committee is to reduce costs and improve patient care through standardization and identification of less expensive substitute items of equal quality.

d. Recommended participants of the committee include—

(1) The chief of logistics.

(2) A nursing methods analyst (NMA) or nursing representative. (Close coordination with the NMA or nursing representative must be established and demonstrated in the MSP.)

(3) A DENTAC representative (as determined by the DENTAC commander).

(4) A materiel branch representative.

(5) An MDS representative.

(6) A central materiel supply representative.

(7) A physician representative.

(8) A representative from the TOE field medical community on the installation may participate as required. The purpose of this representation is to evaluate the impact of standardization actions on the availability of materiel in the IMSA required to support field medical requirements.

e. The functions of the MSC are to—

(1) Establish policy and implement materiel standardization for the MEDDAC/MEDCEN.

(2) Recommend nonstandard consumable medical materiel and equipment as standard items in the MTF based on patient care benefits, cost, and mission requirements.

(a) Items stocked as of the date of the establishment of the program should form the baseline of approved items for use in the activity.Activities should not attempt to revalidate all previous stockage decisions for currently stocked items. The review process for standardization will cause comparison to baseline items and analysis of which item is most appropriate for use in the activity.

(b) Item groups with a common function will be identified for periodic review. Examples of special groups are catheters, surgical packs, needles, syringes, parenteral solutions, and surgical gloves.

(c) Stocked and nonstocked nonstandard items of supply and equipment procurement should be reviewed. Candidates for standardization of supply items will be identified based on demand data or customer requests.Candidates for standardization of equipment will be based on patient care benefits, cost, maintenance support capability, and mission requirements. The IMSA may identify items for potential standardization based on cumulative purchases reaching a designated cost or demand threshold, or a concern that comparable standard items are available from the wholesale system. The activity should focus efforts on items that will have activity-wide usage of more than one supply customer. Items excluded from the standardization process should not be reviewed.

(3) Recommend medical equipment as a standard item in the MTF based on patient care benefits, cost, maintenance support capability, and mission requirements. The goal is to reduce cost and improve patient care by standardizing equipment. Costs are reduced and patient care improved through consistent training, operation, maintenance, and supply support for standardized equipment. New equipment procurements should be reviewed based on activity-wide usage and/or comparable equipment currently on hand. A standardization review should occur if two or more customers use the same equipment or comparable equipment.

(4) Review, monitor, and encourage the use of items stocked at the wholesale (DPSC) and theater level (USAMMCE, 6th MEDLOG Battalion) as appropriate.

(5) Publish standardized expendable and durable items in the IMSA stockage list.

(6) Review items on the D-Day Significant Items List to ensure that D-Day items are stocked and utilized to the maximum extent possible.

f. Additional functions may include as appropriate—

(1) Reviewing HDV local PRs.

(2) Supporting sole source justification for supplies or equipment standardization under the program.

(3) Acting as a forum for the presentation of new products.

(4) Providing approval for examinations of materiel.

Section VI
Medical Instrument Recycling Program

8–21. Program definition

a. 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.

b. Recycling includes—

(1) Replacing missing parts; for example, screws and carbide inserts.

(2) Adjusting for proper tension.

(3) Redefining ratchets.

(4) Sharpening cutting edges.

(5) Cleaning, repolishing, and replating of surfaces.

(6) Realigning tips and edges.

8–22. Implementation

a. Each CONUS MEDDAC or MEDCEN will establish a MIREP if economically feasible based upon a cost-benefit study. Cost inherent in administering the MIREP contract must be judiciously considered. A copy of the cost-benefit study will be retained on file for review by the command logistics review team. If determined not economically feasible, an update review of the cost-benefit study will be conducted annually.

b. The MEDDAC or MEDCEN chief of logistics will operate the MIREP and will publish local procedures for its management. These procedures also apply to supported DENTACs.

8–23. Recycling guidance for the MIREP

a. Instruments that are damaged or unsuitable for use will be turned in to a designated collection point by the using activity. Items will be tagged with their NSN or MCN, where practical, and the total quantity annotated on the tag(s). String or other appropriate binding may be utilized to group like items for ease of management and turn-in.

b. The designated collection point program manager will determine the procedures for turn-ins and account for all receipts, repairs, and disposals utilizing DA Form 2407 as the informal accounting record for each NSN or MCN.If a purchase request is initiated for each turn-in to the contractor, a suspense copy should be retained on file.

c. Recycling costs will be borne by using activities.

d. MIREP assets will remain consumer owned from the time of turn-in until the item is subsequently reissued.

e. All instruments must meet the following recycling criteria:

(1) The instrument is unserviceable or otherwise unsuitable for use.

(2) A replacement item is required to accomplish the mission.

(3) The replacement unit cost exceeds $8.

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

(5) The ARC is D (that is, a durable item) in the AMDF, or it is a similar nonstandard item.

f. 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.

8–24. MIREP 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.

Section VII
Optical Fabrication

8–25. Authority
Spectacles and allied ocular devices are fabricated by AMEDD optical laboratories and units for eligible personnel under AR 40–63/NAVMEDCOMINST 6810.1/AFR 167–3.

8–26. Optical Laboratory Report (RCS MED–199)
a. This report provides data on optical devices fabricated by optical laboratories and units. Instructions for completing DA Form 2717 (Optical Laboratory Report) are in appendix D. The report is used for—

(1) Mobilization planning.
(2) Budget preparation.
(3) Optician assignment.
(4) Analysis of interservice support.

b. Army optical laboratories and units, including those organized as an element of TDA and TOE units will—

(1) Prepare DA Form 2717 for each fiscal quarter as shown in appendix D.

(2) Submit the report to the appropriate medical MACOM or surgeon in two copies (or as prescribed by the command). Dispatch the report no later than the 11th workday after the end of each report period.

c. Commands will forward one copy of each report to HQDA (DASG–LO),5109 Leesburg Pike, Falls Church, VA 22041–3258.

8–27. Optical laboratory operating supplies
a. An optical laboratory is a separate facility, activity, branch, section, unit, or team devoted to the fabrication of prescription eyewear that includes spectacles, protective mask inserts, and similar ocular devices.

b. Operating supplies are those consumable items(components and ancillary supplies) used in the fabrication of prescription eyewear.

c. Laboratory operating supply authorizations are as follows:

(1) The initial supply of consumable items incorporated in optical fabrication assemblages for medical TOE units, except as noted in (2) below, consists of those items required under average conditions for a period of 30 days. The authorizations for individual items are listed in SC 6545–8–P01 and SC 6545–8–P03.

(2) The initial allowance of consumable optical items authorized in SC 6545–8–P02 for the optical division of TOE 8–287H6 consists of quantities required under average conditions for a period of 90 days.

(3) Initial allowances for CONUS TDA optical laboratories are authorized in SC 6545–8–CL–P06 for single-vision laboratories and by USAMEDCOM for multivision laboratories.

d. Laboratory operating supply levels are as follows:

(1) TOE units in OCONUS commands will maintain a 30-day level of operating supplies within optical laboratories.

(2) Optical laboratories in CONUS, organized under a TDA, will maintain a 15-day level of operating supplies within the laboratory.

Chapter 9
Army Reserve Programs

Section I
Management of Army Reserves

9–1. Overview
This chapter provides direction and procedures for the management of the AR AMEDD program segments (formerly referred to as war reserves).Refer to AR 11–11, AR 710–1, and AR 710–2 for specific guidance on AR stocks in general.

9–2. Army Reserves
a. Concept. ARs are specifically computed quantities of materiel acquired in peacetime to satisfy wartime sustainment, until procurement/production sources can furnish materiel. The Army stratifies requirements based on DOD policy and direction.

b. Objectives. The following are the key aspects of the new wartime sustainment AR Program.

(1) Ownership of medical materiel by TSG.

(2) Centralized management and accountability for medical materiel (Class VIII)by USAMMA.

(3) Uncoupling AR/OP stocks from specific commanders in chief (CINCs) and theaters.

(4) Positioning common user stockpiles ashore(CONUS and OCONUS) and afloat to support multiple CINCs and scenarios. These scenarios are referred to as major regional contingencies.

c. Categories.

(1) Army Reserves Sustainment (ARS).
(2) Army Reserves Operational Projects (AROP).
(3) Army Reserves Prepositioned Sets of Equipment(APS).
(a) Army Afloat Prepositioning (PREPO) Program.
(b) RC Decrement–Hospital (RCD–H)Program.
(c) POMCUS.
(d) Army Readiness Package South (ARPS).

d. Positioning.

(1) AR–1 (CONUS): ARS and AROP.
(2) AR–2 (Europe): ARS, AROP, and ARPS.
(3) AR–3 (Army Afloat PREPO): ARS, AROP, and Afloat Brigade with Support.
(4) AR–4 (Pacific): ARS, AROP, and Theater Reserve 7 (TR–7).TR–7 is War Reserve Stock for Allies-Korea. These assets are owned and financed by the U.S. but released to the Army of the Republic of Korea on a declaration of Defense Condition II per existing multiyear omnibus acquisitions.
(5) POMCUS.
(6) RCD–H Program.

e. Major roles.

(1) TSG (DASG–LO) is the executive agent for AMEDD AR program segments (except POMCUS) in terms of programming, resourcing, and approval for temporary loans.

(2) USAMMA (SGMMA–RCW) ensures coordinated and centralized materiel management, requirements determination, acquisition, accountability, and funding of care of supplies in storage (COSIS) and other support costs. USAMMA develops the medical portion of the Army Reserves Stockage List and manages the medical materiel stored in the Army Afloat PREPO Program (AR–3).

(3) DLA, 7th MEDCOM, 18th MEDCOM, U.S. Army Pacific(USARPAC), and Tripler Army Medical Center (TAMC), under appropriate agreements and statements, will ensure decentralized materiel management (e.g., storage, maintenance, rotation, reporting, movement, etc.) for selected AMEDD stocks located at their depots, MEDCENs, or medical materiel/logistics organizations.

(a) AR–1 (CONUS): DLA depots.
(b) AR–2 (Europe): USAMMCE.
(c) AR–4 (Pacific): 6th MEDLOG Battalion, Korea, USARPAC, and TAMC, Hawaii.

9–3. AMEDD Army Reserves Sustainment
a. Concept. ARS is materiel intended to provide support essential to sustain combat operations and post-mobilization training to meet the national military strategy as portrayed in the Defense Planning Guidance.

b. Objective. The objective is to achieve balanced selection, procurement, accountability, and distribution of AMEDD assets Armywide via a single manager, USAMMA.

c. Requirements determination. The Army Reserves Automated Process (ARAP), formerly the War Reserves Automated Process (WRAP), provides standard computation and format for secondary item materiel requirements. The ARAP also generates AR financial data to support the budget submission process. TSG publishes annual guidance describing the procedures for computing and supporting ARS medical levels for OCONUS commands.

d. Inventory management. Assets are acquired, held, and maintained in quantities only to satisfy ARS requirements.

(1) *Serviceability.* Stocks are rotated to ensure they meet condition code A, B, or E requirements. Equipment that satisfies technical manual PMCS standards qualifies for condition code B.

(2) *Shelf life items.* Shelf life materiel and potency dated materiel require rotation whenever feasible to ensure cost reduction/optimal stock availability.

e. Funding. USAMMA monitors the approved sale and replacement/reimbursement of medical ARS stored at depots, centers, and organizations to meet peacetime demands. USAMMA directs the transfer of medical assets from these activities.

9–4. Army Reserves Operational Projects

a. Concept. AROP supports special needs above normal allowances and consists of medical materiel planned to satisfy one or multiple contingencies and OP requirements.

b. Objective. The objective is to develop a common user stockpile of medical materiel centrally managed to support one or multiple approved CINC requirements into a minimally essential AMEDD project.

c. Categories.

(1) *Additive.* Medical materiel requisites in addition to initial issue requirements contained in MTOE, TDA/modified TDA (MTDA), and CTA documents. This AROP automatically increases the authorized acquisition objective (AAO) by the quantities specified in the project.

(2) *Nonadditive*. Medical materiel normally authorized by MTOE, TDA/MTDA, and CTA documents. This type of AROP does not increase the AAO.

d. Major roles. HQDA, FORSCOM, OCONUS MACOMs, and other designated agencies request, justify, and recommend amendment of medical materiel in AROP. TSG, in coordination with the Deputy Chief of Staff for Logistics (DCSLOG), approves amendment of the AMEDD AROP. USAMMA centrally manages and reviews medical materiel requirements within AROP.

e. Inventory management criteria. AROP materiel is stored in condition code A or B. A 30-day maximum supply of repair parts and consumables is authorized for inclusion.

f. Funding. TSG programs, budgets, and funds medical materiel in the AMEDD AROP.

9–5. Army Prepositioned Sets of Equipment

a. Army Afloat PREPO (AR–3).

(1) *Concept.* The Afloat PREPO is an expanding program requiring medical materiel (including DEPMEDS equipped hospitals), ASIOE, and other support equipment (OSE) to provide health service support to planned force structures.

(2) *Objective.* The objective is to provide the right mix of medical and associated materiel for a floating AR of critical common items and equipment that are strategically available, have global application, and support multiple CINCs. This materiel supports light, airborne, air assault, mechanized, and armored divisions as well as associated combat support and combat service support organizations.

(3) *Management.* USAMMA has central management and accountability responsibilities for the Afloat PREPO.

b. AMEDD RC Hospital Decrement Program.

(1) *Concept.* This program segment consists of medical materiel, including DEPMEDS MMS, ASIOE, and OSE positioned in CONUS for use by early deploying RC medical units (USAR and ARNG). This materiel brings RC units from peacetime authorized levels to ALO–1. For DEPMEDS hospital organizations, the MMS are placed in long-term storage (LTS) with requirements reduced by that medical materiel fielded to RC units as minimum essential equipment for training.

(2) *Objectives.* The objectives are to—

(a) Appropriately determine, acquire, position and account for medical and nonmedical materiel required to equip RC hospitals to the level necessary to satisfy deployment goals and schedules.

(b) Provide flexibility and responsiveness to any contingency, emergency, and mobilization.

(c) Support the preparedness of RC hospitals and enhance USR requirements.

(3) *Policy.* Management of the AMEDD RCD–H Program will follow the intent of this regulation and the provisions of AR 220–1 and AR 710–1. Major roles in this program are discussed below:

(a) TSG owns all RCD–H assets and approves the use of these stocks to meet contingency, emergency, and peacetime requirements.

(b) TSG has executive agent responsibility for the RCD–H Program, and, in coordination with DCSLOG, directs the release of assets for contingencies, emergencies, and peacetime requirements.

(c) FORSCOM develops command and deployment plans for RCD–H units and provides guidance to ARCOM and ARNG MEDCOMs and organizations.

(d) USAMMA manages, accounts for, resources, and conducts modernization and sustainment efforts for the RCD–H. USAMMA reports RCD–H formally by the USR feeder reports to ARCOM for COMPO 3 units and to the NGB for COMPO 2 units.

(e) The U.S. Army Materiel Command supports total asset visibility for this program segment, and through MOAs with USAMMA, stores and maintains ASIOE and OSE assets, provides visibility of these assets, and coordinates for their timely release and availability.

(f) DLA, under appropriate agreements and statements, provides logistics and inventory support for RCD–H assets stored in their depots.

(4) *Authorization.* RC units are organized using HQDA approved special requirements codes that define their force structure. For the RCD–H Program, FORSCOM provides a prioritized deployment plan for the RC hospitals to USAMMA for management purposes.

(5) *Accountability.* All assets for RC units are assigned purpose code T for inventory management purposes.

(6) *Funding.* RCD–H materiel is funded from other than mobilization stock fund dollars.

Section II
Prepositioned Materiel Requirements for Contingencies, Emergencies, and Mobilization—Medical Facilities

9–6. CONUS expansion

The mobilization materiel programs identified as Prepositioned Army Reserve Materiel Requirements for Medical Facilities (PARMR–MF) Program is designed to provide materiel to expand or activate medical facilities and establish or expand blood donor centers in CONUS and certain OCONUS areas.This program supports the USAMEDCOM Mobilization Plan.

9–7. Medical Materiel Program for Defense Against Nuclear, Biological, and Chemical Agents

a. Program description. The Medical Materiel Program for Defense Against Nuclear, Biological, and Chemical Agents (MMPDANBC) provides for the procurement, stockpile, storage, maintenance, and distribution of broad spectrum antibiotics, drugs, protectants, biological vaccines, toxoids, antitoxins, chemical defense materiel (CDM), and other related medical products for the prevention and treatment of diseases and effects caused by NBC agents. Biological vaccines, toxoids, and antitoxins are used to treat casualties exposed to biological agents. Medical CDM is used as both a treatment and pretreatment against chemical agents. Antiemetics are used to lessen the effects of ionizing radiation.

b. Program objectives. The MMPDANBC's primary objective is to provide a mechanism for HQDA, OTSG, to centrally fund, procure, consolidate, and store strategic medical NBC defense materiel stockpiles. The MMPDANBC's purpose is to enhance medical NBC defense to Army forces during war operations, other than war operations, and contingency operations (under HQDA, DCSOPS, direction). The MMPDANBC enhances medical NBC defense through improved asset visibility, providing the Army the ability to crosslevel and redirect stocks.

Note. OCONUS MACOMs with requirements for MMPDANBC to support

nonmilitary personnel will procure and manage these stocks from the retail stock fund.

c. Medical CDM. The information that follows relates only to the medical CDM portion of the MMPDANBC.

(1) *Program categories.*

(a) The MMPDANBC will include only individual service member (SM) issue materiel, which includes the following: Nerve Agent Antidote Kit (Mark I),6505–01–174–9919; Pyridostigmine Bromide Tablets or Nerve Agent Pyridostigmine Pretreatment, 6505–01–178–7903; and Diazepam Autoinjectors or Convulsant Antidote for Nerve Agents (CANA), 6505–01–274–0951.Individual SM materiel will be issued under HQDA, DCSOPS, direction. At the conclusion of those operations identified in paragraph *b*above, and after redeployment, CDM will be reported and returned to the central storage locations identified in paragraph (2)(*d*)below.

(b) Not included in the MMPDANBC are items distributed for both SKOs and MES use. These component items include: atropine autoinjectors, pralidoxime chloride autoinjectors, and CANA. MACOMs will continue to use consumer funds for programming and budgeting for replacement CDM which are components of SKO/MES. CDM authorized as components of medical SKO/MES will continue to be stored at unit level *for the active component.* FORSCOM must ensure that units plan, program, and budget for SKO/MES replacement CDM materiel. MES requirements computation/authorizations will be published in MES computer listings/diskettes available from USAMMA and in appropriate supply catalogs(SC 6545–8 series). Replacement for CDM authorized as SKO/MES component materiel must be managed and replaced in accordance with the policies and procedures set forth in chapter 5.

(2) *Program roles and responsibilities.*

(a) Materiel release authority. HQDA, DCSOPS, in coordination with HQDA, OTSG.

(b) Ownership and funding. HQDA, OTSG, will program, budget, fund, and coordinate distribution of strategic stockpile materiel procured for individual SM issue.

(c) Management responsibility. USAMMA will be responsible for requirements determination, in accordance with CTA 8–100, or as determined by HQDA, OTSG.USAMMA will coordinate storage locations and COSIS requirements with separate custodial activities. USAMMA will be responsible for providing materiel disposition instructions to units upon redeployment.

(d) Storage and reporting responsibility. MACOMs having subordinate medical logistics organizations serving as CDM central storage locations will ensure compliance of storage and maintenance criteria as follows. All MACOMs are responsible for exercising prudent care, custody, and safekeeping of CDM issued to units and individuals under their control. Further, MACOMs will assure that subordinate units report the accurate status of CDM upon redeployment.MMPDANBC CDM will not be issued from central storage locations to units or individuals, except as approved by HQDA (DCSOPS and OTSG). OTSG will coordinate release with USAMMA.Medical logistics organizations serving as central storage locations will comply with the special storage requirements for CDM, for example, security and refrigeration criteria. Storage requirements will be according to current cataloging data.

Note. At the time of this printing, storage requirements were as follows: CANA—a note Q item—must be stored in a vault or safe at a controlled room temperature (59–86 degrees Fahrenheit or 15–30 degrees Celsius), Pyridostigmine Bromide Tablets must be stored under refrigeration (between 35 to 46 degrees Fahrenheit or two to eight degrees Celsius), and MARK I Kits must be stored at controlled room temperatures (59–86 degrees Fahrenheit or 15–30 degrees Celsius) with access limited to selected persons.

Upon redeployment, all CDM assets issued to units and individual soldiers will be returned to the central storage location designated by USAMMA. Redeploying units will consolidate CDM assets and report to USAMMA the NSNs, quantities, lot numbers, and other pertinent information in a timely manner. Based on the information provided by redeploying units, USAMMA will generate disposition instructions.

(3) *Issue and replacement of individual SM issued CDM.*

(a) Issue procedures. During periods of imminent unit deployment as described in paragraph *b* above, HQDA (DCSOPS and OTSG) will authorize USAMMA to direct the release of medical CDM from central storage facilities.

(b) Replacement procedures. HQDA central stockpiles will be replaced upon expiration or use.

9–8. Accounting for stocks of Army reserves for medical materiel mobilization programs

a. All medical items held for these programs will be accounted for on the IMSA stock record account. Nonmedical equipment held as PARMR–MF for activation or expansion of medical facilities will be accounted for on the installation consolidated property account.

b. Activities will identify equipment requirements under project codes "OWV" for PARMR–MF and"OWU"for blood donor center.

c. All accounting records for medical materiel mobilization programs will reflect the requirement and financed level. The requirement level will be the quantity that the activity has the capability to store and maintain. The financed level is the quantity that has been obtained toward the requirement and represents the quantity that should always be on hand or on order.

d. All records for stock held for medical materiel mobilization programs will be clearly marked or stamped "Medical Mobilization Stocks." The documents will be maintained as an integrated part of the stock record account.

Appendix A
References

Section I
Required Publications

ADSM 18–HL3–RPB–IBM–UM
Army Medical Department Property Accounting System (AMEDDPAS) Users Manual.(Cited in paras 4–18*a* and 6–2*k*(2).)

AMDF
Army Master Data File. (Cited in paras 1–4*d*(2)(*c*), 2–3*a*, 2–13*e*, 2–17*b*(1), 2–30*a*, 3–14*c*, 3–16*a*(3), 3–16*b*(2), 3–17*a*, 3–24*c*, 3–45*a*(1), 3–48*b*(4)(*a*), 3–52*a*, 3–53, 3–63*c*, 4–2*e*, 5–12*b*, and 8–23*e*(5).)

AR 5–9
Intraservice Support Installation Area Coordination. (Cited in para 6–2*l*(2)(*b*).)

AR 12–12/DLAR 4140.60/SECNAVINST 4355.17/AFR 67–7/ MCO 4140.1E
Processing Discrepancy Reports Against Foreign Military Sales Shipments.(Cited in para 3–18*c*(2).)

AR 37–1
Army Accounting and Fund Control (AMS). (Cited in paras 3–24*a*, 3–39*a*, 3–42*f*, 4–23*a*, 6–16*b*, and D–8*c*.)

AR 40–2
Army Medical Treatment Facilities—General Administration. (Cited in paras 2–7*c*, 2–9*b*(4), 3–20*e*, 3–24*a*, 3–26*a*, 3–26*h*, 3–43*c*(1), 3–56*a*(4), 3–56*b*(4)(*a*), 3–73*d*,3–75, and 8–19*a*.)

AR 40–3
Medical, Dental, and Veterinary Care. (Cited in paras 3–24*k*, 3–26*k*, 3–26*l*, 3–75, and 4–19*a*(2).)

AR 40–5
Preventive Medicine. (Cited in paras 3–50*a*,3–50*b*, 3–50*e*(2), 3–50*e*(3)(*c*), and 8–15*b*(7).)

AR 40–7
Use of Investigational Drugs and Devices in Humans and the Use of Schedule I Controlled Drug Substances. (Cited in paras 3–26*a* and 3–26*h*.)

AR 40–14/DLAR 1000.28
Control and Recording Procedures for Exposure to Ionizing Radiation and Radioactive Materials. (Cited in para 3–68*a*.)

AR 40–38
Clinical Investigation Program. (Cited in para 2–9*b*(1).)

AR 40–60
Policies and Procedures for the Acquisition of Medical Materiel.(Cited in paras 2–6, 4–3*g*, 5–1, 5–2*b*, and 6–2*h*.)

AR 40–63/NAVMEDCOMINST 6810.1/AFR 167–3
Ophthalmic Services. (Cited in paras 3–24*j*,8–25, and D–5*a*.)

AR 40–65/NAVMEDCOMINST 6700.4/AFR 167–13
Review Procedures for High Cost Medical Equipment. (Cited in para 4–10*g*.)

AR 40–68
Quality Assurance Administration. (Cited in para 2–12*b*.)

AR 40–501
Standards of Medical Fitness. (Cited in para 4–15*a*.)

AR 40–538/BUMEDINST 6700.2B/AFR 167–5
Property Management During Patient Evacuation. (Cited in paras 3–47*a*and 4–28*a*(1)(*a*).)

AR 55–38/NAVSUPINST 4610.33/AFR 75–18/MCO P4610.19/ DLAR 4500.15
Reporting of Transportation Discrepancies in Shipments. (Cited in paras 3–18*a* and 3–18*c*(1).)

AR 70–1
Army Acquisition Policy. (Cited in paras 1–4*c*,2–9*b*(2), and 6–20*a*.)

AR 71–13
The Department of the Army Equipment Authorization and Usage Program.(Cited in paras 4–1*a*(1), 4–1*a*(2),4–6*c*, and 4–8*c*.)

AR 190–40
Serious Incident Report. (Cited in para 3–18*c*(3).)

AR 190–50
Physical Security for Storage of Controlled Medical Substances and Other Medically Sensitive Items. (Cited in paras 3–3*d*,3–56*a*, 3–56*b*(5), and 3–67.)

AR 200–1
Environmental Protection and Enhancement. (Cited in paras 3–37*b*, 3–50*a*, and 3–50*b*.)

AR 220–1
Unit Status Reporting. (Cited in paras 4–4*e*,5–13*a*, 5–15*b*(4), 6–4*a*, 6–4*b*, 6–4*c*,9–5*b*(3), and app E.)

AR 310–49
The Army Authorization Documents System (TAADS). (Cited in paras 4–4*c*, 4–6*c*, 4–8*c*,5–5*d*(1), and 5–5*e*(3).)

AR 385–11
Ionizing Radiation Protection (Licensing, Control, Transportation, Disposal, and Radiation Safety). (Cited in paras 3–43*c*(2) and 3–68*b*.)

AR 385–69
Biological Defense Safety Program. (Cited in para 3–51.)

AR 420–47
Solid and Hazardous Waste Management. (Cited in para 3–50*a*.)

AR 700–4
Logistics Assistance Program (LAP). (Cited in paras 1–4*a*(9) and 6–19*b*(2).)

AR 700–68/DLAR 4145.25/NAVSUPINST 4440.128C/MCO 10330.2C/AFR 67–12
Storage and Handling of Compressed Gases and Gas Liquids in Cylinders, and of Cylinders. (Cited in paras 3–44*a*(2) and 3–48*b*(3).)

AR 700–131
Loan of Army Materiel. (Cited in paras 4–22*b*,4–22*d*, and 5–15*g*(2).)

AR 700–138
Army Logistics Readiness and Sustainability. (Cited in paras 5–12*c*, 6–4*a*, 6–4*b*, and 6–4*c*.)

AR 700–142
Materiel Release, Fielding, and Transfer. (Cited in para 5–11*a*.)

AR 710–1
Centralized Inventory Management of the Army Supply System. (Cited in paras 4–3*b*(1), 9–1, and 9–5*b*(3).)

AR 710–2
Supply Policy Below the Wholesale Level. (Cited in paras 2–1, 3–1*c*, 3–2*b*, 3–3*c*,3–12*c*, 3–13*a*, 3–13*b*, 3–18*a*, 3–38*e*, 3–39*a*, 3–40*c*, 3–41*e*, 3–41*f*, 4–3*h*, 4–4*i*, 4–18*b*, 4–24*b*, 4–28*c*(1), 4–29*a*, 5–5*d*(1), 5–6*a*(2), 5–6*b*, 5–14*c*, 6–18*a*(3), 6–21*e*(1), 6–21*e*(4), 6–23, 7–1,7–5*c*, 8–9, and 9–1.)

AR 725–50
Requisitioning, Receipt, and Issue System. (Cited in paras 2–24*b*(5), 3–3*g*, 3–16*b*(2), 3–19*b*, 3–44*b*, 3–45*a*, 3–45*c*, 3–45*d*(6), 3–48*a*, 3–48*e*, 3–62*e*(1), 3–62*f*(2)(*b*),3–62*h*, 3–63*f*(1), and 4–25*a*.)

AR 735–5
Policies and Procedures for Property Accountability. (Cited in paras 3–1*c*, 3–39*a*, 4–19*h*(2), 4–19*h*(3), 4–19*j*(3), 4–28*b*(1), and 5–5*f*(1).)

AR 735–11–2/DLAR 4140.55/SECNAVINST 4355.18/AFR 40–54
Reporting of Item and Packaging Discrepancies. (Cited in paras 3–18*a*, 3–18*c*(2), and 3–18*c*(3).)

AR 750–1
Army Materiel Maintenance Policy and Retail Maintenance Operations.(Cited in paras 6–3*a*(1), 6–9*b*, 6–16*b*, 6–18*a*(3), and 6–18*b*.)

AR 750–2
Army Materiel Maintenance, Wholesale Operations. (Cited in para 6–3*a*(1).)

AR 750–10
Modification of Materiel and Issuing Safety-of-Use Messages and Commercial Vehicle Safety Recall Campaign Directive. (Cited in para 6–20*a*.)

AR 755–3
Recovery and Utilization of Precious Metals. (Cited in paras 3–49*a*and 3–49*b*(1).)

Code of Federal Regulations (CFR)
Note: CFRs can be obtained by writing to the Superintendent of Documents, ATTN: New Orders, P.O. Box 371954, Pittsburgh, PA 15250–7954.

21 CFR
Food and Drugs (Cited in paras 4–20*d*, 6–6*d*,6–6*d*(1), and 6–10*b*.)

29 CFR
Labor (Cited in paras 3–50*d*, 8–10*b*,8–15*b*(5), and 8–15*b*(9).)

40 CFR
Public Buildings, Property, and Works(Cited in paras 2–24*a*(1) and 3–49*c*.)

CTA 8–100
Army Medical Department Expendable/Durable Items. (Cited in paras 5–6*a*(3)(*a*) and 9–7*c*(2)(*c*).)

DA PAM 700–142
Instruction for Materiel Release, Fielding, and Transfer. (Cited in paras 5–11*a* and 5–11*c*.)

DA PAM 710–2–1
Using Unit Supply System (Manual Procedures). (Cited in paras 2–1,3–15*b*, 3–15*d*, 3–41*e*, 4–3*h*, 4–18*b*, 4–24*b*, 4–28*a*(1)(*a*), 4–29*a*, 5–6*a*, 6–21*e*(1),6–21*e*(4), and 6–23.)

DA PAM 710–2–2
Supply Support Activity Supply System: Manual Procedures. (Cited in paras 2–1, 3–12*b*(1), 3–12*c*,3–13*a*, 3–13*b*,3–15*b*, 3–15*d*, 3–39*a*, 3–40*c*, 3–41*e*, 4–24*b*, 5–6*a*(3)(*a*), 6–23*f*, and 8–9.)

DOD 4145.19–R–1
Storage and Materials Handling. (Cited in para 3–38*e*.)

DOD 4160.21–M
Defense Reutilization and Marketing Manual. (Cited in paras 3–48*a*, 3–48*b*, 3–49*a*, 3–49*b*(1), 3–50*a*, 4–24*c*, and 4–25*a*.)

DOD Directive 4160.22
Recovery and Utilization of Precious Metals. (Cited in paras 3–49*a* and 3–49*b*(1).) (This directive may be obtained from the Naval Publications and Forms Center, Code 3015, 5801 Tabor Avenue, Philadelphia, PA 19120, using a DD Form 1425 (Specifications and Standards Requisition).)

DOD Directive 6015.5
Joint Use of Military Health and Medical Facilities and Services. (Cited in para 2–4*a*.) (This directive may be obtained from the Naval Publications and Forms Center, Code 3015, 5801 Tabor Avenue, Philadelphia, PA 19120, using a DD Form 1425.)

DOD Directive 6055.10
Receipt and Administration of Bulk Liquid Oxygen for Medical Use. (Cited in para 2–15*a*.) (This directive may be obtained from the Naval Publications and Forms Center, Code 3015, 5801 Tabor Avenue, Philadelphia, PA 19120, using a DD Form 1425.)

DOD Instruction 6050.5
DOD Hazard Communication Program. (Cited in para 3–50*d*.) (This instruction may be obtained from the Naval Publications and Forms Center, Code 3015, 5801 Tabor Avenue, Philadelphia, PA 19120, using DD Form 1425.)

DOD Medical Catalog (DOD MED CAT), Volume II
Sets, Kits, and Outfits. (Cited in paras 2–13*e*, 2–17*b*(5), 2–24*a*, 3–17*a*, and 3–26*b*(1).)

DOD Medical Catalog (DOD MED CAT), Volume III
Master Cross-Reference List. (Cited in paras 2–13*e*, 2–17*b*(5), 2–24*a*, 3–16*a*(3), 3–16*b*(2), 3–17*a*, and 3–26*b*(1).)

Federal Supply Catalog (FSC)
DOD Section, Medical Materiel. (Cited in paras 2–14*c*(1), 3–7*a*(1), 3–16*b*(2), 3–48*b*(4)(*a*),3–52*a*, 3–53, and 3–54*a*.)

FM 10–15
Basic Doctrine Manual for Supply and Storage. (Cited in para 3–38*b*.)

JCAHO Manual
Joint Commission on Accreditation of Healthcare Organizations Accreditation Manual for Hospitals. (Cited in para 8–15*b*(8).) (The current edition of this publication may be obtained from JCAHO, 875 N. Michigan Ave., Chicago, IL 60611.)

MIL–STD–1691
Construction and Materiel Schedule for Military Medical and Dental Facilities. (Cited in paras 4–2*b*, 4–7*a*(3), and 4–7*a*(4).) (This publication may be obtained from the Naval Publications and Forms Center, Code 3015,5801 Tabor Avenue, Philadelphia, PA 19120, using DD Form 1425.)

NATO STANAG 2907
Procedures for Reporting and for Initial Disposition of Unsatisfactory Medical Materiel and Drugs. (Cited in para 3–70.) (This publication may be obtained from the Naval Publications and Forms Center, Code 3015, 5801 Tabor Avenue, Philadelphia, PA 19120, using DD Form 1425.)

NFPA Standard 99
Standard for Health Care Facilities. (Cited in paras 6–5*a*(1), 6–5*a*(2), 6–5*a*(3), 6–5*c*, 6–5*e*, 6–24*a*, 6–24*d*, 6–24*e*, and 6–25.) (This publication may be obtained from the National Fire Prevention Association, Battery March Park, Quincy, MA 02269.)

QSTAG 287
Procedures for Reporting and Initial Disposition of Unsatisfactory Drugs.(Cited in para 3–70.) (This publication may be obtained from the Naval Publications and Forms Center, Code 3015, 5801 Tabor Avenue, Philadelphia, PA 19120, using DD Form 1425.)

QSTAG 291
Interface of Medical Supply Procedures. (Cited in para 2–5*c*.) (This publication may be obtained from the Naval Publications and Forms Center, Code 3015, 5801 Tabor Avenue, Philadelphia, PA 19120, using DD Form 1425.)

SB 8–75–MEDCASE
Army Medical Department Supply Information. (Cited in paras 3–14*d*, 3–16*d*, 3–24*l*, 3–31*a*, 4–7*a*(4), 4–7*b*, 4–7*c*(1), 4–7*c*(4), 4–8*d*, 4–10*g*, 4–11, 4–13*b*, 4–17*b*, 4–18*g*, 6–26*b*, and C–4.)

SB 8–75 series
Army Medical Department Supply Information. (Cited in paras 1–4*d*(1), 2–12*a*(2), 2–13*b*, 2–13*c*, 2–17*b*(3), 2–20*h*(4), 2–24*a*(4), 2–24*b*(3), 2–27*a*(3), 2–28*a*, 3–17*c*, 3–24*b*, 3–26*j*, 3–37*d*, 3–41*d*(1), 3–50*a*, 3–50*b*, 3–52*a*, 3–52*d*(1), 3–62*d*, 3–62*e*(1), 3–62*f*(1)(*d*), 3–63*e*, 3–64*a*, 3–64*b*, 3–69*a*(1), 3–72*a*, 3–75, 3–76*b*(4), 4–5*c*, 4–15*c*, 5–4*a*, 5–4*c*, 5–8*a*,5–13*c*(2), 6–2*l*(3), 6–3*b*(2)(*e*), 6–4*c*, 6–14*d*, 6–14*f*, 6–18*a*(2)(*b*), and 6–23*c*.)

SB 700–20
Army Adopted/Other Items Selected for Authorization/List of Reportable Items. (Cited in paras 4–1*a*(1) and 4–4*d*.)

SC 6545–8–CL–HR series
Sets, Kits, and Outfits Components List. (Cited in para 5–6*a*(2).)

TB MED 1
Storage, Preservation, Packaging, Packing, Maintenance, and Surveillance of Materiel—Medical Activities. (Cited in paras 2–17*b*(4), 6–2*j*, and 6–11*a*(2).)

TB MED 7
Maintenance Expenditure Limits for Medical Materiel. (Cited in paras 3–43*b*(2)(*c*), 6–8, 6–9*d*, 6–10*c*, 6–14*c*, 6–16*b*, and 6–16*e*.)

TB MED 525
Control of Hazards to Health from Ionizing Radiation Used by the Army Medical Department (Cited in paras 3–68*a* and 3–68*b*.)

TB 8–6515–001–35
Calibration and Repair of Audiometric Equipment. (Cited in paras 6–7*a* and 6–7*b*.)

TB 38–750–2
Maintenance Management Procedures for Medical Equipment. (Cited in paras 6–2*k*(1), 6–5*b*, 6–6*c*, 6–6*e*, 6–17*d*(2), and 6–20.)

TB 43–180
Calibration and Repair Requirements for the Maintenance of Army Materiel.(Cited in paras 6–17*c*(3), 6–17d(3), 6–17*e*(2), and 6–17*e*(3).)

TB 740–10/DLAM 4155.5/AFR 67–43, appendix M
Quality Control Depot Storage Standards (app M, Medical Supplies).(Cited in paras 2–13*d*, 2–13*e*, 2–17*b*(2), 2–17*c*, 2–19*a*, 2–20*a*(5), and 3–45*d*(6).)

TM 38–410/DLAM 4145.11/NAVSUP PUB 573/AFR 69–9/MCO 4450.12
Storage and Handling of Hazardous Materiels. (Cited in para 3–37*b*.)

TM 743–200–1
Storage and Materials Handling. (Cited in paras 3–37*b*,3–37*e*, and 3–38*b*.)

TM 743–200–2
Storage Modernization. (Cited in para 3–38*b*.)

Section II
Related Publications

A related publication is merely a source of additional information. The user does not have to read it to understand this publication.

AR 10–54
Field Operating Agencies of the Office of The Surgeon General

AR 10–64/OPNAVINST 6700.2/AFR 160–29/MCO 5420.18A
Joint Field Operating Agencies of the Office of the Surgeon General of the Army

AR 11–11
(C) War Reserves (U)

AR 25–1
The Army Information Resources Management Program

AR 25–400–2
The Modern Army Recordkeeping System (MARKS)

AR 32–4/DLAR 4235.18/AFR 67–125/NAVSUPINST 4400.70C/MCO 4400.137A
Special Measurement Clothing and Footwear, Orthopedic Footwear, Guidons, Streamers and Flags

AR 37–100–FY
The Army Management Structure (AMS)

AR 55–355/NAVSUPINST 4600.70/AFR 75–2/MCO P4600.14B/DLAR 4500.3
Defense Traffic Management Regulation

AR 70–25
Use of Volunteers as Subjects of Research

AR 73–1
Test and Evaluation Policy

AR 190–51
Security of Unclassified Army Property (Sensitive and Nonsensitive)

AR 220–10
Preparation for Oversea Movement of Units (POM)

AR 335–15
Management Information Control System

AR 380–5
Department of the Army Information Security Program

AR 385–40
Accident Reporting and Records

AR 700–9
Policies of the Army Logistics System

AR 700–43/DLAM 4215.1/NAVSUP PUB 5009/AFM 78–9
Management of Defense-Owned Industrial Plant Equipment (IPE)

AR 700–49/DLAR 4140.27/AFR 400–52/MCO 4443.10
Loan of DLA Stock Fund Materiel

AR 700–84
Issue and Sale of Personal Clothing

AR 700–127
Integrated Logistic Support

AR 700–139
Army Warranty Program Concepts and Policies

AR 708–1
Cataloging and Supply Management Data

AR 710–3
Asset Transaction Reporting System

AR 740–1
Storage and Supply Activity Operations

CTA 50–909
Field and Garrison Furnishings and Equipment

DFARS
Defense Federal Acquisition Regulation Supplement

DOD 6010.8–R
Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

FAR
Federal Acquisition Regulation

FEDLOG
Federal Logistics Data on Compact Disk

SC 6545–8 series
Sets, Kits, and Outfits Components List

SC 6545–8–CL–P06
Optical Equipment Set, Ophthalmic Laboratory, CONUS, Type I (NSN 6545–00–105–0104)
Optical Equipment Set, Ophthalmic Laboratory, CONUS, Type II (NSN 6545–00–105–0123)
Optical Equipment Set, Ophthalmic Laboratory, CONUS, Type III (NSN 6545–00–105–0124)
Optical Equipment Set, Ophthalmic Laboratory, CONUS Type IV (NSN 6545–00–105–0140)

SC 6545–8–P01
Optical Fabrication Unit, Field No. 1 (Semimobile) (NSN 6645–00–292–9683) (LIN N22210)

SC 6545–8–P02
Optical Fabrication Unit, Field No. 2 (Base with Laboratory) (NSN 6545–00–292–9696) (LIN N22347)

SC 6545–8–P03
Optical Fabrication Unit, Portable, Field (NSN 6545–00–931–5130) (LIN N22073)

TM 8–6500–001–10–PMCS
Operator's Preventive Maintenance Checks and Services for Reportable Medical Equipment (Consolidated)

TOE 8–287H6
Medical Supply, Optical, and Maintenance Unit

RCS MED–199
Optical Laboratory Report

RCS MED–250
MEDCASE Report

Section III
Prescribed Forms

DA Form 2717
Optical Laboratory Report. (Prescribed in para 8–26.)

DA Form 3321
Request for Acknowledgement of Loaned Durable Medical Equipment.(Prescribed in paras 4–19*j*(2)(*a*) and(*d*).)

DA Form 4996–R
Quality Control Card. (Prescribed in para 2–14*d*.)

DA Form 4997–R
Locator Card. (Prescribed in para 3–38*c*.)

DA Form 4998–R
Quality Control and Surveillance Record for TOE Medical Assemblage.(Prescribed in paras 5–6*a*(2)(*b*)and 5–6*a*(3)(*b*).)

SF 380
Reporting and Processing Medical Materiel Complaints/Quality Improvement Report. (Prescribed in paras 3–70 and 3–72.)

Section IV
Referenced Forms

DA Form 444
Inventory Adjustment Report (IAR)

DA Form 1296
Stock Accounting Record

DA Form 1687
Notice of Delegation of Authority—Receipt for Supplies

DA Form 2064
Document Register for Supply Actions

DA Form 2407
Maintenance Request

DA Form 2409
Equipment Maintenance Log (Consolidated)

DA Form 3161
Request for Issue or Turn-In

DA Form 3862
Controlled Substances Stock Record

DA Form 3949
Controlled Substances Record

DA Form 5027–R (TEST)
MEDCASE Program Requirements

DA Form 5028–R (TEST)
MEDCASE Support and Transmittal Form

DA Form 5621–R
General Leakage Current Measurements

DA Form 5622–R
EKG Leakage Current Measurements

DA Form 5624–R
DC Defibrillator Inspection Record

DA Label 175
Defibrillator Energy Output Certification

DD Form 771
Eyewear Prescription

DD Form 1391
FY, Military Construction Project Data

DD Form 1425
Specifications and Standards Requisition

DD Form 2161
Referral for Civilian Medical Care

DD Form 2163
Medical Equipment Verification/Certification

DEA Form 224
New Application for Registration Under Controlled Substances Act of 1970.(Contact the nearest DEA regional office to obtain this form.)

FDA Form 2579
Report of Assembly of a Diagnostic X-Ray System. (This form may be obtained from the Food and Drug Administration, Center for Device and Radiological Health, 1390 Piccard Drive, Rockville, MD 20850.)

SF 361
Transportation Discrepancy Report

SF 364
Report of Discrepancy (ROD)

SF 700
Security Container Information

SF 702
Security Container Check Sheet

Appendix B
Format Guidance for an Evaluation of a Commercial Item Request

B–1. Submission procedures
Submit requests for Evaluation of a Commercial Item in writing through the Commander, USAMEDCOM, ATTN: MCHA–P, Fort Sam Houston, TX 78234–6000. Include the information noted in paragraph B–2 below.

B–2. Information Necessary for Commercial Item Requests
a. Description and essential characteristics of item to be evaluated. (Include manufacturer's name, model number, and name, address, and telephone number of the manufacturer's representative. Attach descriptive brochures, price list, and any other available literature.)

b. Reason for request. (Give the name of the department that will use the item, the purpose of the item, and whether comparable equipment exists in the requesting facility.)

c. Benefits. (Cite the benefits that can be expected from the use of this item in terms of improved health care, efficiency, and economy.)

d. Compatibility. (Indicate whether the item is compatible with existing equipment or systems. Explain.)

e. Equivalent standards items. (If an equivalent standard item exists, indicate why it is not suitable.)

f. AMEDD application. (State whether the item could be used in other AMEDD activities, either fixed or field. Identify the type of activities; for example, large MEDDAC, combat support hospital, or battalion aid station.)

g. Comparable items.

(1) (If known, give a list of all manufacturers and model designations of the items.)

(2) (If item is one of a kind, so state.)

h. Vendor services (if known). (State the services the vendor will provide at no cost to the Government, to include those in (1) through(5) below.)

(1) (If known, give a list of list of all manufacturers and model designation of the items.)

(2) Provide special operator or maintenance training (if required). (State specifically what is required.)

(3) Provide maintenance (unique maintenance beyond the capability of the evaluation activity.)

(4) Supply expendables.

(5) Pay for site preparation and restoration.

i. Evaluation time. (Estimate how long the item will be evaluated, the number of staff, and the workload involved.)

j. Logistical data or information. (State the medical professional and logistical data or information expected to be derived from this evaluation. Detail is important, since this information serves in part to guide the materiel inquiry process. If the request is approved, this information will be required for evaluation planning.)

k. Contacts.

(1) (List individuals and institutions, and their telephone numbers, who are known to have experience with the item(s).)

(2) (Give the name and telephone number of the evaluation project officer.)

Appendix C
MEDCASE Report (RCS MED–250)

C–1. Submission requirements
All activities and commands that participate in the MEDCASE Program will submit a MEDCASE Report to their MEDCOM. MEDCOMs will submit a consolidated command report to Commander, USAMMA, ATTN: SGMMA–OM, Fort Detrick, Frederick, MD 21702–5001. The command report must arrive at USAMMA before 31 January each year. Data submitted will be as of 31 December of the prior year. USAMMA will forward the report to OTSG. The data is used for the annual update of the Five-Year Defense Program in the OPA appropriation.

C–2. Dollar requirements
Report dollar requirements for each of the 5 program years in the format shown in table C–1. Activities operating with AMEDDPAS will submit the automated RCS MED–250 report to their MEDCOM. MEDCOMs will display requirements by the command total and individual total for each subordinate health care activity. Activities and MEDCOMs will attach a narrative analysis identifying any future requirements not reflected in the automated report data, and defining any significant problem areas and their impact on the health care mission.

C–3. Property book data
Property book data will be reported in the format shown in table C–2.This data is available from AMEDDPAS as part of the RCS MED–250. Dollar amount will be the total amount in each unit price category. Do not include other items that will be replaced with nonmedical funds.

C–4. Additional information
Additional detailed information on RCS MED–250 and a sample of the automated AMEDDPAS output report are contained in SB 8–75–MEDCASE.

Table C–1
Format for Five-Year Defense Program dollar requirements

Medical Care Support Equipment Program
Dollar Requirements (fiscal years through)

Budget line item	FY	FY	FY	FY	FY
BLIC NF					
(expansion/new installation)					
Total dollar requirement	$	$	$	$	$
Items less than $200 unit price					
Items unit price $200 to $14,999					
Items unit price $15,000+					
BLIC UR					
(replacement/modernization)					
Total dollar requirement	$	$	$	$	$
Items less than $200 unit price					
Items unit price $200 to $14,999					
Items unit price $15,000+					

Table C–2
Format for property book data reporting

Medical Care Support Equipment Program
Property Book Data (as of 31 December_____)

Unit price categories	Dollar value	Property book line items	Individual items on hand
MEDCASE type equipment			
Total property book	$		
Items less than $200 unit price	$		
Items unit price $200 to $14,999	$		
Items unit price $15,000+	$		
Audiovisual equipment			
Total property book	$		
Items unit price less than $15,000	$		
Items unit price $15,000+	$		

Appendix D
Instructions for Using DA Form 2717 (RCS MED–199)

D–1. Section A—Summary of Workload

a. Lines 1 through 5. Data will be reported in columns c through h with a total of all reportable elements in column b.

(1) Active military personnel will be reported in columns c, d, and e, as appropriate. Marine Corps personnel will be included in column e.

(2) Retired personnel of all military Services and their dependents will be reported in column f.

(3) Dependents of active military personnel will be reported in column g.

(4) All other personnel authorized spectacles will be reported in column h.

b. Line 1. The number of prescribed pairs of spectacles that remain to be fabricated at the end of the prior report period.

c. Line 2. The number of pairs of spectacles prescribed by eye clinics on DD Form 771 (Eyewear Prescription). Where more than one pair of spectacles or allied devices are prescribed on a single prescription, the number of pairs will be recorded rather than the number of prescription forms received.

d. Line 3. Total of lines 1 and 2.

e. Line 4. Total number of pairs of spectacles and allied devices fabricated by the laboratory or unit during the report period, including pairs that were fabricated by commercial facilities. (See instruction for line 28.) Individual lens replacement that does not involve replacement of the frame will not be included on line 4 but will be reported separately on line 29.

f. Line 5. Number of pairs of spectacles remaining on which action has not been completed at the end of the report period.

D–2. Section B—Breakdown of Pairs of Spectacles Fabricated

Data for lines 6 through 14 will be reported in the same manner as described in paragraph D–1*a* above.

a. Lines 6 through 10. All standard frames fitted with standard lenses will be reported on the appropriate line.

b. Lines 12 and 13. Any pair of spectacles which consist of at least one nonstandard component (frame or lenses) will be entered on appropriate lines.

c. Lines 11 and 14. The total of line 11 plus line 14 will equal line 4, Section A.

D–3. Section C—Lens Surfacing

a. Line 15. The total number of single lens that required sphere surfacing.

b. Line 16. The total number of single lens that required cylinder surfacing.

D–4. Section D—Prescription Referrals (OCONUS (commands) Only)

a. Line 17. The short title of the optical laboratory to which

spectacle prescriptions beyond the capacity of the reporting laboratory or unit are referred for fabrication.

b. Line 18. Total number of pairs of spectacles beyond the reporting unit's capability to fabricate that were referred to the supporting optical laboratory.

D–5. Section E—Reimbursement Spectacles

a. Line 19. Total number of pairs of spectacles reported on line 4 for which reimbursement was required under AR 40–63/NAVMEDCOMINST 6810.1/AFR 167–3.

b. Line 20. The dollar amount received as reimbursement for spectacles reported on line 19.

D–6. Section F—Special Procedures

a. Line 21. The number of spectacles that were fabricated with tinted lenses. Subtotals on lines 22 and 23 will indicate the number of pairs used in aviation spectacles and all other frames respectively.

b. Line 24. The number of pairs of spectacles in which color and magnesium fluoride coated lenses were used. Subtotals on lines 25 and 26 will indicate the number of pairs with color and magnesium fluoride coating, respectively.

c. Line 27. Number of pairs of glass industrial safety thickness lenses (3 mm minimum thickness).

d. Line 28. The number of spectacles reported on line 4 for which the lens prescription was referred to commercial laboratories for fabrication will be reported in block 36.

e. Line 29. The number of individual lens replacements made without any frame replacement. (Do not include this data in Section A.)

D–7. Section G—Personnel Strength

a. Line 30. TOE or TDA authorized strength for the laboratory at the end of the reporting period.

b. Line 31. For military, enter personnel strength on hand as indicated on the morning report at the end of the reporting period. For civilians, enter personnel strength (including foreign nationals) as shown at the end of the reporting period.

D–8. Section H—Cost Data

This section will be completed only by optical laboratories and sections operating in CONUS facilities and in OCONUS depots.

a. Block 32. Total of blocks 33 through 37.

b. Block 33. Cost of component parts of spectacles and allied ocular devices.

c. Block 34. Cost for military personnel, computed in accordance with compensation rate tables in AR 37–1.

d. Block 35. Civilian personnel costs will consist of elements of expense 1100, 1200, 1600, 1700, and 2800 as defined in AR 37–100–FY.

e. Block 36. Cost of contract fabrication indicated on line 28.

f. Block 37. Cost of contract services such as lens coating.

D–9. Remarks

Remarks will include, but not be limited to, the following:

a. Cost of other operating supplies not included in block 33 (repair parts, supplies, and materials).

b. Pairs of half-eye spectacles fabricated.

c. Pairs of spectacles with plastic lenses fabricated. When applicable, separately identify finished stock single-vision and multivision surface work production. Indicate quantities of each category fabricated in-house and by contract.

d. Breakout of workload and reimbursement reported on lines 19 and 20.Separately identify category of customer (ARNG, USAR, dependents, and other)and type of eyewear provided (aviation, spectacles, mask inserts, and other).Indicate dollar amount of reimbursement for each breakout entry.

e. Data which is explanatory to line entries, trends or developments in fabrication workloads, supply deficiencies, and other pertinent remarks on fabrication problems.

Appendix E
Equipment On Hand Readiness Computation Procedures

E–1. Computation procedures for individual assemblages

a. Identify the unit's reportable medical assemblages by LIN (ERC P and A)according to AR 220–1 and unit MTOE.

b. Identify the component NSNs/lines within each reportable medical assemblage. Exclude the following components, if applicable:

(1) All ASIOE which are medical assemblage components but appear separately on the unit's MTOE.

(2) P&D items. (See chap 5.)

c. Identify remaining components by ARC N(nonexpendable), D (durable), or X(expendable).

d. Using automated or manual procedures, determine the on-hand percentage for each medical assemblage component NSN/line (all ARC N, D, and X components). Identify the percentage of component NSNs/lines that have an on-hand percentage of 75 percent or higher measured against authorized quantities in current assemblage listing. (See table E–1 for a sample worksheet to record this information.)

e. Use table E–2 to complete *f*and *g* below.

Table E–2
Determining C–level ratings

Rating level	Definition
C–1	100% of component lines meet 75% standard.
C–2	90% to < 100% of component lines meet 75% standard.
C–3	75% to < 90% of component lines meet 75% standard.
C–4	Less than 75% of component lines meet 75%standard.

f. Determine a C-level rating for each assemblage based on the percentage of all ARC N, D, and X NSNs/lines that meet a 75-percent-on-hand standard.

g. Determine a C-level rating for each assemblage based on the percentage of only ARC N NSNs/lines that meet the 75-percent-on-hand standard.

h. Based on the results of *f* and *g*above, use the lower of the two C-level ratings as the overall assemblage rating for each reportable medical set.

i. A C-level rating of C–4 means that the assemblage is not sufficiently complete to be used for its intended purpose and is not to be considered on hand for EOH readiness reporting purposes. C-levels of C–1, C–2, and C–3 are considered sufficiently complete for EOH readiness purposes. However, a C–3 rating identifies an assemblage as marginally complete.

E–2. Unit overall rating

a. Upon completion of individual medical assemblage EOH computations, the unit should refer to AR 220–1 for procedures for determining the unit overall USR EOH rating.

b. Unit commanders may choose to upgrade or downgrade a unit's overall C-level, however, resource area ratings cannot be changed.

Table E–1
Sample worksheet for readiness computations

NSN	Nomenclature	U/I	Account Req. code	Qty. Auth.	75% Qty.	Qty. on hand	75% Y/N
6525–00–601–0600	CASSETTE 9⅜ X 10 IN	EA	N	3	3	3	Y
6525–00–603–1250	GRID RAD 10 X 12 STR	EA	N	1	1	1	Y
6525–00–608–0620	SE X-RAY FILM	SE	N	1	1	1	Y
6525–00–930–0575	RADIOGRAPHIC PAP 10 SEC	PG	X	12	9	8	N
6530–00–660–0034	SUPPORT LITTER FOLDING	PR	D	2	2	1	N
6532–00–935–9765	APRON X-RAY PROTECTIVE	EA	D	2	2	2	Y
6545–00–914–3500	CHEST MED INST SUP NO. 5	EA	N	1	1	1	Y
7530–00–612–4000	ENVELOPE PHOTO NEGAT	HD	X	1	1	0	N

Glossary

Section I
Abbreviations

AAC
acquisition advice code

AAO
authorized acquisition objective

ABA
appropriation and budget activity account code

ADPE
automatic data processing equipment

AE
aeromedical evacuation

AFM
Air Force Manual

AFR
Air Force Regulation

AIG
address indicator group

ALO
authorized level of organization

AMDF
Army Master Data File

AMEDD
Army Medical Department

AMEDDC&S
Army Medical Department Center and School

AMEDDPAS
Army Medical Department Property Accounting System

AO
area of operation

APS
Army Reserves Prepositioned Sets

AR
Army Reserves (materiel stocks)

ARAP
Army Reserve Automated Process

ARC
accounting requirements code

ARCOM
U.S. Army Reserve Command

ARNG
Army National Guard

AROP
Army Reserves Operational Projects

ARPS
Army Readiness Package South

ARS
Army Reserves Sustainment

ASIOE
associated support items of equipment

ASL
authorized stockage list

AT
annual training

AVF
asset visibility file

BLIC
budget line item code

BPA
blanket purchasing agreement

BUMEDINST
Bureau of Medicine and Surgery Instruction

CAGE
commercial and Government entity

CANA
convulsant antidote for nerve agent

CBS–X
Continuing Balance System—Expanded

CDM
chemical defense materiel

CDMML
Consolidated Defective Medical Materiel List

CFP
Contingency Force Pool

CHAMPUS
Civilian Health and Medical Program of the Uniformed Services

CIIC
controlled inventory item code

CINC
commander in chief

COMMZ
communications zone

CONUS
continental United States

COSIS
Care of Supplies in Storage

CP
collection point

CPD
central processing and distribution

CTA
common tables of allowances

CVC
calibration, verification, and certification

CZ
combat zone

D-Day
deployment day (attack day)

DA
Department of the Army

DAAS
Defense Automatic Addressing System

DAMPL
Department of the Army master priority list

DBPA
decentralized blanket purchasing agreement

DCSLOG
Deputy Chief of Staff for Logistics

DCSOPS
Deputy Chief of Staff for Operations

DEA
Drug Enforcement Administration

DENTAC
dental activity

DEPMEDS
Deployable Medical Systems

DES
dental equipment set(s)

DHP
Defense Health Program

DIC
document identifier code

DLA
Defense Logistics Agency

DLAM
Defense Logistics Agency Manual

DLAR
Defense Logistics Agency Regulation

DMS
dental materiel set(s)

DMSB
Defense Medical Standardization Board

DMSO
division medical supply officer

DOD
Department of Defense

DODAAC
Department of Defense activity address code

DODD
Department of Defense Directive

DPSC
Defense Personnel Support Center

DRMO
Defense Reutilization and Marketing Office

EOH
equipment on hand

EOQ
economic order quantity

ERC
equipment readiness code

FAR
Federal Acquisition Regulation

FDA
Food and Drug Administration

FEDLOG
Federal Logistics Data on Compact Disc

FIA
financial inventory accounting

FLIS
Federal Logistics Information System

FM
field manual

FOA
field operating agency

FORSCOM
U.S. Army Forces Command

FSC
Federal supply classification

FSS
Federal supply schedule

FY
fiscal year

GOCOM
U.S. Army Reserve General Officer Command

GSA
General Services Administration

HDV
high dollar value

HQDA
Headquarters, Department of the Army

HRPN
health related product number

IMSA
installation medical supply activity

IPD
issue priority designator

ISSA
Inter-Service Support Agreement

JCAHO
Joint Commission on Accreditation of Healthcare Organizations

JMMC
Joint Military Medical Command

LAP
Logistics Assistance Program

LAV
logistics assistance visit

LIN
line item number

LOA
letter of authorization

LOGCAT
logistical category

LTS
long-term storage

MAC
maintenance allocation chart

MACOM
major Army command

MATDACS
Materiel Distribution and Collection Systems

MCN
management control number

MCO
Marine Corps Order

MCSC
materiel category structure code

MDS
materiel distribution service

MEDASM
Medical Assemblage Management

MEDCASE
medical care support equipment

MEDCEN
medical center

MEDCOM
medical command

MEDDAC
medical department activity

MEDLOG
medical logistics (battalions)

MEDSTEP
Medical Standby Equipment Program

MES
medical equipment set(s)

MFP
materiel fielding plan

MFT
materiel fielding team

MIDI/MEIS
Military Item Disposal Instructions/Military Environmental Information Source

MIIN
medical item identification number

MILCON
military construction

MIL-STD
military standard

MILSTRIP
Military Standard Requisitioning and Issue Procedures

MIREP
Medical Instrument Recycling Program

MMBP
Military Medical Benefits Property

MMPDANBC
Medical Materiel Program for Defense Against Nuclear, Biological, and Chemical Agents

MMQC
medical materiel quality control

MMS
medical materiel set(s)

MOA
memorandum of agreement

MOS
military occupational specialty

MOV
materiel obligation validation

MPL
mandatory parts list

MRE System
MEDCASE Requirements and Execution System

MRO
materiel release order

MRS
medical resupply set

MSC
materiel standardization committee

MSDS
Materiel Safety Data Sheets

MSO
medical supply officer

MSP
materiel standardization program

MSPM
medical supply planning module

MST
mobile support team

MTDA
modification table(s) of distribution and allowances

MTF
medical treatment facility

MTOE
modification table(s) of organization and equipment

NAVMEDCOMINST
Navy Medical Command Instruction

NAVSUPINST
Navy Supply Instruction

NAVSUP PUB
Navy Supply Publication

NBC
nuclear, biological, and chemical

NDC
National Drug Code

NFPA
National Fire Protection Association

NGB
National Guard Bureau

NICP
national inventory control point

NMA
nursing methods analyst

NMP
national maintenance point

NRC
Nuclear Regulatory Commission

NSN
national stock number

OCONUS
outside continental United States

O/D
obligations to demand (ratio)

OMA
Operation and Maintenance, Army

OMAR
Operation and Maintenance, Army Reserve

OMD
Operation and Maintenance, Defense

OMNG
Operation and Maintenance, National Guard

OP
operational project

OPA
Other Procurement, Army

OPD
Other Procurement, Defense

OPNAVINST
Navy Operating Instruction

ORI
operational readiness inventory

ORS
optical resupply set

OSE
other support equipment

OSHA
Occupational Safety and Health Administration

OST
order and shipping time

OTSG
Office of The Surgeon General

P&D
potency and dated

P&T
pharmacy and therapeutics

PA
procurement appropriation

PAD
patient administration division

PARMR–MF
prepositioned Army reserve materiel requirement for medical facilities

PARMS
prepositioned Army reserve materiel stock

PARMS–MF
prepositioned Army reserve materiel stock for medical facilities

PBAC
Program Budget and Advisory Committee

PBO
property book officer

PD
purchase description

PLL
prescribed load list

PMBS
precious metal-bearing scrap

PMC
precious metals coordinator

PMCS
preventive maintenance checks and services

PMM
precious metals monitor

POC
point of contact

POMCUS
prepositioned materiel configured to unit sets

PR
purchase request

PREPO
prepositioning (program)

PRS
prepackaged resupply set

QCP
Quality Control Program

QSTAG
Quadripartite Standardization Agreement

RC
Reserve Component

RCD–H
Reserve Component Decrement—Hospital

RCRA
Resource Conservation and Recovery Act

RIC
routing identifier code

RMW
regulated medical waste

RO
requisitioning objective

RSL
recommended stockage list

RTS–MED
Regional Training Sites—Medical

SB
supply bulletin

SC
supply catalog

SECNAVINST
Secretary of the Navy Instruction

SICC
service items control center

SKO
set, kit, and outfit

SLC
shelf life code

SM
service member

SMDA
Safe Medical Devices Act

SOP
standing operating procedure

SSA
supply support activity

SSN
social security number

STANAG
standardization agreement

STANFINS
Standard Army Financial System

STARC
State Area Command

TAADS
The Army Authorization Documents System

TAEDP
Total Army Equipment Distribution Plan

TAMC
Tripler Army Medical Center

TAMMIS
Theater Army Medical Management Information System

TAMMIS–MEDSUP
Theater Army Medical Management Information System—Medical Supply

TB
technical bulletin

TB MED
technical bulletin, medical

TDA
table(s) of distribution and allowances

TI
technical inspection

TM
technical manual

TMC
troop medical clinic

TMDE
test, measurement, and diagnostic equipment

TMDE–GP
test, measurement, and diagnostic equipment—general purpose

TMDE–SP
test, measurement, and diagnostic equipment—special purpose

TOE
table(s) of organization and equipment

TPF
total package fielding

TR–7
Theater Reserve—7

TSG
The Surgeon General

UA
unit assemblage

UIC
unit identification code

USAHFPA
U.S. Army Health Facilities Planning Agency

USAMEDCOM
U.S. Army Medical Command

USAMEDDBD
U.S. Army Medical Department Board

USAMMA
U.S. Army Medical Materiel Agency

USAMMCE
U.S. Army Medical Materiel Center, Europe

USAMRMC
U.S. Army Medical Research and Materiel Command

USAR
U.S. Army Reserve

USARPAC
U.S. Army, Pacific

USPFO
U.S. property and fiscal officer

USR
unit status report

VI
verification inspection

WRAMC
Walter Reed Army Medical Center

Section II
Terms

Army Master Data File
An official source of supply management data used in medical logistics. It is published monthly by the U.S. Army Materiel Command.

Army medical command
An organization that has command over one or more MEDCEN, MEDDAC, or medical research activities. Includes U.S. Army Medical Command, U.S. Army Medical Research and Materiel Command, 7th Medical Command, and 18th Medical Command.

Calibration, verification, and certification (CVC) services
To determine compliance of medical equipment with applicable specifications or standards and to make the necessary corrections or to compare the item with a certified device, tool, or test equipment standard.

Capital expense equipment
Equipment having a unit price of $200 to $4, 999.

Capital investment equipment
Equipment with a unit price of $5,000 or more.

Catalog Master Data File
An official source of supply management data used in medical logistics by activities operating under TAMMIS. It is published monthly.

Demand satisfaction
The percentage of customer demands for stocked lines that are satisfied by 100 percent of the quantity demanded.

Deployable Medical Systems (DEPMEDS)
Standard DOD modular medical and dental materiel sets that are configured into hospitals for use in a wartime theater of operations or as fixed contingency hospitals in peacetime.

Durable
Class VIII items valued at $199 or less that retain their original identity and are not consumed in use and nonmaintenance significant medical furniture items valued between $200 and $999. Durable items are identified with an ARC of D in the AMDF or DOD Medical Catalog.

Expendable
A Class VIII item that is consumed or loses its identity in use. Items are identified with an ARC of X in the AMDF and Catalog Master Data File.

Hospital linen management
A unique system for managing linen in health care activities. It is based on the need for responsive, sanitary, and economic linen operations. It consists of all action involved in the requisitioning, storage, accounting, distribution, repair, cleaning, and safeguarding of hospital linen.

Hospital linen
Linen used in direct patient care or in support of direct patient care. It normally includes selected hospital and surgical clothing and hospital bedding and linen items in the Federal Supply Catalog (DOD Section, Medical Materiel (FSC 6530, 6532, and 7210)) and similar nonstandard items.

Installation medical supply activity (IMSA)
In CONUS, the SSA for medical materiel for an installation or geographic area. OCONUS, it is normally the primary SSA for medical materiel for a designated geographic area.

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.

Materiel demonstration
Showing, use, or application of an item by the vendor. It does not involve any action by Army personnel beyond observing the operation of the product by the vendor.

Materiel Distribution and Collection System (MATDACS)
Internal hospital system designed to increase efficiency and cost effectiveness in the provision of medical logistics support. (See chap 8 for additional information.)

Materiel evaluation
Formal investigation by an activity of materiel that may have AMEDD-wide potential to improve health care or efficiency.

Materiel examination
Use of an item by an activity to determine whether the item or similar item should be purchased. The materiel examination does not generally exceed 30 days.

Medical care support equipment (MEDCASE)
That equipment required in AMEDD TDA fixed health care activities that is authorized for acquisition through OPA and DOD MILCON funding programs.

Medical equipment (including dental and veterinary items)
Consists of those devices used in the medical diagnosis, therapy, and treatment of injury or disease. This equipment consists primarily of FSC 6500 items that are standardized by the DMSB and are procured by the DPSC for TSG to implement health service support for the Army. It also consists of similar commercial, nonstandard items used primarily in fixed treatment facilities to provide state-of-the-art patient care. The equipment is maintained and repaired by medical equipment repairers organic to the medical unit or treatment facility.

Medical Standby Equipment Program (MEDSTEP)
Includes end items, components, or assemblies used to support activities with serviceable items when the primary item is unserviceable and is economically repairable (formerly called operational readiness float).

Military Medical Benefits Property
Consists of equipment loaned from a treatment facility to eligible patients when needed for the treatment of injury or disease.

Minor expense equipment
Equipment with a unit price of less than $1, 000.

Minor medical equipment sets
Grouping of medical and other items under a single NSN, with the components DLA- or DPSC-managed (may be Service regulated).

Nonexpendable
Class VIII items valued at $200 or more that retain their original identity and are not consumed in use and nonmaintenance significant medical furniture items valued at $1,000 or more. Items are identified with an ARC of N in the AMDF and the DOD Medical Catalog and require property book accountability.

Nonstandard national stock number
Describes an item assigned an NSN that has not been approved by the DMSB and does not have DMSB established essential characteristics.

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.

Service-unique medical equipment sets
A grouping of medical and other items under a single NSN, with components Service managed.

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). A Type III complaint does not necessarily require suspension of the item.

Section III
Special Abbreviations and Terms
This section contains no entries.

Index

This index is organized alphabetically by topic and subtopic.Topics and subtopics are identified by paragraph number.

RESERVED

NSN	DESCRIPTION	INSP FREQ	DATE LAST INSP	DATE NEXT INSP

QUALITY CONTROL CARD

For use of this form, see AR 40-61; the proponent agency is OTSG

NO	MANUFACTURER	LOT NUMBER	EXP DATE	DATE MFG	SHELF LIFE	DATE RECD
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

NSN	DESCRIPTION	INSP FREQ	DATE LAST INSP	DATE NEXT INSP

DA FORM 4996-R, APR 94

REPLACES DA FORM 4996-R, AUG 81, WHICH IS OBSOLETE

NSN	DESCRIPTION

LOCATOR CARD

For use of this form, see AR 40-61, the proponent agency is OTSG

BULK LOCATIONS		BIN LOCATIONS	
1		1	
2		2	
3		3	
4		4	
5		5	

NSN	DESCRIPTION

DA FORM 4997-R, AUG 81

QUALITY CONTROL AND SURVEILLANCE RECORD FOR TOE MEDICAL ASSEMBLAGES

For use of this form, see AR 40-61; the proponent agency is OTSG

NO	LOCATION	MANUFACTURER	CONTRACT NO (If available)	LOT/BATCH NUMBER	EXP/MFR DATE (If available)	QTY ON HAND	DATE LAST INSPECTION	DATE NEXT INSPECTION

NSN	DESCRIPTION	UNIT OF ISSUE	NOTES	INSPECTION FREQUENCY	SHELF LIFE/ ESTIMATED SHELF LIFE

DA FORM 4998-R, APR 94

REPLACES DA FORM 4998-R, AUG 81, WHICH IS OBSOLETE

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TEXT FORMATTER ... Version 2.45

PIN: 000520–000
DATE: 11-10-99
TIME: 08:28:47
PAGES SET: 92

DATA FILE: r40.fil
DOCUMENT: AR 40–61
DOC STATUS: NEW PUBLICATION