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MEDICAL EVACUATION

Headquarters, Department of the Army

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MEDICAL EVACUATION

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MEDICAL EVACUATION

Contents

***This publication supersedes Chapters 1–7 and Appendixes A, B, D–F, K, L, and N of FM 8-10-6 dated 14 April 2000, and FM 8-10-26 dated 16 February 1999.**

Figures

Tables

Preface

This field manual (FM) provides doctrine, as well as techniques and procedures for conducting medical evacuation and medical regulating operations. Medical evacuation encompasses both the evacuation of Soldiers from the point of injury (POI) or wounding to a medical treatment facility (MTF) staffed and equipped to provide essential care in theater and further evacuation from the theater to provide definitive, rehabilitative, and convalescent care in the continental United States (CONUS) and the movement of patients between MTFs or to staging facilities. Medical evacuation entails the provision of en route medical care; supports the joint health service support (JHSS) system; and links the continuum of care. In addition, it discusses the difference between medical evacuation and casualty evacuation (CASEVAC), as well as coordination requirements for and the use of nonmedical transportation assets to accomplish the CASEVAC mission. This publication is intended for use by medical commanders and their staffs, command surgeons, and nonmedical commanders involved in medical evacuation operations.

Users of this publication are encouraged to submit comments and recommendations to improve this publication. Comments should include the page, paragraph, and line(s) of the text where the change is recommended. The proponent for this publication is the United States (US) Army Medical Department (AMEDD) Center and School (USAMEDDC&S). Comments and recommendations should be forwarded, in letter format, directly to **Commander, USAMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-5052** or by using the e-mail address: medicaldoctrine@amedd.army.mil.

This publication applies to the Active Army, the Army National Guard (ARNG)/Army National Guard of the United States (ARNGUS), and the U.S. Army Reserve (USAR), unless otherwise stated.

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

Use of trade or brand names in this publication is for illustrative purposes only and does not imply endorsement by the Department of Defense (DOD).

The staffing and organization structure presented in this publication reflects those established in base tables of organization and equipment (TOE) and are current as of the publication print date. However, such staffing is subject to change to comply with manpower requirements criteria outlined in Army Regulation (AR) 71-32. Those requirements criteria are also subject to change if the modification table of organization and equipment (MTOE) is significantly altered.

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

TITLE	STANAG	QSTAG
Stretchers, Bearing Brackets, and Attachment Supports	2040	
Medical Employment of Air Transport in the Forward Area	2087	
Medical and Dental Supply Procedures	2128	
Minimum Labeling Requirements for Medical Materiel		436
Documentation Relative to Medical Evacuation, Treatment, and Cause of Death of Patients	2132	470
Road Movements and Movement Control	2454	

TITLE	STANAG	QSTAG
Orders for the Camouflage of the Red Cross and Red Crescent on Land in Tactical Operations	2931	
Aeromedical Evacuation	3204	

When amendment, revision, or cancellation of this publication is proposed which will affect or violate the international agreements concerned, the preparing agency will take appropriate reconciliatory action through international standardization channels. These agreements are available on request from the Standardization Documents Order Desk, 700 Robins Avenue, Building 4, Section D, Philadelphia, Pennsylvania 19111-5094.

The AMEDD is in a transitional phase with terminology. This publication uses the most current terminology; however, other FM 4-02-series and FM 8-series may use the older terminology. Changes in terminology are a result of adopting the terminology currently used in the joint and/or NATO and ABCA Armies publication arenas. Also, the following terms are synonymous and the current terms are listed first:

- Medical logistics (MEDLOG); health service logistics (HSL); and combat health logistics (CHL).
- Roles of care, echelons of care, and level of care.
- Combat and operational stress control (COSC) and combat stress control (CSC).
- Behavioral health (BH) and mental health (MH).
- Chemical, biological, radiological and nuclear (CBRN) and nuclear, biological, and chemical (NBC).
- Stability operations; stability, security, transition, and reconstruction (SSTR) operations; and stability operations and support operations.

Introduction

The Army Health System (AHS) is a complex system of interrelated and interdependent systems which provides a continuum of medical treatment from the POI or wounding through successive roles of health care to definitive, rehabilitative, and convalescent care in the CONUS, as required. *Medical evacuation* is the system which provides the vital linkage between the roles of care necessary to sustain the patient during transport. This is accomplished by providing en route medical care and emergency medical intervention, if required, and to enhance the individual's prognosis and to reduce long-term disability.

Medical evacuation occurs at the tactical, operational, and strategic levels and requires the synchronization and integration of service component medical evacuation resources and procedures with the DOD worldwide evacuation system operated by the United States Transportation Command (USTRANSCOM).

Army medical evacuation is a multifaceted mission accomplished by a combination of dedicated ground and air evacuation platforms synchronized to provide direct support (DS), general support (GS), and area support within the joint operations area (JOA). At the tactical level, organic or DS medical evacuation resources locate, acquire, treat, and evacuate Soldiers from the POI or wounding to an appropriate MTF where they are stabilized, prioritized, and, if required, prepared for further evacuation to an MTF capable of providing required essential care within the JOA.

Although the most recognized mission of Army medical evacuation assets is the evacuation and provision of en route medical care to battlefield wounded, the essential and vital functions of medical evacuation resources encompass many additional missions and tasks that support the JHSS system. Medical evacuation resources are used to transfer patients between MTFs within the JOA and from MTFs to United States Air Force (USAF) mobile aeromedical staging facilities (MASFs) or aeromedical staging facilities (ASFs); emergency movement of Class VIII, blood and blood products, medical personnel and equipment; and serve as messengers in medical channels.

Medical regulating provides the interface with the DOD worldwide medical evacuation system by determining the patient's destination (the MTF best suited to provide the required care) and scheduling the means to transport the patient with the required en route medical care. Formal medical regulating begins at Role 3, however technological advances in information management (IM)/information technology (IT) are permitting this capability to be used at Role 1 and Role 2 MTFs in some situations.

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Chapter 1

Overview of Army Health System Operations and Medical Evacuation

The AHS is the Army component of the military health system (MHS). Its capabilities are focused on delivering health care across the continuum of military operations—from the POI or wounding, through the JOA, to the CONUS support base. The two missions of the AHS are to provide health service support (HSS) (casualty care, medical evacuation, and medical logistics) and force health protection (FHP) (casualty prevention). The AHS is focused on promoting wellness, preventing casualties due to disease and nonbattle injuries (DNBIs), and providing timely and effective casualty care and management. Medical evacuation is the key factor in ensuring the continuity of care provided to our Soldiers by providing en route medical care during evacuation, facilitating the transfer of patients between MTFs to receive the appropriate specialty care, and ensuring that scarce medical resources (personnel, equipment, and supplies [to include blood]) can be rapidly transported to areas of critical need on the battlefield.

SECTION I — ARMY HEALTH SYSTEM

1-1. The provision of AHS is governed by well established and time-tested principles and rules which ensure the care provided to our Soldiers is timely and effective. For an in-depth discussion of these principles, rules, and roles of medical care, refer to FM 4-02.

1-2. The AHS is comprised of 10 medical functions. They are—

- Medical command, control, communications, computers, and intelligence.
- Medical treatment.
- Medical evacuation.
- Hospitalization.
- Dental services.
- Preventive medicine (PVNTMED) services.
- Combat and operational stress control (COSC).
- Veterinary services.
- Medical logistics.
- Medical laboratory support.

1-3. Army health system resources are arrayed across the battlefield in successive levels of support. These successive levels have increased medical care capabilities at each higher level. Medical evacuation and the provision of en route medical care ensures an uninterrupted continuum of care is maintained while Soldiers are moved through the roles of medical care to the MTF best suited to treat the patient's specific injuries.

PRINCIPLES OF ARMY HEALTH SYSTEM

1-4. The principles of AHS provide a framework in which medical planners can ensure that comprehensive plans are developed to support the tactical commander's operation plan (OPLAN). The

principles of AHS are conformity, continuity, control, proximity, flexibility, and mobility. For this publication, the discussion of these principles has been focused toward the medical evacuation mission. For a general discussion of how these principles relate to the overall AHS mission, refer to FM 4-02.

CONFORMITY

1-5. Participating in the development of the OPLAN or the operation order (OPORD) ensures that the medical planner conforms to strategic, operational, and tactical plans. This is the most fundamental element for effectively providing AHS and ensures medical influence over the execution of medical evacuation operations. Only by participating in the orders process and developing a medical evacuation plan, will the medical planner ensure that medical evacuation support is arrayed on the battlefield in the right place at the right time and synchronized across operational commands to maximize responsiveness and effectiveness.

CONTINUITY

1-6. En route medical care provided during medical evacuation must be effective and continuous to prevent interruptions in the continuum of care. An interruption in medical treatment may result in an increase in morbidity, mortality, and disability. No patient is evacuated any farther than his physical condition or the military situation requires.

1-7. Medical evacuation resources provide the linkage between the roles of care within the JOA. They also provide interface with other deployed elements of the MHS operated by other services to enhance and facilitate the continuum of care from the POI to the CONUS support base.

CONTROL

1-8. Medical planners must ensure medical control is exercised over the execution of ground medical evacuation operations and that medical influence (technical and operational supervision) is exercised over the execution of aeromedical evacuation (AE) operations. Furthermore, medical planners must ensure the medical evacuation system is responsive to changing requirements and tailored to effectively support the forces within an assigned area of operations (AO). Since medical evacuation resources are limited, it is essential that medical control and influence be retained at the highest level consistent with the tactical situation.

1-9. A thorough and comprehensive medical evacuation plan is essential to establishing and maintaining control of medical evacuation operations characterized by decentralized execution of the plan. The medical evacuation plan complies with the combatant command guidance and intent and maximizes the use of scarce medical evacuation resources. When directed by the combatant command, Army air and ground ambulances may support operations conducted by other services, allied and coalition partners, and the host nation (HN).

PROXIMITY

1-10. The location of medical evacuation assets in support of combat operations is dictated by orders and the tactical situation (mission, enemy, terrain and weather, troops and support available, time available, and civil considerations [METT-TC]). Accurately determining time and distance factors and the availability of evacuation resources are critical to determining the disposition of evacuation assets. The speed with which medical evacuation is initiated is extremely important in reducing morbidity, mortality and disability. Medical evacuation time must be minimized by the effective disposition of resources, ensuring close proximity of both supported elements and MTF. Medical evacuation assets cannot be located so far forward that they interfere with the conduct of combat operations. Conversely, they must not be located so far to the rear that medical treatment is delayed due to lengthy evacuation routes.

1-11. Medical evacuation resources, both ground and air, are arrayed on the battlefield to best support both the tactical commander and the AHS. Depending upon the situation, evacuation resources may be placed

in a DS role to support maneuvering forces or GS, during stability operations which are centrally located to accomplish an area support mission.

FLEXIBILITY

1-12. Changes in tactical plans or operations may require redistribution or reallocation of medical evacuation resources. Therefore, the medical evacuation plan must be designed to ensure flexibility and agility as well as enhance the ability to rapidly task-organize and relocate medical evacuation assets to meet changing battlefield requirements. Medical planners must also ensure medical control and influence is exercised through the orders process and facilitates the synchronization of air and ground evacuation assets to rapidly clear the battlefield.

MOBILITY

1-13. Medical evacuation assets must have the same mobility and survivability capability (such as armor protection) as the forces supported. This mobility and survivability ensures that medical evacuation resources can rapidly respond and that evacuation routes do not become too lengthy. Medical evacuation assets also enhance the mobility of forward deployed MTFs by rapidly evacuating their patients to the next role of medical care.

BATTLEFIELD RULES

1-14. The AMEDD has developed a set of battlefield rules to aid in establishing priorities and to resolve competing priorities within AHS activities. These rules are intended to guide the medical planner to resolve system conflicts encountered in designing and coordinating AHS operations. Although medical personnel seek always to provide the full scope of AHS services and support in the best possible manner, during every combat operation there are inherent possibilities of conflicting support requirements. The planner or operator applies these rules to ensure that the conflicts are resolved appropriately. These battlefield rules are depicted in Table 1-1.

Table 1-1. Army Medical Department Battlefield Rules

AMEDD BATTLEFIELD RULES
BE THERE (MAINTAIN A MEDICAL PRESENCE WITH THE SOLDIER)
MAINTAIN THE HEALTH OF THE COMMAND
SAVE LIVES
CLEAR THE BATTLEFIELD OF CASUALTIES
PROVIDE STATE-OF-THE-ART MEDICAL CARE
ENSURE EARLY RETURN TO DUTY OF THE SOLDIER

BE THERE

1-15. Ensure that medical evacuation assets are in close proximity to supported elements to enhance response time, increase Soldier confidence and be a combat multiplier. This is accomplished by complementing organic medical evacuation assets with medical evacuation assets placed in DS, GS, and area support roles.