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DENTAL SERVICE SUPPORT OPERATIONS

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Dental Service Support Operations

Contents

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Preface

This field manual (FM) provides doctrinal guidance for the employment of dental units conducting dental service support missions. The manual is intended for use by medical and nonmedical unit commanders and their staffs.

This manual has been completely revised and sequenced in order to achieve a more concise document with an improved flow of information. The focus is to provide discussion of the dental service support mission, the organization of medical/dental units, and the conduct of dental service support operations.

The staffing and organizational structures and positions presented in this manual reflect Medical Force 2000, Medical Reengineering Initiative, and Army transformation organizations established in tables of organization and equipment (TOEs). These tables were current at the time this manual was published. The organization of these units is subject to change in order to comply with manpower requirements criteria outlined in Army Regulation (AR) 71-32. These organizations are also subject to change at the unit level in order to meet wartime requirements and changes are reflected in the units' modified table of organization and equipment.

This publication implements or is in consonance with the following North Atlantic Treaty Organization (NATO) International Standardization Agreements (STANAGs):

NATO STANAG	TITLE
2014	Formats for Orders and Designation of Timings, Locations and Boundaries
2068	Emergency War Surgery
2122	Medical Training in First-Aid, Basic Hygiene and Emergency Care
2931	Orders for the Camouflage of the Red Cross and the Red Crescent on Land in Tactical Operations

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.

The proponent of this publication is the United States (U.S.) Army Medical Department Center and School (USAMEDDC&S). Send comments and recommendations in a letter format directly to the **Commander, USAMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-5052** or at e-mail address: Medicaldoctrine@amedd.army.mil. All recommended changes should be keyed to the specific page, paragraph, and line number. A rationale should be provided for each recommended change to aid in the evaluation of that comment.

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

The use of the term *continental United States (CONUS)* includes the continental U.S., Hawaii, Alaska, and its territories and possessions.

The 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).

Chapter 1
Overview of Dental Service Support

SECTION I — IMPORTANCE OF ARMY DENTISTRY

MISSION

1-1. The mission of the Army Dental Care System is to provide Soldier-focused dental services in a timely and cost-effective manner that supports America's Army.

1-2. Stability operations, a part of full spectrum operations, are recognized in Department of Defense Directive 3000.05 and FM 3-0. As a result, the expanding mission of the Dental Corps includes supporting the main tenets of stability operations. For more detailed discussions refer to FM 3-0 and FM 8-42.

SOLDIER

1-3. The Soldier as the centerpiece of the U.S. Army is the basic guarantor of mission success. As such, his health and physical fitness are vitally important. Equally important is the Soldier's oral and dental health, which if not properly maintained can result in the Soldier becoming nondeployable and if already deployed, can render him nonmission-capable.

1-4. There are many reasons why a Soldier's oral and dental health can break down. This is especially true while a Soldier is deployed. There are a number of causes which can contribute to a decline in a Soldier's oral and dental health. Some of the more common causes include—

- Stress-induced compromise of the immune system.
- Inadequate oral and dental hygiene practices.
- Use of tobacco products.
- Accidental and combat-related injury to the face.

1-5. In addition to those considerations already listed, mission, enemy, terrain and weather, troops and support available, time available, civil considerations (METT-TC) may also present situations where Soldiers will not have ready access to a dental treatment facility (DTF) when routine dental care may be all that is required to correct a minor problem before it becomes more serious.

1-6. Review of past U.S. military deployments suggests that the longer a deployment lasts the more likely a Soldier is to experience a dental emergency. The same review also indicates that as a deployment lengthens there are fewer opportunities and resources available to enhance, maintain, and improve a Soldier's dental health. It is for these reasons that dental service support assets are organic to maneuver and movement units of the Army.

1-7. Although the primary focus of this publication is dental service support provided in theater, it is important to understand that the emphasis on a Soldier's oral and dental health begins at the time that he enters the Army and continues throughout his service commitment.

IMPACT OF DENTAL EMERGENCIES ON UNIT READINESS

1-8. Historically, 20 to 25 percent of all deployed Soldiers have experienced a dental emergency during a one-year deployment. The significance of this statistic is the potential impact on a unit's ability to execute its mission. The following examples are provided:

- During World War II, specifically 1943, the greatest numbers of Soldier complaints were in regard to the lack of adequate dental support.
- During the Korean War, 133,720 dental visits were recorded. These visits resulted in 493,441 dental procedures being performed.
- During the Vietnam War, dental emergencies for deployed U.S. Navy and U.S. Marine Corps personnel averaged 200 dental emergencies per one thousand Sailors and Marines deployed per year.
- During deployment processing for Operation Desert Shield over 150,000 Army National Guard and Reserve Component Soldiers were processed through DTFs in the CONUS. Over 40,500 of these Soldiers required panographic x-rays and 33,000 required dental treatments to be classified as deployable. The result was a mobilization system that was severely stressed and its ability to quickly process Soldiers for deployment was degraded.
- A review of the 12th Evacuation Hospital patient treatment records during Operation Desert Shield and Operation Desert Storm indicated that approximately 14 percent of Soldiers reporting for sick call were seen for dental emergencies. Once a detailed analysis of the information was completed the percentage of dental emergencies was actually found to be higher than 14 percent.
- Mobilization and deployment dental processing during Operation Desert Shield and Operation Desert Storm was provided to 243,829 DOD personnel between 2 August 1990 and the end of the war. Five reserve dental units and a number of individual mobilization augmentees were activated to help with the massive dental workload brought on by reserve force mobilization. This period also saw the stateside dental capability depleted by deployment of Active Army dental personnel.

1-9. The examples in paragraph 1-8 provide us with valuable insight regarding the number of Soldiers that may require dental treatment during a lengthy deployment. They also illustrate that when dental care is not readily available and Soldiers must be evacuated for treatment of dental emergencies, those Soldiers may be separated from their units for extended periods of time.

1-10. Based on the information provided above, it is easy to conclude that good oral and dental health is a force multiplier and that ready access to dental care can contribute significantly to unit readiness and morale.

SECTION II — ARMY DENTAL READINESS

DENTAL READINESS

1-11. Dental readiness refers to a Soldier's dental health as it relates to his worldwide deployment status. Dental readiness is fundamental to maintaining unit readiness and reducing noncombat dental casualties during deployments. Community oral health protection emphasizes not only oral health, but also general wellness and overall fitness of our Soldiers and all authorized beneficiaries. Army Regulation 40-35 provides guidance for the development and conduct of dental readiness and community oral health protection programs for all authorized beneficiaries of the Army Dental Care System. It describes the Dental Readiness Program for Active Army Soldiers and other programs that benefit all members of the Army community.

1-12. Lessons learned from previous mobilizations indicate that—

- Little time is available for treatment of dental emergencies during mobilization and deployment operations.
- High levels of dental readiness and dental preparedness reduce mobilization dental processing and treatment time.
- Three to five days is the average length of time a Soldier is lost to his unit when he must be evacuated for dental emergencies.

1-13. Due to the potential impact that dental emergencies may have on a unit's readiness, preventive dentistry programs must be actively supported by leaders.

1-14. High levels of premobilization dental readiness significantly reduce the number of dental emergencies experienced by deployed Soldiers.

1-15. Unit commanders, leaders at every level, the Army Dental Care System, and the Soldier all share the responsibility for the dental readiness of the command.

1-16. The importance of dental readiness cannot be overstated. Failure to maintain high levels of dental readiness adversely impacts on the ability of units to quickly mobilize and deploy. Army dental service support-specific Generating Force operations are addressed in Appendix A.

DENTAL READINESS PROGRAM

1-17. The Dental Readiness Program provides methods developed to reduce the risk of Soldiers becoming noncombat-related dental casualties when such an event could jeopardize the success of the mission. Dental Readiness Program methods include—

- Annual dental examinations in order to determine the oral and dental fitness and classification of each Soldier in the command.
- Priority examinations and treatment appointments for Soldiers who are at high risk or who have not had recent dental examinations (dental Class 3 and dental Class 4).
- Monthly dental readiness reports to unit commanders that identify the dental risk profile of the unit.

DENTAL CLASSIFICATIONS

1-18. Every Soldier is assigned a dental classification based on the results of a thorough oral and dental examination. The classification is a dentist's best judgment of the state of a Soldier's oral and dental health and is used to determine the likelihood that a patient will experience a dental emergency during a deployment. Dental classification criteria are provided in Appendix B.

PROCEDURES

1-19. The dental records of every Active Army Soldier will be screened on arrival at a new permanent duty station.

- Active Army Soldiers inprocessing at their permanent duty stations whose dental records indicate that no examination has been performed within the previous 6 months or who are dental Class 3 or dental Class 4 must have a dental examination at the local DTF prior to completing their inprocessing procedures. Every effort will be made to achieve dental Class 1 or dental Class 2 for all inprocessing Soldiers prior to reporting to their unit.
- Soldiers whose records indicate they are in dental Class 1 or dental Class 2 will have their next annual dental examination scheduled no later than 13 months from the date of completion of their last dental examination and readiness classification.
- Every Soldier's record will also be screened to ensure a panographic x-ray is present and that it is of adequate quality for diagnostic/identification purposes. If no panographic x-ray is present, one will be taken and placed in the dental record. There is no time requirement on updating panographic x-rays; however, the existing images must accurately represent the current oral and dental condition of the Soldier.

1-20. Soldiers in basic training or advanced individual training are required to have a dental readiness examination. This is dependent on the absence of a dental emergency, the availability of time during the training cycle, and the ability of local DTF to schedule and examine these Soldiers. If no examination occurs at this time, they must be examined at their first permanent duty station immediately upon inprocessing.

1-21. Soldiers will have their dental readiness classification updated annually by a clinical examination. Soldiers who fail to receive a dental examination by the last day of the 13th month from the date of their last examination or dental readiness update are automatically classified as dental Class 4 and are then placed in a nondeployable status.

1-22. Appointments for dental treatment required to achieve a satisfactory dental readiness status are scheduled according to the Soldier's current dental classification.

- Soldiers in dental Class 1 require no treatment.
- Soldiers in dental Class 2 are counseled on their dental needs and every effort must be made to move that patient to dental Class 1.
- Soldiers in dental Class 3 will have the condition causing the potential dental emergency described in the narrative portion of their dental health record so they may be reclassified to dental Class 1 or dental Class 2 as soon as the condition is corrected. Personnel in dental Class 3 will receive expedited treatment to remove them from this unsatisfactory dental classification. The immediate goal of expedited treatment is to take care of the patients most urgent dental needs and to avoid a potential dental emergency.

1-23. Prior to a Soldier's reassignment to an overseas location, his dental treatment records will be screened. Soldiers listed as dental Class 3 or dental Class 4 will not be cleared for overseas movement until they receive the necessary dental treatment to place them in at least dental Class 2 or unless otherwise approved in accordance with Department of the Army (DA) Pamphlet (DA Pam) 600-81. Dental screening should be completed at least 7 days prior to their actual rotation date.

1-24. Soldiers in dental Class 3 and dental Class 4 normally are not to be deployed unless the mission dictates otherwise. In these circumstances, a waiver may be granted by the installation commander with a recommendation from a dental officer in the rank of colonel or above.

ORGANIZATIONAL RESPONSIBILITIES

1-25. Commanders are responsible for the dental readiness of the Soldiers assigned to their command. Commanders must establish and implement procedures that will ensure that their command meets dental readiness standards as required by the Dental Readiness Program. Commanders will make their personnel available for appointments and maintain surveillance over the program to ensure the following:

- The supporting unit's dental clinic is the sole custodian of all unit personnel dental records. Newly arriving Soldiers will turn in their dental records to dental personnel for initial screening.
- When outprocessing a duty station, Soldiers whose records indicate no examination in the previous 6 months or who are a dental Class 3 or dental Class 4 will have dental examinations prior to completing their outprocessing procedures. If a Soldier outprocesses without achieving dental Class 1 or dental Class 2, they must receive priority care at their next duty location for a dental examination and/or to eliminate the emergent dental care problem. The unit's executive officer and senior noncommissioned officer (NCO) will be notified to assure follow-up care through the supporting dental clinic.
- All Soldiers in the unit will report for annual dental examinations. The unit is responsible for providing current personnel rosters to the supporting dental facility. The DTF uses these rosters to verify that each Soldier's dental treatment record is on file.
  - The supporting dental clinic provides rosters to the unit through both the Medical Protection System and Corporate Dental Application at 60 days and again at 30 days prior to their Soldiers being listed as dental Class 4.
  - The unit ensures that Soldiers listed as dental Class 3 or dental Class 4 or who require an annual dental examination are available for examination. The units also establish policies and procedures for dealing with Soldiers who are in repeated noncompliance.
- Emphasis should be placed on ensuring that Soldiers being assigned to recruiting duty, full-time manning programs for the Reserve Component, Reserve Officers' Training Corps duty, and military assistance group or embassy duty are in dental Class 1 before departing for their new assignments.

- Emphasis must be placed on ensuring that Soldiers in early deployment forces are maintained in a dental Class 1 or dental Class 2 status.

1-26. Commanders of dental activities, dental clinic commands, and separate active Army dental units are responsible for assisting supported units in maintaining the readiness of Soldiers.

1-27. Dental activity/dental clinic commands/dental unit commanders are responsible for the following functions:

- Serve as dental readiness advisors to unit commanders to assure compliance with the goal of 95 percent dental readiness (dental Class 1 and dental Class 2 combined).
- Screen dental records of newly arrived Soldiers to establish their dental readiness classification.
- Assist unit commanders in the elimination of dental Class 3 and dental Class 4 ratings by timely unit notification and coordination of appointments. Rosters are delivered in person or made available electronically at 60 days and then again at 30 days prior to the Soldier's required annual examination date.
- Provide monthly updates to the unit or its supporting personnel activity on changes in each Soldier's dental classification and date of last dental examination.
- Conduct audits of dental records annually against the unit's Dental Readiness Program roster located in Corporate Dental Application.

ORAL HEALTH THREATS

1-28. The two common threats to a Soldier's oral health are chronic disease and oral and maxillofacial injury.

- Chronic diseases include ulcerative gingivitis, acute pericoronitis, and periodontal abscesses, all of which are known to become exacerbated during periods of fatigue, nutritional deficiencies, poor oral hygiene, and physical and psychological stress. Milder gingival and periodontal disease may also increase in incidence and severity.
- Oral and maxillofacial injuries may result from both battle injury and nonbattle injury in operational settings.

1-29. Oral infections, resulting from chronic disease or maxillofacial injury, can advance to life-threatening oropharyngeal fascial space infections or cavernous sinus thrombosis if inappropriately managed.

SECTION III — CATEGORIES OF DENTAL CARE

PREVENTIVE DENTISTRY

1-30. Although preventive dentistry is not technically a category of dental care it is an extremely important component of the dental program. The results of good preventive dental care practices are healthy teeth and gums and the absence of oral disease. Therefore, Soldiers who incorporated good preventive dental hygiene practices are far less likely to become dental casualties due to disease while deployed.

1-31. Preventive dentistry incorporates primary, secondary, and tertiary preventive measures taken to reduce or eliminate conditions that may decrease a Soldier's fitness to perform his mission and which could result in the Soldier being removed from his unit for treatment.

1-32. Individual preventive dental care practices include—

- Eating a balanced diet.
- Brushing and flossing of the teeth and gums on a regular basis.
- Abstaining from using tobacco products.

1-33. These measures can effectively prevent the development of tooth decay and oral disease. The application of fluoride and sealants combined with regular dental checkups and oral screenings can prevent tooth decay and identify oral disease at its most treatable stages.

1-34. Due to the potential impact that dental emergencies can have on unit readiness, preventive dentistry programs must be actively supported by leaders.

1-35. A Soldier's dental readiness is determined by a thorough examination of the mouth. The standards used to determine a Soldier's dental readiness and classification are outlined in the DOD Oral Health and Readiness Classification System (see Appendix B). The purpose of this classification system is to help commanders estimate how many of their Soldiers are likely to require treatment for dental emergencies during a deployment. Commanders can minimize personnel losses to treatment or medical evacuation by ensuring that as many Soldiers as possible are dental Class 1 or dental Class 2 prior to deployment.

OPERATIONAL DENTAL CARE

1-36. Dental care provided for deployed Soldiers in theater is referred to as operational dental care. Operational dental care consists of emergency dental care and essential dental care.

EMERGENCY DENTAL CARE

1-37. Emergency dental care is care designed to provide relief of oral pain, elimination of acute infection, control of life-threatening oral conditions (hemorrhage, cellulitis, or respiratory difficulty), and treatment of trauma to teeth, jaws, and associated facial structures. It is considered the most austere form of dental care provided to deployed Soldiers who are engaged in tactical operations.

1-38. Since dentists are not assigned to Role 1 medical treatment facilities (MTFs), the battalion surgeon or physician assistant can provide limited emergency dental treatment until the patient can be seen by a dentist. Common examples of emergency treatments include—

- Simple extractions.
- Temporary fillings.
- Administration of analgesics.
- Administration of antibiotics.

ESSENTIAL DENTAL CARE

1-39. Essential dental care is generally considered the highest category of operational dental care available in the theater. Essential dental care includes dental treatments which are performed in order to prevent potential dental emergencies and maintain the oral fitness of Soldiers. Essential dental care enhances the individual Soldier's combat readiness and can prevent lost duty time. It is for these reasons that essential dental care is made readily available. Soldiers who are categorized as dental Class 2 (untreated oral disease) or dental Class 3 (potential dental emergencies) should receive essential care as soon as the tactical situation and availability of dental assets permit.

1-40. Emergency treatments performed by dental officers include—

- Definitive restorations.
- Minor oral surgery.
- Exodontic, periodontic, and prosthodontic procedures.

COMPREHENSIVE DENTAL CARE

1-41. Comprehensive dental care consists of any and all procedures which are required to restore an individual to optimal oral health, function, and esthetics. Due to the complexity of the procedures and the length of time generally required to perform them, comprehensive dental care is normally provided only in the CONUS-support base. When comprehensive dental care is made available in theater, it is usually reserved for Army Health System plans in which extended periods of reception, staging, onward movement, and integration in theater are anticipated. The dental assets providing this degree of dental care are located within Role 3 MTFs.

SECTION IV — ADDITIONAL WARTIME ROLES

MASS CASUALTY SCENARIOS

1-42. Dental personnel have the additional wartime role of augmenting medical personnel during mass casualty situations. Under these circumstances, dental officers may be called upon to augment and assist the medical staff of these facilities in treating the sick and injured.

1-43. Dental officers and personnel may be called upon to render assistance in the following areas:

- Surgical procedures.
- Forensic dental identification.
- Maxillofacial injury treatment.
- Soft tissue wound management.
- Chemical, biological, radiological, and nuclear (CBRN) casualty management.
- Orthopedic injury treatment.
- Initial burn treatment.
- Intravenous infusion techniques.
- Intubation of surgical patients and patients with compromised airways.
- Infection control and sterile techniques.

1-44. While the focus on additional wartime roles has generally been on the individual provider, collective use of the dental unit or its subordinate elements may also be appropriate when the situation requires a consolidated medical response.

VETERINARY DENTAL SUPPORT

1-45. An additional wartime role for dental personnel involves providing dental treatment for military working dogs. On those occasions when military working dogs require emergency dental care or treatment for injuries involving their teeth, Veterinary Corps officers may request the assistance of Dental Corps officers to treat these animals.

SECTION V — ELIGIBILITY DETERMINATION FOR DENTAL CARE

1-46. During interagency and multinational operations, common questions are: "Who is eligible for care in a U.S. Army-established MTF?" and "What is the extent of care authorized?" For a detailed discussion regarding eligibility determination for care refer to FM 4-02.

1-47. Numerous categories of personnel seek care in U.S. facilities that are located in austere areas where host nation civilian medical infrastructure is nonexistent or is not capable of providing adequate care. A determination of eligibility and whether reimbursement for services is required is made at the highest level possible and in conjunction with the supporting staff judge advocate. Additionally, the Department of State and/or military staff sections (such as the Assistant Chief of Staff, Civil Affairs [G-9]) may also be involved in the determination process. Each operation is unique and the authorization for care is based on appropriate U.S. and international laws, DOD directives and DOD instructions, ARs, doctrine, and standing operating procedures (SOPs). Other factors impacting on the determination of eligibility are command guidance, practical humanitarian and medical ethics considerations, availability of U.S. Army Health System assets (in relationship to the threat faced by the force), and the potential training opportunities for Army Health System forces.

1-48. Basic documents required for determining eligibility of beneficiaries include AR 40-400; FM 27-10; relevant sections of Title 10, United States Code; relevant DOD directives and DOD instructions; acquisition and cross servicing agreements; orders from higher headquarters; interagency agreements such as memorandum of understanding and memorandum of agreement; and appropriate multinational agency guidance for the specific operation. If contractor personnel are present, a copy of the relevant sections of

their contracts should be on file to delineate specific medical services to be rendered. Additionally, for contract workers, a point of contact for the contracting company and a point of contact for the administration of the contract should be maintained.

1-49. Finally, the political-military environment of the area of operations must be taken into account as the command and control headquarters and its higher headquarters develop the eligibility matrix. The eligibility matrix should be as comprehensive as possible. If necessary, it should include eligibility determination by name. Refer to FM 4-02 for an example of an eligibility matrix. If individuals arrive at the emergency medical service section of the MTF who are not included in the medical/dental support matrix, the MTF must always stabilize the individual first and then determine the patient's eligibility for care. The command point of contact for eligibility determinations should be contacted immediately. Further, care will be provided in accordance with the SOP pending eligibility determination. (For example, a host nation civilian presents himself at the gate and requests medical treatment. Although on the surface it may appear that he is not eligible for care, this determination can only be made after a medical assessment is completed by competent medical personnel. In some cases, the individual may have to be brought into the MTF to accomplish an adequate medical assessment. Conducting a medical assessment does not obligate the U.S. military to provide the full spectrum of medical care. Although it does obligate the MTF to provide immediate stabilization for life-, limb-, and eyesight-threatening medical conditions and to prepare the patient for evacuation to the appropriate civilian or national contingent MTF when the patient's medical condition permits.)

Note. Any individual requesting medical care should receive a timely medical assessment of his condition. Even though the individual is not eligible for treatment, life-, limb-, or eyesight-saving procedures warranted by the individual's medical condition are provided to stabilize the individual for transfer to the appropriate civilian or other nation MTF.

1-50. The MTF staff must be familiar with the medical care available in the area of operations from other sources. These could include multinational or host nation military (tactical and strategic) forces, nongovernmental organizations or international organizations such as the United Nations, and local civilian resources. When appropriate and by knowing the level and types of care available, the MTF staff can plan for the continued care of the patient after initial stabilization is provided in the U.S. MTF and the patient can be transferred to another facility for continued care.

1-51. It is essential that eligibility for medical care guidance is disseminated and understood by the chain of command and all civilians and military members of the deployed force. The Army Health System commander must be able to articulate the basic concepts for medical eligibility determinations. This means that he will need to condense them into simple, easily understood instructions and widely disseminate them through electronic means or other media (such as pocket-sized cards). As the chief planner for medical operations, the Army Health System commander must ensure that this information is contained in the appropriate operation plan and operation order and briefed to the appropriate senior leadership of the command.

SECTION VI — DETAINEE DENTAL OPERATIONS

CONCERNS AND ISSUES

1-52. The primary unique concern in detainee medical operations is security. Designing the placement and location of chairs and the clinic floor plan should be to increase emphasis on security within the theater internment facility rather than patient privacy. Equipment and supplies should be accounted for at all times. All instruments should be inaccessible to detainees. Detainees should be visible to guards at all times. Detainees should not have ready access to exits. When detainees are being treated, weapons assigned to the dental staff must be secured.

EXAMINATIONS

1-53. The initial screening examination of detainees is used to identify obvious swelling, trauma, abscess, excessive bleeding, and lesions.

- Screening is done as a *look-see*, which is completed by using a flashlight and tongue depressor.
- When one or more of the above are noted, the detainee should be brought to the dental clinic immediately for a more involved examination with x-rays and treatment, if necessary.
- Prescriptions are written as deemed necessary for the treatment of the detainee's dental condition.

1-54. Screening examination findings are recorded on Standard Form (SF) 603 (Health Record—Dental) and SF 603A (Medical Record—Dental-Continuation) and placed in the detainee's medical record which was initiated during the medical screening conducted when the detainee was inprocessed to the theater internment facility.

- Obvious findings recorded include extractions (such as root tips or nonrestorable caries), restorable caries, and partially impacted wisdom teeth.
- Detainees are asked if pain is involved and the response is noted.

TREATMENT SCREENING PROCEDURES

1-55. After detainees have been medically inprocessed to the theater internment facility, periodic screens may be required to intercept dental emergencies.

1-56. A specific detainee may be referred for dental evaluation and treatment from a number of areas. The procedure for requesting a specific detainee to report for dental evaluation and treatment is to provide a memorandum to the military police the night before, requesting the detainee report in the morning. The detainee can be referred by—

- Consults turned in from doctors.
- Medical inprocessing screens.
- Sick call.
- Follow-ups from the previous day.

1-57. When detainees come for treatment, the treatment is documented on a new SF 603 and SF 603A.

- The detainee's name and internment serial number is written in pen and his domicile location is entered in pencil as this may change.
- The SF 603 and SF 603A are maintained in the detainee's individual medical record. The medical record is requested from the supporting patient administration division, as required.

1-58. Evaluation and determination of required treatment consists of the following:

- The dentist and translator screen the detainee's medical history for any adverse reaction to previous dental treatment.
- The detainee is asked where and what kind of pain he is experiencing. This is documented on the SF 603 and SF 603A.
- Radiographs are taken of the teeth that the detainee has complained about. The dental officer determines whether other teeth need to be x-rayed that may require dental treatment.
- Once taken, the dentist is notified and reads the x-ray. The assistant is then told what type of treatment to setup for.
  - Detainees are informed through a translator of treatment required.
  - They have the opportunity to either accept or refuse treatment.
  - If treatment is refused, they are informed of the complications that may result from not having treatment and the refusal is noted in their dental records.

1-59. Detainees often do not get to eat breakfast before they come in the morning; therefore, the dental clinic maintains nutritional support drinks in the clinic, for those detainees who—

- Need to take pain medication immediately.
- Will have extensive oral surgery (several teeth taken out in one day).
- Are diabetic (given before receiving treatment).

1-60. Once the dental procedure is completed, if a—

- Prescription is required and subsequently written, it will include the detainee's name, internment serial number, and domicile location.
- Prescription for an immediate dose is written, the assistant will take it down to the pharmacy to have it filled.
- Prescription is written for the detainee to take later, this is indicated across the top and turned in to the pharmacy.

1-61. Once the detainee is finished with the dental procedure, the military police are asked to return the detainee to the compound, hospital ward, or holding cell as appropriate.

- Postoperative instructions are given through a translator.
- An immediate dose of medication is given (if required).

Note. Detainees are not permitted to keep medications on their person. After the initial medication is given in the clinic, other doses of the medication will be provided per established procedures in the theater internment facility SOP.

- The guard is asked to bring in the next detainee. For security reasons, a maximum number of detainees permitted in the clinic at one time is established. This is dependent upon the size of the area and the number of providers.
- Follow-up examinations will be requested as needed.

WEAPONS

1-62. Weapons belonging to staff members should not be allowed into the clinic area when detainees are being examined or treated. Weapons should be secured in predesignated areas in accordance with established policies and procedures. This will ensure that they are inaccessible to detainees.

TRANSLATORS

1-63. A translator is required during all dental treatment of detainees. The translator is required to assist the dental officer in ensuring the medical history is accurately reviewed, to inform the detainee of the procedures to be performed, and to translate the concerns of the detainee to the dental officer and of the dental officer to the detainee during treatment.

PHOTOGRAPHS

1-64. There are stringent regulations pertaining to the photographing of detainees. Medical photographs will only be used to document preexisting conditions and traumatic injuries and to provide a basis for justification of why treatment was performed. Any medical photographs taken become a part of the detainee's medical record.

SICK CALL AND EMERGENCIES

1-65. Dental emergencies (such as bleeding, externally expanding abscesses, pain, and trauma) are treated immediately after emergency room notification, dental evaluation, and confirmation of urgency.

HOSPITAL PATIENTS

Inpatients

1-66. Inpatients are treated on a per consult basis either at the bedside or in the clinic based on ambulatory capacity. All detainee inpatients must be under guard when leaving the ward and continuously while they are off the ward. Detainee inpatients cannot move within the facility or to the clinic unless under guard.

Dental Inpatients

1-67. Detainees admitted for reasons related to dental emergencies may be admitted by the emergency room physician per dental consult and emergency care required. Discharge is per mutual agreement between medical and dental staff.

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Chapter 2

Organization and Employment of Dental Units

SECTION I — CONCEPT OF OPERATIONS

MODULARITY

2-1. The modular force is based on brigade-sized elements with specialized capabilities. Because of their size and mobility they are capable of conducting expeditionary and joint operations and once deployed are better able to quickly respond to ever-changing mission requirements. Modular units allow Army planners to tailor the force to be flexible and agile. Specifically tailoring the force reduces strategic lift requirements and enables the U.S. to put combat power where it is needed in considerably less time than previously possible. To better support the modular force the Army Medical Department (AMEDD) command and control organizations have also been redesigned to be more modular.

2-2. The modular design of medical units gives the medical command (deployment support) (MEDCOM [DS]) the ability to—

- Assist in deploying the optimal mix of medical capabilities.
- Ensure seamless, state-of-the-art medical and dental care, regardless of location.
- Provide tested and proven systems to the battlefield and ensure the provision of the right care at the right place and time.
- Promote scalability through easily tailored, capabilities-based packages that result in improved tactical mobility, reduced footprint, and increased modularity for flexible task organization.
- Provide and enable the joint force commander the ability of choosing augmentation packages which enable rapid synchronization and deployment of desired medical capabilities.
- Maintain a regional focus in support of the combatant commander's theater engagement strategy.

PROXIMITY

2-3. To ensure that Soldiers have ready access to dental treatment, dental assets are organic to the supporting medical companies/troops of the brigade combat teams (BCTs), armored cavalry regiments, special forces groups (SFGs), and civil affairs units.

2-4. Placing dental assets in close proximity to the Soldiers that they support provides two key benefits. These are—

- Soldiers are able to be seen, evaluated, treated, and quickly returned to duty with less time away from their unit.
- Soldiers are less likely to be evacuated to a higher role of care DTF for routine dental treatment which results in fewer Soldiers being lost to the unit.

2-5. Based on the current force structure, dental service support assets are located in three specific organizational areas. The placement of dental assets in these areas ensures that Soldiers have ready access to dental treatment when they need it. The result is prompt treatment and rapid return to duty. Another benefit is that fewer Soldiers are medically evacuated and subsequently lost to their unit for extended periods of time.

SECTION II — DENTAL STAFF POSITIONS AND RESPONSIBILITIES

DENTAL STAFF OFFICER AND NONCOMMISSIONED OFFICER POSITIONS

2-6. Dental staff officers and NCOs at all levels of command and within each role of care are responsible for developing and implementing dental policies and procedures and providing running estimates and plans for how they will provide dental support for their respective commands.

2-7. The dental staff officers and NCOs determine what resources are required to adequately support the troop population in their area of operations. They develop running estimates for inclusion in Army Health System annexes to the operation plan. Based upon real assets in theater (refer to FM 5-0, FM 8-42, and FM 8-55 for information concerning the preparation of Army Health System estimates and plans), they provide technical guidance on dental matters to subordinate dental units. They monitor the oral health of the supported troops and the readiness of all assigned dental assets (personnel and equipment). They continually evaluate Army Health System dental support plans to determine dental resource requirements and adequacy of available assets. Specific duties may include surveillance of the—

- Operational readiness status of dental resources in the area of operations.
- Operational requirements of supported troops (for example, number and types of units supported or in the area of operations; number of troops being supported; the anticipated duration of the operation; the tactical situation; the location and distribution of supported units; and the expressed needs of commanders).
- Provision of dental services to enemy prisoners of war, retained personnel, and detainees.
- Provision of dental services to other supported populations when authorized and directed to provide care.

ARMY

2-8. There is no dental surgeon located within the Army Service component command (ASCC) surgeon's cell.

MEDICAL COMMAND (DEPLOYMENT SUPPORT)

2-9. The MEDCOM (DS) headquarters company has a dental surgeon and a preventive dentistry officer, and one senior dental NCO position reflected on its TOE.

2-10. The MEDCOM (DS) dental surgeon is the senior colonel, (area of concentration [AOC] 63R) in the MEDCOM (DS). He is responsible for —

- Establishment of an effective and consistent program for dental services and dental operations on a theaterwide basis.
- Theaterwide collection and consolidation of dental treatment data and forwarding the data to the central data repository.
- Developing theater-level policies and procedures to be executed by subordinate dental service support assets.
- Exercising technical supervision over all the dental units in the theater if the medical brigade (MEDBDE) is not deployed.
- Directing the dental service element of the headquarters.
- Providing dental staff support to the MEDCOM (DS) commander.

2-11. The MEDCOM (DS) headquarters company has a dental surgeon and a preventive dentistry officer, and one senior dental NCO position reflected on its TOE.

2-12. The MEDCOM (DS) preventive dentistry officer (AOC 63H) supports the MEDCOM (DS) dental surgeon in all staff actions. Specific duties include—

- Providing oral health surveillance information in support of policy and procedure development.
- Developing plans and orders concerning oral fitness and preventive dentistry programs.
- Recommending dental treatment policies.
- Developing programs for dental support of foreign humanitarian assistance operations.
- Ensuring theaterwide collection of dental workload information.

2-13. The MEDCOM (DS) staff dental NCO is a sergeant major (military occupational specialty [MOS] 68Z5O.) His duties include—

- Supervising the general administrative functions and coordination of personnel assignments.
- Evaluating the training programs and requirements.
- Assisting dental staff officers in the administrative and technical supervision of subordinate dental facilities.
- Assisting in the development of running estimates for operational plans.
- Providing technical assistance in planning and staffing of subordinate dental facilities.

MEDICAL BRIGADE

2-14. The MEDBDE headquarters staff does not have dental personnel assigned to serve as a dental surgeon or senior dental NCO. When technical advice and assistance is required regarding dental issues they consult with the senior subordinate dental company commander (AOC 63R) and the senior dental NCO (MOS 68E4O) in their area of operations. This officer serves as the MEDBDE dental surgeon whose principle responsibility is to advise the chief, professional services on the dental health of the command and the supported troop population. His duties and responsibilities include—

- Exercising technical supervision over dental assets in assigned hospitals and dental units subordinate to the MEDBDE.
- Monitoring preventive dentistry programs within the command and determining dental readiness rates.
- Developing policy, procedures, and protocols for dental treatment within the MEDBDE DTFs.
- Advising the chief, professional services when augmentation of oral and maxillofacial surgical resources is required.
- Providing consultation to MEDBDE MTFs on medical evacuation requirements for dental surgical patients entering the U.S. Air Force (USAF) evacuation system.

2-15. The MEDBDE dental surgeon may also be called upon to serve as the division dental surgeon. His responsibilities in this capacity include providing technical supervision for subordinate dental officers that are assigned to medical companies in support of BCTs, armored cavalry regiments, SFGs, and civil affairs units at unit level, as well as for dental assets assigned within the MEDBDE.

2-16. The duties and responsibilities of the dental NCO tasked with the providing the MEDBDE with advice and assistance, in concert with the command dental surgeon, include—

- Monitoring dental activities for the command.
- Receiving reports from subordinate units, consolidating the data, and forwarding it to his higher headquarters.
- Coordinating policies, procedures, and protocols for the treatment of dental conditions and preventive dentistry programs.
- Recommending priority of fill and assignment of dental personnel to subordinate dental elements.
- Serving as the principal NCO providing technical assistance to subordinate unit enlisted dental personnel.

2-17. Dental officers (AOC 63A) assigned to medical companies in support of BCTs, armored cavalry regiments, SFGs, and civil affairs units serve as the dental surgeons for the parent unit. Dental officers assigned to brigade support medical companies serve as advisors to the brigade commanders on matters involving unit dental readiness. They use dental classification information provided by the supporting DTFs to accurately determine the dental readiness of the organization and make recommendations on how to improve the unit's dental readiness posture. Additional responsibilities involve providing running estimates and recommendations concerning the delivery of dental support for BCT operations.

SECTION III — UNIT-LEVEL DENTAL SUPPORT

AREA SUPPORT SQUADS

2-18. Area support squads are assigned to medical companies at either brigade-level or with the echelons above brigade medical companies (area support) and provide dental service support within BCTs, armored cavalry regiments, SFGs, civil affairs, and echelons above brigade units. Area support squads are organic to all medical companies/troops. Although collocated within the area of operations of the Soldiers that they support, forward dental treatment teams may be overwhelmed by the number of patients and unable to fully support the patient population without assistance. Also the echelons above brigade area support squad dental element may have more than they can adequately support. In those situations, the dental company (area support) can augment the area support squad to treat the increased number of patients being seen.

PERSONNEL

2-19. Personnel assigned to the area support squad of a medical company are depicted in Table 2-1.

Table 2-1. Dental personnel organic to a typical area support squad

Paragraph	*Paragraph Description*	*Title*	*Grade*	*AOC/MOS*
06	Area Support Squad	General Dentist	O3	63A
		Dental Specialist	E4	68E1O

SECTION IV — COMBAT SUPPORT HOSPITAL DENTAL SUPPORT

DENTAL SERVICES SECTION AND OPERATING ROOM/CENTRAL MATERIEL SERVICES SECTION

2-20. Dental service support within the combat support hospital is provided by the dental services section. The dental services section provides routine dental care, treatment for maxillofacial injuries, and oral surgery support for hospital staff, patients, military personnel in the immediate area, and patients referred by other MTFs in the area.

2-21. When performing surgical procedures, the oral and maxillofacial surgeon will generally require the assistance of other operating room personnel to assist him while conducting maxillofacial surgical procedures.

PERSONNEL

2-22. Personnel assigned to the operating room/central materiel services and dental services section of the combat support hospital are depicted in Table 2-2.

Table 2-2. Dental personnel organic to the combat support hospital

Paragraph	*Paragraph Description*	*Title*	*Grade*	*AOC/MOS*
07	Operating Room/Central Materiel Services Section	Oral and Maxillofacial Surgeon	O4	63N00
		Dental Specialist	E4	68E1O
09	Dental Services Section	Comprehensive Dentist	O4	63B00
		Preventive Dentistry Sergeant	E5	68E2O
		Dental Specialist	E4	68E1O

SECTION V — AREA DENTAL SUPPORT

MISSION

2-23. Area dental support for units that do not have organic dental assets is provided by the—

- Medical company (dental services) (TOE 08478L000).
- Dental company (area support) (TOE 08473A000).

2-24. Both dental companies provide operational dental care and both have dental assets which can deploy when and where necessary to provide augmentation and or reinforcement to the area support squads.

Note. All medical companies (dental services) (TOE 08478L000) are being converted to the Medical Reengineering Initiative dental company (area support) (TOE 08473A000).

MEDICAL COMPANY (DENTAL SERVICES)

2-25. The medical company (dental services) (TOE 08478L000) is a Medical Force 2000-designed unit (see Figure 2-1).

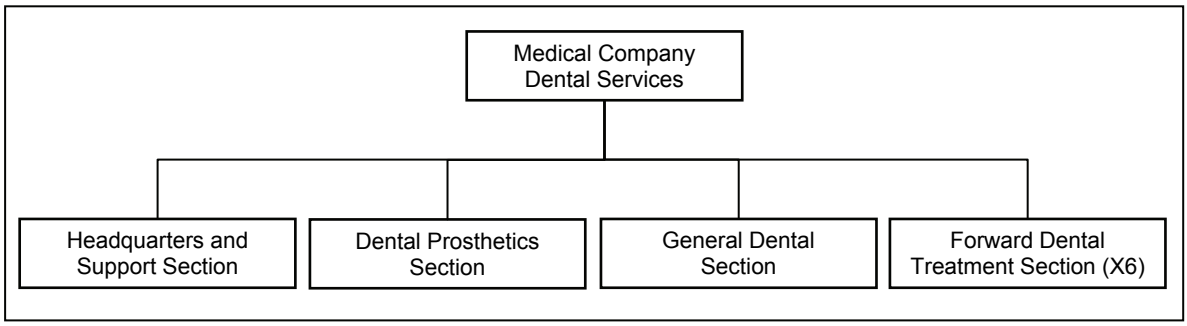

Figure 2-1. Medical company (dental services)

MISSION

2-26. The mission of the medical company (dental services) is to provide operational dental care consisting of emergency and essential dental care.

ASSIGNMENT

2-27. When deployed, the medical company (dental services) will be assigned to the medical battalion (multifunctional) (TOE 08485G000). Once in place they can deploy forward dental treatment sections to provide area dental support.

EMPLOYMENT

2-28. The medical company (dental services) is employed with the MEDCOM (DS) or the MEDBDE within a theater. Dental teams may be employed in the BCT area to provide forward emergency and preventive dental care.

BASIS OF ALLOCATION

2-29. The medical company (dental services) is employed on the basis of allocation of one per 20,000 troops supported.

CAPABILITIES

2-30. The medical company (dental services) provides the following:

- Operational dental care, which is composed of emergency and essential dental care, including limited prosthodontic specialty care.
- Up to six dental treatment teams performing dental services for small or forward troop concentrations.
- Augmentation to the advanced trauma management capabilities of other MTFs during mass casualty situations.
- One cook (MOS 92G1O) to augment the field feeding capabilities of the supporting unit.
- Maintenance of own property book.

2-31. Individuals assigned to this unit are provided weapons for personal defense and protection of patients under their care.

2-32. This unit performs unit maintenance on all equipment except communications-electronic and communications security equipment.

DEPENDENCIES

2-33. This unit is dependent on—

- The supported unit or ASCC for finance, religious, legal, laundry and bath, clothing exchange, supplemental transportation support, and communications-electronic and communications security maintenance.
- Medical command (DS) or MEDBDE for health service support/force health protection, field feeding, vehicle refueling, and vehicle recovery.

FUNCTIONS AND REQUIREMENTS

2-34. The headquarters and support section provides command and control for the company and vehicle and generator maintenance support.

2-35. The dentistry/prosthetics section provides prosthodontic support to deployed troops.

2-36. The general dental section provides operational dental care consisting of emergency dental care and essential dental care on an area basis.

2-37. The forward dental treatment section provides operational dental care consisting of emergency dental care and essential dental care on an area basis in forward troop concentrations. It reconstitutes brigade dental assets and is organized with six forward treatment teams.

MOBILITY

2-38. This unit is capable of transporting 70,700 pounds (5,719 cubic feet) of TOE equipment with organic vehicles. This unit has 71,896 pounds (5,781 cubic feet) of TOE equipment requiring transportation.

2-39. This unit requires 50 percent of its TOE equipment to be transported in a single lift using organic vehicles.

PERSONNEL

2-40. Table 2-3 lists all personnel assigned to the medical company (dental services) (TOE 08478L000).

Table 2-3. Medical company (dental services)

PARAGRAPH NUMBER AND TITLE	*ADDITIONAL SKILL IDENTIFIER*	*GRADE*	*AOC/MOS*	*TITLE*	*STAFFING LEVEL*
01 HEADQUARTERS AND SUPPORT SECTION		O5	63R00	COMMANDER	1
		O3	70B67	EXECUTIVE OFFICER	1
		E8	68E5M	FIRST SERGEANT	1
		E6	63B3O	MOTOR SERGEANT	1
		E5	63B2O	WHEELED VEHICLE MECHANIC	1
		E5	92A2O	EQUIPMENT RECORDS/PARTS SERGEANT	1
		E5	92Y2O	SUPPLY SERGEANT	1
		E4	42A1O	HUMAN RESOURCES SPECIALIST	1
		E4	52D1O	POWER-GENERATION EQUIPMENT REPAIRER	1
		E4	63B1O	WHEELED VEHICLE MECHANIC	1
		E4	68A1O	BIOMEDICAL EQUIPMENT SPECIALIST	1
		E4	68G1O	PATIENT ADMINISTRATION SPECIALIST	1
		E4	68J1O	MEDICAL LOGISTICS SPECIALIST	1
		E4	74D1O	CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR DECONTAMINATION SPECIALIST	1
		E4	74D1O	CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR SPECIALIST	1
		E3	92G1O	COOK	1
02 DENTAL PROSTHETICS SECTION		O5	63R00	CHIEF DENTAL SERVICES	1
		O4	63F00	PROSTHODONTIST	1
		O3	63A00	GENERAL DENTAL OFFICER	3
		E7	68E4O	DENTAL NONCOMMISSIONED OFFICER	1
		E6	68E3O	SENIOR DENTAL SERGEANT	2

Table 2-3. Medical company (dental services) (continued)

PARAGRAPH NUMBER AND TITLE	*ADDITIONAL SKILL IDENTIFIER*	*GRADE*	*AOC/MOS*	*TITLE*	*STAFFING LEVEL*
02 DENTAL PROSTHETICS SECTION (continued)	N5	E6	68E3O	SENIOR DENTAL LABORATORY SERGEANT	1
	X2	E5	68E2O	PREVENTIVE DENTISTRY SERGEANT	1
		E5	68E2O	DENTAL SERGEANT	1
	N5	E5	68E2O	DENTAL LABORATORY SERGEANT	1
	N5	E4	68E1O	DENTAL LABORATORY SPECIALIST	2
		E4	68E1O	DENTAL SPECIALIST	1
	X2	E4	68E1O	PREVENTIVE DENTISTRY SPECIALIST	1
		E3	68E1O	DENTAL SPECIALIST	2
03 GENERAL DENTAL SECTION		O4	63B00	CHIEF DENTAL SERVICE	1
		O3	63A00	GENERAL DENTAL OFFICER	3
		E7	68E4O	DENTAL NONCOMMISSIONED OFFICER	1
		E6	68E3O	SENIOR DENTAL SERGEANT	1
	X2	E5	68E2O	PREVENTIVE DENTISTRY SERGEANT	1
		E5	68E2O	DENTAL SERGEANT	1
		E4	68E1O	DENTAL SPECIALIST	1
	X2	E4	68E1O	PREVENTIVE DENTISTRY SPECIALIST	1
04 FORWARD DENTAL TREATMENT SECTION		O4	63B00	CHIEF DENTAL SERVICES	1
		O3	63A00	GENERAL DENTAL OFFICER	5
		E6	68E3O	SENIOR DENTAL SERGEANT	1
		E4	68E1O	DENTAL SPECIALIST	6

DENTAL COMPANY (AREA SUPPORT)

2-41. The dental company (area support) (TOE 08473A000) is a Medical Reengineering Initiative-designed unit (see Figure 2-2).

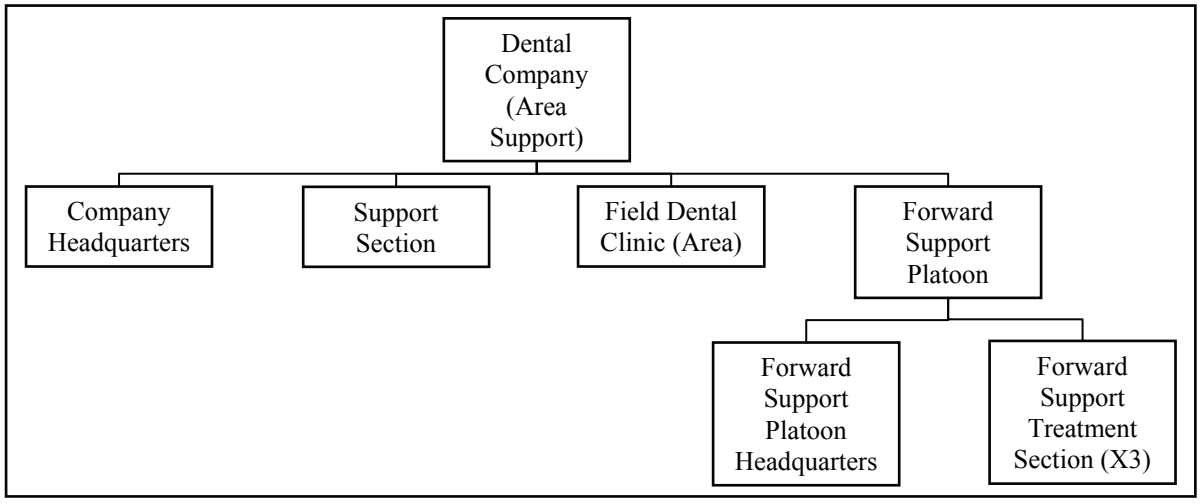

Figure 2-2. Dental company (area support)

MISSION

2-42. The mission of the dental company (area support) is to provide operational dental care consisting of emergency and essential dental care designed to eliminate potential dental emergencies on an area basis.

ASSIGNMENT

2-43. The dental company (area support) is assigned to the MEDCOM (DS) or MEDBDE.

EMPLOYMENT

2-44. The dental company (area support) is employed with the MEDCOM (DS) or MEDBDE within a theater. Dental teams may be employed in the BCT area to provide forward emergency and preventive dental care.

BASIS OF ALLOCATION

2-45. The dental company (area support) is employed on the basis of allocation of one company per 43,000 Soldiers supported in the theater. This is based upon the ratio of one dentist in support of 1,175 troops.

CAPABILITIES

2-46. The dental company (area support) provides—

- Command and control of subordinate dental elements.
- Operational dental care, consisting of emergency dental care and essential dental care.
- Reinforcement and reconstitution of BCT and armored cavalry regiment dental assets.
- Far forward operational dental care to small and forward deployed troop concentrations. This section is composed of 3 forward support treatment sections. Each section is composed of 6 treatment teams for a total of 18 forward treatment teams to provide area support.
- Augmentation of medical assets during mass casualty situations.
- One cook to augment the supporting food service element.

2-47. Soldiers assigned to this company are issued weapons (pistols, rifles, and squad automatic weapons) for personal defense and protection of patients under their care. Due to the forward nature of their mission, 100 percent of the Soldiers assigned to the forward support treatment teams are issued weapons.

2-48. This unit performs unit maintenance on all organic equipment, except communications-electronic and communications security equipment.

DEPENDENCIES

2-49. The dental company (area support) is dependent on—

- Appropriate elements of the corps or ASCC for health service support/force health protection, religious, legal, finance, personnel and administrative services, food service, water, supplemental transportation support, and communications-electronic repair and communications security equipment repair and maintenance.
- Appropriate elements of the corps or ASCC for security of enemy prisoners of war and detainee patients and U.S. prisoner patients.

FUNCTIONS AND REQUIREMENTS

2-50. The company headquarters provides supervision and command and control of the company.

2-51. The support section provides nonclinical support activities to include wheeled vehicle, power generation, and medical equipment maintenance.

2-52. The field dental clinic (area) provides operational dental care consisting of emergency dental care and essential dental care.

2-53. The forward support platoon headquarters provides command and control and administrative support to the treatment sections.

2-54. The three forward support treatment sections provide operational dental care consisting of emergency dental care and essential dental care throughout the combat zone and isolated troops concentrations.

MOBILITY

2-55. This unit is capable of transporting 133,700 pounds (11,073.0 cubic feet) of TOE equipment with organic vehicles. This unit has 79,758 pounds (6,473.3 cubic feet) of TOE equipment requiring transportation.

2-56. This unit requires 50 percent mobility of TOE equipment and supplies to be transported in a single lift using its authorized organic vehicles.

PERSONNEL

2-57. Table 2-4 lists all personnel assigned to the dental company (area support) TOE 08473A000.

Table 2-4. Dental company (area support)

PARAGRAPH NUMBER AND TITLE	*ADDITIONAL SKILL IDENTIFIER*	*GRADE*	*AOC/MOS*	*TITLE*	*STAFFING LEVEL*
01 COMPANY HEADQUARTERS		O6	63R00	COMMANDER	1
		O5	67A00	EXECUTIVE OFFICER	1
		E8	68E5M	FIRST SERGEANT	1
		E5	92Y2O	SUPPLY SERGEANT	1
	E3	E4	42A1O	EXECUTIVE ADMINISTRATIVE ASSISTANT	1

Table 2-4. Dental company (area support) (continued)

PARAGRAPH NUMBER AND TITLE	*ADDITIONAL SKILL IDENTIFIER*	*GRADE*	*AOC/MOS*	*TITLE*	*STAFFING LEVEL*
01 COMPANY HEADQUARTERS (continued)		E4	42A1O	HUMAN RESOURCES SPECIALIST	1
		E4	74D1O	CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR DECONTAMINATION SPECIALIST	1
		E4	74D1O	CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR SPECIALIST	1
		E4	92Y1O	ARMORER	1
		E3	92G1O	COOK	1
02 SUPPORT SECTION		E7	68E4O	OPERATIONS SERGEANT	1
		E6	63B3O	MOTOR SERGEANT	1
		E5	52D2O	POWER GENERATION EQUIPMENT REPAIRER	1
		E5	63B2O	WHEELED VEHICLE MECHANIC	1
		E5	68J2O	MEDICAL LOGISTICS SERGEANT	1
		E4	63B1O	WHEELED VEHICLE MECHANIC	1
		E4	68A1O	BIOMEDICAL EQUIPMENT SPECIALIST	1
		E4	92A1O	EQUIPMENT RECORDS/PARTS SPECIALIST	1
		E3	52D1O	POWER GENERATION EQUIPMENT REPAIRER	1
		E3	63B1O	WHEELED VEHICLE MECHANIC	1
03 FIELD DENTAL CLINIC (AREA)		O5	63B00	COMPREHENSIVE DENTAL OFFICER	1
		O5	63D00	PERIODONTIST	1
		O5	63D00	ENDODONTIST	1
		O5	63F00	PROSTHODONTIST	1
		O3	63A00	GENERAL DENTAL OFFICER	5
		E7	68E4O	DENTAL NONCOMMISSIONED OFFICER	1
		E6	68E3O	SENIOR DENTAL SERGEANT	2
	N5	E6	68E3O	SENIOR DENTAL LABORATORY SERGEANT	1
	X2	E5	68E2O	PREVENTIVE DENTISTRY SERGEANT	2
		E5	68E2O	DENTAL SERGEANT	1
	N5	E5	68E2O	DENTAL LABORATORY SERGEANT	2

Table 2-4. Dental company (area support) (continued)

PARAGRAPH NUMBER AND TITLE	*ADDITIONAL SKILL IDENTIFIER*	*GRADE*	*AOC/MOS*	*TITLE*	*STAFFING LEVEL*
03 FIELD DENTAL CLINIC (AREA) (continued)	N5	E4	68E1O	DENTAL LABORATORY SPECIALIST	3
		E4	68E1O	DENTAL SPECIALIST	3
	X2	E4	68E1O	PREVENTIVE DENTISTRY SPECIALIST	4
		E4	68G1O	PATIENT ADMINISTRATION SPECIALIST	1
		E3	68E1O	DENTAL SPECIALIST	5
04 FORWARD SUPPORT PLATOON HEADQUARTERS		O4	63B00	COMPREHENSIVE DENTAL OFFICER	1
		O3	70B67	FIELD MEDICAL ASSISTANT	1
		E7	68E4O	PLATOON SERGEANT	1
05 FORWARD SUPPORT TREATMENT SECTION		O4	63B00	CHIEF DENTAL SERVICES	3
		O3	63A00	GENERAL DENTAL OFFICER	15
		E6	68E3O	SENIOR DENTAL SERGEANT	3
		E5	68E2O	DENTAL NONCOMMISSIONED OFFICER	3
		E5	68E2O	DENTAL SERGEANT	3
		E4	68E1O	DENTAL SPECIALIST	6
		E3	68E1O	DENTAL SPECIALIST	6

Note. For purposes of clarity and ease of discussion the medical company (dental services) and the dental company (area support) will, from this point forward, be referred to in general terms as *dental company*.

Chapter 3
Dental Unit Operations

SECTION I — ESTABLISHING THE DENTAL TREATMENT FACILITY

SITE SELECTION CONSIDERATIONS

3-1. When establishing a DTF in the field careful consideration should be given to the location and choice of terrain on which the DTF will be operating. Some of the advantages that a carefully selected site offers include: easy access to the facility; a smooth flow of vehicle traffic into and out of the area; concealment; defensibility; and adequate drainage during inclement weather.

3-2. There are many factors that influence where the DTF should be located all of which are METT-TC driven. Considerations which influence the location of the DTF include the—

- Mission.
- Commander's intent.
- Specifics of the operation plan.

3-3. Additional considerations which should be taken into account when establishing the location of the DTF include—

- Placing the DTF on terrain that—
  - Provides easy access to routes of evacuation and which is accessible to the supported troops.
  - Provides good drainage, is free of obstacles, and provides adequate space to operate.
  - Is cleared of mines, improvised explosive devices, booby traps, and CBRN hazards.
  - Enables or enhances communications capabilities.
  - Provides natural cover and concealment.
  - Is easy to defend in the event of attack.
  - Is free of garbage dumps, landfills, toxic industrial materials or other waste disposal sites.
- Placing the DTF on or within easy reach of terrain that has sufficient space for incoming and outgoing air ambulances and ground ambulance turnaround.
- Placing the DTF as far as possible/practical from—
  - Terrain that is a likely breeding site for flies, mosquitoes, and other pests.
  - Structures, facilities, or equipment that may be considered likely targets for the enemy.

3-4. If the unit's mission requires that it relocate frequently, establishing a complete treatment area may not be practical. Under these circumstances the DTF may choose to set up an expedient shelter under which to conduct treatment operations. Time may allow only essential services, shelters, and equipment will be used. If however, it is anticipated that the unit will be located at one site for an extended period of time, existing shelters or buildings when available, may be used.

SHELTERING THE DENTAL TREATMENT FACILITY

3-5. When providing dental care in a field environment the DTF should be established so that the patients and staff are sheltered from the elements. It is also desirable to have some degree of environmental control.

EXPEDIENT SHELTERS

3-6. Expedient shelters are generally more convenient and easier to establish and use when a unit is conducting a movement and must provide emergency dental care. Expedient shelters may be as simple as a tarp being erected to shield the patient and dental staff from the sun or rain. In situations where weather and terrain permit, a shaded area adjacent to the route of march will suffice. It may be as simple as setting up on the tailgate of a vehicle which may be adequate for the immediate situation.

TENTS

3-7. All U.S. Army field dental units are equipped with tents. The types of tentage available to a unit are based on common tables of allowance and the unit's modified table of organization and equipment.

Note. When a unit replaces existing tents, selection criteria for new tents must include compatibility with the unit's existing heating, cooling, and electrical requirements and capabilities.

3-8. Tents provide dental personnel with a shelter system that is quick to setup and strike. Their portability and convenience are especially useful for forward deployed dental treatment teams. Tents are easy to camouflage and conceal and allow flexibility in site selection.

SEMIPERMANENT BUILDINGS

3-9. Semipermanent buildings are generally constructed and used in base clusters or forward operating bases particularly in long-term stability operations. Semipermanent buildings offer a number of features that make them very desirable. The structures can be built to specific dimensions which are required to establish and operate a DTF.

BUILDINGS OF OPPORTUNITY

3-10. Buildings of opportunity present a number of distinct advantages and should be used whenever possible. These may include electrical lighting, air conditioning and central heat, telephones, running water, and toilets. Prior to establishing a DTF in an existing structure, the building must first be inspected and approved for occupancy by the supporting engineers. The buildings existing layout may pose a significant challenge to dental personnel when trying to establish an efficient layout.

SECTION II — ADMINISTRATIVE TOOLS AND REQUIREMENTS

DENTAL RECORDS

3-11. Maintenance and disposition of dental treatment records are governed by AR 40-66.

OUTPATIENT TREATMENT RECORDS

3-12. Outpatient treatment records are prepared for each patient treated by a U.S. Army DTF. An outpatient treatment record will be prepared by the first DTF to which a person reports for outpatient treatment. After being initiated, the outpatient treatment record will be kept at the DTF.

DENTAL TREATMENT FACILITY TREATMENT LOGBOOKS

3-13. The DTF's daily dental treatment logs are maintained by the dental officer at each DTF. The DTF logbook is maintained by each DTF to record the names, rank, and unit of the patients treated at that DTF, and the patient's disposition. Other useful information includes the date, time, and the reason for the visit and whether the treatment provided was for disease and nonbattle injury or battle injury-related conditions.

This log is retained for the clinics record and the information provides a valuable source of data for statistical reporting.

DENTAL REPORTS

DAILY DENTAL UNIT STATUS REPORT

3-14. The daily dental unit status report provides a brief summary of supported units' current dental condition. The frequency with which the report is submitted is situationally dependant. The report is submitted to the dental company's higher headquarters.

QUARTERLY DENTAL ACTIVITY REPORT

3-15. The quarterly dental activity report is a summary of the DTF's activities during the quarter. This report is required to be submitted to the DTFs higher headquarters by the 15th of the month following each fiscal quarter of the year by the division/corps surgeon (see Figure 3-1, p 3-4). For example, each DTF will submit a report covering the period 1 July through 30 September not later than the 15th of October of that year. If participation in an operation or exercise ends before the end of a quarter, the final dental activity report will be due 15 days after return to the home station.

Unit Information

3-16. The dental activity report will include—

- Dates of the report period.
- Name and location of unit or DTF.
  - Description of facilities.
  - Dental unit or DTF movement during report period.

Personnel Information

3-17. Personnel information includes the name, rank, and AOC for officers and the name, rank, and MOS and additional skill identifier for all enlisted personnel.

- Identity of the officer in charge and noncommissioned officer in charge.
- Date of arrival and departure of all personnel.
- Awards, honors, and achievements.
- Dental and organizational equipment to include deficiencies, excesses, problems, and recommendations.
- Supply and maintenance, to include deficiencies, excesses, problems, and recommendations.
- Units supported, to include date support began and date support terminated.
- Activities and programs (for example, foreign humanitarian assistance, preventive programs, professional and unit training, and distinguished visitors).
- Suggestions for improvement.

Purpose

3-18. The dental activity report is intended to keep command channels informed of the status of dental resources and activities in the field. The report provides commanders with a tool that may be used to address specific issues and concerns.

3-19. After a complete initial report is submitted, subsequent reports need not repeat information which has not changed. Unless changes are made on subsequent reports, it may be assumed that the data furnished in the previous reports are still valid and serve as a cumulative record of dental service for that unit.

42nd Dental Company (Area Support)
Quarterly Dental Activity Report

Reporting Period	From	To

Personnel Assigned		Arrived	Departed
Commander/OIC			
Executive Officer			
First Sergeant/NCOIC			

Personnel Awards, Honors, and Achievements

Supported Units

Equipment Deficiencies, Excesses, Problems, and Recommendations

Supply and Maintenance Deficiencies, Excesses, Problems, and Recommendations

Activities and Programs (Humanitarian and Civic Assistance, Preventive Programs, Professional and Unit Training, and Distinguished Visitors)

Suggestions for Improvement

Figure 3-1. Sample dental activity report

3-20. Daily dental unit status reports and quarterly dental activity reports are submitted through command channels to the MEDCOM, DS dental surgeon. The DTF dental reports are retained at the dental facility and are available for audit if needed. Medical command and dental command surgeons extract data which is used to assess resource management and professional policy needs before forwarding reports to the next higher level. A summary of the DTF's daily dental activities report is the only numerical manipulation required at the DTF level. Dental surgeons and dental commanders may extract additional information required to prepare their quarterly dental activities report.

ANNUAL HISTORICAL REPORT

3-21. This regulation prescribes procedures for providing the DA with annual reports of administrative, professional, and operational activities of the AMEDD. They are essential as reference and source material for the historical programs and missions of the AMEDD. They are frequently referred to when data are required by or requested of the AMEDD in its current operations. The reports are also used as teaching reference material. For a detailed discussion on historical reports refer to AR 40-226.

Format

3-22. Reports will be written in narrative form and prepared on one side of 8 X 10 1⁄2-inch paper. Each page will be identified at the top by the preparing agency designation and calendar year and numbered consecutively in the center of lower margin.

3-23. A margin of 1 1⁄2 inches will be left at the top and left of each page.

3-24. Each report will be stapled by not more than two staples along the left margin. No other form of fasteners will be used.

Suggested Contents

3-25. The following topics are suggestions. It is not intended that each should be reported on solely because it is mentioned. The report should include any subjects which are appropriate to adequately reflect all important activities of the reporting unit.

- Mission. Identify unusual mission assignments; include changes in mission and/or unit relocation and reasons therefore.
- Organization. Important changes in organization and reasons therefore; include an organizational chart for clarity.
- Personnel. Unusual factors which significantly influence staffing of major professional and administrative elements or other considerations which have significance for development of personnel staffing guides.
- Training. Significant and unusual training activities, objectives, and programs.
- Materiel. Significant and unusual supply and maintenance programs.
- Construction. Major construction, alteration, or repair programs.
- Patient care and evaluation. Major professional policies or procedures for inpatient or outpatient care; unusual cases of historic importance; special problems and their solutions; comments on significant patient evacuation experience; significant accomplishments and trends.
- Health and environment. Significant factors affecting the health of the command such as incidence, epidemiology, and control of infectious diseases; environmental hygiene; occupational health service and nutrition; Army health nursing programs and activities and where indicated, medical and health problems of the civilian or multinational military population in the area.
- Dental service. Significant factors relating to operation of dental services, progress, and accomplishments in preventive dentistry and continuing educational programs.

DENTAL READINESS AND COMMUNITY ORAL HEALTH PROTECTION REPORT

3-26. Dental readiness is fundamental to maintaining unit readiness and reducing noncombat dental casualties during deployments. Community oral health protection emphasizes not only oral health, but also general wellness and overall fitness of our Soldiers and all authorized beneficiaries. Army Regulation 40-35 provides guidance for the development and conduct of the Dental Readiness and the Community Oral Health Protection programs for all authorized beneficiaries of the Army Dental Care System. It describes the Dental Readiness Program for active duty Soldiers and other programs that benefit all members of the Army community.

3-27. The Dental Readiness and Community Oral Health Protection programs include the following components:

- Dental Readiness Program.
- Clinical Oral Health and Health Promotion Program.
- Community Health Promotion and Disease Prevention Program.

SECTION III — CLINICAL OPERATIONS

PATIENT SAFETY

3-28. Patient safety in the health care setting involves a variety of clinical and administrative activities that organizations undertake to identify, evaluate, and reduce the potential for harm to beneficiaries and to improve health care quality. Effective patient safety initiatives seek to control untoward events before they occur and, as such, elements of risk assessment, risk identification, and risk reduction or containment are involved.

3-29. Leaders in MTFs play a critical role in the facility-based patient safety program given the influence that leaders exert on activities directly associated with this program (such as performance improvement, environmental safety, and risk management). Although the beneficiary is the central focus of patient safety, it is difficult to create an organization-wide patient safety initiative that excludes staff, Family members, and others. Many of the activities implemented to improve patient safety (for example, security, fire safety, equipment safety, infection control, and falls prevention) encompass staff and others, as well as patients. Patient safety is a critical component of both a table of distribution and allowances and/or TOE organization's comprehensive safety efforts. As such, patient safety activities and processes must be effectively integrated with those of the existing MTF/DTF Safety Program. Patient safety and the reporting of adverse events, especially sentinel events, are likewise important in the field environment. Wherever practical, efforts must be made by leadership to emphasize patient safety and to minimize patient harm associated with the provision of health care to Soldiers.

3-30. Universal precautions will be implemented by all dental personnel. To prevent cross-contamination barrier protection materials are included in the dental equipment set (DES). Dental equipment sets are discussed in Appendix C.

INFECTION CONTROL AND EXPOSURE CONTROL

3-31. All U.S. Army DTFs and all U.S. Army dental health care workers are governed by infection control policies and regulatory guidance provided by the—

- Assistant Secretary of Defense for Health Affairs.
- Office of The Surgeon General.
- Dental Command (DENCOM).
- Occupational Safety and Health Administration.
- Centers for Disease Control and Prevention.

3-32. All Army dental units must adhere to infection control/exposure programs based on existing regulatory guidance. These programs provide site specific guidance in all aspects of infection and exposure control for dental health care workers.

QUALITY ASSURANCE PLAN

3-33. The quality assurance plan is a tool which dental commanders can use to ensure that deployed Soldiers have access to the same quality of care that they would at their home station DTF. The plan allows the dental commander to make a standardize assessment of Soldiers access to care, quality of care provided, effectiveness and utilization of dental assets and resources, and risk management considerations and solutions. Quality assurance plans are discussed in detail in Appendix D.

WASTE MANAGEMENT

3-34. Dental units generate three types of waste materials, they are—

- General waste.
- Hazardous waste.
- Medical waste (to include regulated medical waste).

3-35. For a detailed discussion regarding the collection, handling, and disposal of waste materials refer to FM 4-02.17. Proper handling and disposal of medical waste is required to protect the force and avoid environmental contamination. Assistance with the removal and disposal of medical waste is normally available through supporting engineer units, preventive medicine teams, and local MTFs.

RADIOLOGY OPERATIONS

3-36. The ability to produce x-ray images is an important diagnostic tool in modern dentistry. It is for this reason that handheld digital x-ray equipment is an integral part of each DES. As with all radiology operations, applicable safety precautions must be put in place and observed to reduce the threat of injury associated with this type of equipment.

3-37. Dental radiology equipment is found in the dental company (area support), medical company (dental services), forward treatment sections, and in brigade support medical companies and medical companies (area support). The handheld digital x-ray equipment is capable of producing a full range of intraoral x-rays and, when necessary, may be used for other medical procedures.

3-38. Operation of handheld digital x-ray equipment is an additional responsibility of the dental specialists assigned to the unit. As with all radiology operations, the use of patient protective aprons is mandatory when x-ray images are being made.

3-39. The manufacturer's instructions and guidelines for the care and use of x-ray equipment and associated materials must be followed. These procedures and precautions should be addressed in the unit's clinical standing operating procedures (CSOPs).

FIELD DENTISTRY

3-40. Providing dental care in a field environment requires the same basic equipment, clinical skills, and standards of practice, as that provided in garrison DTFs. There are, however, unique challenges to dental personnel working in a field environment presented by the varying terrain features, environmental conditions, availability or lack of facilities, and the tactical situation. To effectively support and quickly return Soldiers to duty, dental personnel must be capable of working quickly and accurately in a field environment.

3-41. Dental treatment can be provided as soon as a suitable working area and power are established. Patient care operations performed in the field are performed in much the same manner as they would be in a garrison environment. The objective, as previously stated is to provide the necessary care and return Soldiers to duty as quickly as possible.

PROSTHODONTIC CARE OPERATIONS

3-42. Soldiers who wear dentures that begin to cause discomfort and pain, are damaged, or are lost are classified as dental casualties. These casualties can be treated by the dental company prosthodontic section which is capable of repairing or replacing dentures in the field. Dental company DES contain the tools and materials necessary to provide temporary fixed prosthodontic coverage and cementation. Additionally, each forward treatment section of the medical company (dental services) and forward treatment section of the dental company (area support) are equipped with emergency denture repair kits to effect prosthodontic repairs.

3-43. Theater prosthodontic laboratory capabilities include—

- Wax records and bases.
- Impression procedures and cast fabrication.
- Stain and glazing.
- Immediate transitional resin dentures.
- Die fabrication and trimming.
- Relining/rebasing.
- Repairs.

3-44. Patient requirements that exceed the capability of the theater laboratory can be mailed through the Army Post Office system back to CONUS area dental laboratories for fabrication.

3-45. The benefit of this capability is that the unit is not required to keep the additional personnel and equipment on hand. The savings in weight and cube contributes significantly to the mobility of the unit.

MEDICAL EVACUATION OF DENTAL PATIENTS

3-46. When dental patients require care that exceeds the capacity of their supporting dental unit they may require medical evacuation to the next role of care DTF. Medical evacuation of these patients is no different than that which is provided for combat casualties or severe illnesses. The medical evacuation assets that routinely provide evacuation support for a unit will transport dental casualties based on their medical condition and the evacuation precedent assigned to that patient.

STANDING OPERATING PROCEDURE

3-47. A SOP is a set of instructions or steps which enables Soldiers following it to complete a job safely, with no adverse impact on the environment, meets regulatory guidance and compliance standards, and in such a manner that maximizes operational and production requirements.

3-48. An SOP may take one of two forms within the medical community; the CSOP and tactical standing operating procedure (TSOP).

- The TSOP outlines how the unit conducts operations in a tactical environment. An example might cover CBRN detection and response issues, perimeter defense, road marches, and so forth.
- The CSOP (see Appendix E) addresses how the unit establishes and operates the clinical areas of the DTF; how it performs the patient care mission; and how the unit establishes patient flow into, through, and out of the DTF. The CSOP also address issues regarding equipment operation, maintenance, and safety.

3-49. Every dental unit must develop, publish, update, and train assigned personnel to established standards outlined in the unit's SOPs.

DEVELOPING THE STANDING OPERATING PROCEDURE

3-50. After writing and testing SOPs for each job, test SOPs before putting them into effect. Revise SOPs after an on-the-job trial. Also revise the SOP when changes or modifications are made to equipment, machinery, buildings or other structures, or procedures within the immediate work area that might affect performance of a job, or the environment in which it is performed.

3-51. It is not practical to write SOPs for each job that requires this level of detail overnight. To effectively meet this challenge, priorities must be established. New SOPs should be written when new equipment or processes create new work situations. It may be necessary to write or rewrite SOPs when new information suggests benefits from modifying work practices to improve performance. Accident investigations might show that procedural, safety and environmental guidelines are insufficient, incomplete, or even missing for certain jobs or parts of jobs. Systematically update all safety and environmental guidelines by asking Soldiers to evaluate existing SOPs and other documents that contain

work safety and environment guidelines. Then rank these jobs as to which should be revised first through last. These procedures could be revised, perhaps by the groups that ranked them.

3-52. Because SOPs are used for a variety of reasons and audiences, they first must be comprehensive, which means they are as long as necessary to cover a job. For long SOPs or for jobs performed infrequently, it pays to keep the long form SOP handy. Once a Soldier is familiar with a process, he will most likely be able to perform a series of short SOP steps from memory. These steps can be written as a short form SOP. If someone is going to use a short-form SOP, it should be prepared after a full long-form SOP has been tested and approved and should be handed out after a Soldier has passed the appropriate training.

3-53. Unit SOPs should always reflect the guidance contained in the parent organization's SOPs.

References

3-54. List all publications that guide or govern the reader in this subject area (for example, ARs, FMs, other SOPs, policy memorandums, and so forth). Use a separate subparagraph for each. Give the full title of each, to cite—

- Publications, give the type of publication (AR, FM, or similar designation), its number, date of publication, and title. If there is no publication number, cite the title, date of publication, and source of where the publication can be obtained.
- Correspondence, give the type of correspondence, office symbol, date, and subject.
- Meetings and telephone calls, list the type, the parties involved and their units, the date, and the subject.
- Electronic mail messages, give the type, name of the sender, the sender's organization, the subject, and the date.

Purpose

3-55. Write a precise purpose statement that indicates what specific goal the publication serves. For example: Purpose: To specify the procedures required to perform operator maintenance on the field dental chair.

Summary

3-56. In a paragraph less than one inch deep, recap the main points of your document. Write it after you have written the *Responsibilities* and *Procedures* paragraphs. Summarize (do not introduce) the key points, but be precise. Write complete sentences in the present tense.

Scope

3-57. State to whom the SOP applies and under what specific conditions it applies.

Definitions

3-58. Define all terms your readers might not fully understand. If not needed, omit this paragraph.

Responsibilities

3-59. Focus here on WHO does WHAT. List precise duties for key persons or groups.

- Specify WHOM you are addressing. Write a short title. For example: Commander, 123rd Dental Company (Area Support).
- Write imperative sentences as if addressing the person directly. Use the present tense and active voice. Start with an action verb. Avoid unneeded helping verbs such as *must*, *will*, or *will be*.
- Maintain parallelism in your lists. If you have a subparagraph *a* or *a*(1), have a subparagraph *b* or *b*(1).

Procedures

3-60. Focus here on the sequence of events to be followed. In chronological or topical order, describe exactly what happens. Indicate WHO does WHAT, WHEN, HOW, to WHOM, and in WHAT order.

3-61. Write declarative sentences with a subject and a verb in the present tense and active voice. Describe what happens. For example: On the day of firing, the supply sergeant provides a warming tent at the range. He also issues meals, ready-to-eat and collects money from Soldiers on separate rations.

3-62. Create new paragraphs or use enclosures to discuss miscellaneous administrative and logistical topics.

Files

3-63. If applicable state what files or records must be kept, otherwise omit this paragraph.

DENTAL SUPPORT PLANNING

3-64. As with all Army operations, dental support planning is METT-TC driven. Dental unit commanders must be actively involved in the planning process. This assures that the plans they develop effectively implement guidance given by their higher headquarters. It also helps to ensure that the plan is coordinated with, and integrated into the overall operation planning process. For specific guidance on the military decision-making process refer to FM 5-0 and FMI 5-0.1. For dental planning considerations for Army Health System operations, refer to FM 8-42 and FM 8-55. This process leads to rehearsal and the execution and assessment of the mission.

SECTION IV — CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR OPERATIONS

FUNDAMENTALS

3-65. Upon notification and or verification of a CBRN attack, dental units immediately cease dental treatment operations and assume the appropriate levels of mission-oriented protective posture.

3-66. Due to their proximity to the combat forces which they support, dental units must be able to operate successfully in CBRN environments. Successful operations hinge on their ability to recognize and respond to the CBRN threat. Their ability to respond appropriately prevents injury, damage, or loss of both personnel and materiel.

3-67. The best defense against CBRN weapons is using the fundamental principles of contamination avoidance. Avoiding the hazard is possible by maintaining current situational awareness which will report where a weapons release has occurred and which specific CBRN hazards is present in the area of operations. For detailed discussion regarding CBRN avoidance operations refer to FM 3-11.3.

3-68. Successful contamination avoidance prevents disruption to operations and organizations by minimizing unnecessary time in cumbersome protective postures and by minimizing decontamination requirements. Successful avoidance may be achieved by bypassing contamination or calculating the best time to cross contaminated areas. Avoiding contamination requires the ability to recognize the presence or absence of CBRN hazards in the air; on water, land, personnel, equipment, and facilities; and at short and long ranges.

3-69. The three fundamentals of CBRN defense are contamination avoidance, protection, and decontamination.

KNOWLEDGE OF HAZARDS

3-70. Contamination avoidance begins with the knowledge of hazards that may be encountered. This includes the physical characteristics, field behavior, and employment techniques that may be used. A thorough intelligence preparation of the battlefield is also essential to avoidance. Understanding the threat's CBRN capabilities and delivery systems allows the joint force commander to employ the assets necessary to protect the force. Because the detectors have technical and practical limitations, they should be integrated and networked throughout the operational environment in order to provide maximum coverage against threats.

PRINCIPLES OF AVOIDANCE

3-71. The principles of avoidance include the elements of detecting, identifying, predicting, warning, reporting, marking, relocating, and rerouting. Detection in CBRN environments is the act of locating CBRN hazards by using detectors or monitoring and survey teams. The implications of detection include the following:

- Standoff detection provides the warning of an approaching cloud (not a specific chemical-biological warfare agent) in sufficient time to implement protective measures before agent contamination occurs.
- Treatment is dependent upon the type of agent encountered. Focus should be on identifying the type of agent dispersed in an attack so that the best possible treatment can be rendered as early as possible.
- Verification, (reconnoitering and monitoring) provides critical information to support decisions regarding national strategic direction and integration.
- Surface contamination (monitoring) assists the commander with their decision making process. The results of monitoring will allow them to make decisions, such as whether decontamination is necessary or whether bypass routes are needed.
- Unmasking (dewarning) is a means of detecting the reduction of contamination to acceptable levels. A comparison of methods and results from the earlier detection of an agent will be an important aspect of determining when to unmask.

DECONTAMINATION

3-72. Chemical, biological, radiological, and nuclear agent contamination should be avoided when possible. When this is not possible, personnel and equipment must be decontaminated to reduce or eliminate the risk to personnel and to make equipment serviceable. Decontamination procedures will not degrade the performance of personnel or equipment and will not harm the environment. For detailed discussion regarding CBRN decontamination operations, refer to FM 3-11.5

3-73. The levels of decontamination are immediate, operational, thorough, and clearance.

- Immediate decontamination minimizes casualties and limits the spread or transfer of contamination.
- Operational decontamination sustains operations by reducing the contact hazard, limiting the spread of contamination, and eliminating or reducing the duration that mission-oriented protective posture equipment must be used.
- Thorough decontamination reduces contamination to the lowest detectable level by the use of tactical level capabilities. The intent of thorough decontamination is to reduce or eliminate the level of mission-oriented protective posture. This is accomplished by units (with or without external support) when operations and resources permit.
- Clearance decontamination is conducted to verify that all residual hazards have been mitigated to levels acceptable for unprotected personnel, technical decontamination team and their equipment.

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Appendix A

Generating Force Operations

THE ARMY

A-1. The Army derives its existence and mission from the Constitution of the United States and from legislation, principally U.S. Code, Title 10. Field Manual 1 describes the origins, organization, and mission of the Army at greater length.

A-2. In brief, the Army's primary task is to provide capabilities to conduct prompt and sustained combat incident to operations on land. It is responsible for the preparation of land forces necessary for the effective prosecution of war except as otherwise assigned and, in accordance with integrated joint mobilization plans, for the expansion of the peacetime components of the Army to meet the needs of war.

A-3. The Army calls these capabilities land power. Land power is the ability by threat, force, or occupation to promptly gain, sustain, and exploit control over land, resources, and people.

A-4. To provide the requisite land power capabilities, the Army has two functionally discrete but organizationally integrated entities known as the Operational Army and the Generating Force. The Operational Army provides the bulk of Army capabilities to the joint force for the conduct of full spectrum operations. The Generating Force generates and sustains the Operational Army, but can also provide some specialized land power capabilities to the joint force.

A-5. An organization's primary purpose distinguishes it as part of the Operational Army or the Generating Force. The primary purpose is the end to which the entity devotes most of its emphasis and resources. Army transformation and the current operational environment have blurred and sometimes erased the conceptual lines that distinguished between the Operational Army and the Generating Force, however. The Army will provide the capability that meets the operational need most effectively without regard to its status as Operational Army or Generating Force.

THE OPERATIONAL ARMY

A-6. The Operational Army is composed of organizations whose primary purpose is to participate in full-spectrum operations as part of the joint force.

A-7. The Operational Army consists of the Army Modular Force that is trained and organized to fight as part of the joint force. Modular organizations can be quickly assembled into strategically responsive force packages able to rapidly move wherever needed. They can quickly and seamlessly transition among types of operations. Modular organizations provide the bulk of forces needed for sustained land operations. In addition to conventional modular forces, the Army will continue to provide the major special operations force capabilities (both land and air) in support of the U.S. Special Operations Command's global mission.

A-8. Operational Army units are typically assigned to combatant commanders, with the Army executing its responsibilities to organize, train, and equip Operational Army units through the ASCCs.

THE GENERATING FORCE

A-9. The Generating Force consists of those Army organizations whose primary mission is to generate and sustain the Operational Army's capabilities for employment by joint force commanders. The Generating Force also possesses operationally useful capabilities for employment by or in direct support of joint force commanders.

BUILDING THE FORCE

A-10. Building the dental component of the Operational Army is accomplished by actively recruiting licensed dental personnel and by offering scholarships to prospective dental officers. Once on active duty, officers attend the officers' basic course to familiarize them with their duties and responsibilities and how they are expected to support the Operational Army. Enlisted dental personnel undergo advanced individual training at the USAMEDDC&S to become dental assistants, dental hygienists, and area dental laboratory specialists. These formal training courses are designed to prepare new officer and enlisted personnel to fill positions throughout the Army.

SUSTAINING THE FORCE

A-11. The DENCOM is responsible for sustaining both the dental force component of the Operational Army and the Operational Army at large. They accomplish this mission by ensuring that their cadre of experienced NCOs and officers attend AOC/MOS-specific professional development courses. Attendances of these courses provide the skill sets and tools that are necessary to successfully lead Soldiers in the conduct of their duty performance to enable the Army Dental Care System to provide the best care possible.

SUSTAINING THE OPERATIONAL DENTAL FORCE

A-12. Sustaining the operational dental force is accomplished by conducting both officer and NCO professional development courses at the USAMEDDC&S. These courses are designed to educate and train experienced officers and NCOs to fill positions of greater scope and responsibility throughout the Army. These courses are—

- Basic Noncommissioned Officers Course.
- Advanced Noncommissioned Officers Course.
- Basic Officer Leader Course.
- Officers Advanced Course.
- Captains Career Course.
- Army Medical Department Precommand Course.
- Executive Medical Skills Course.
- Dental Management Development Course.

SUSTAINING THE OPERATIONAL ARMY

A-13. Sustaining the Operational Army is in fact the reason that the Army Dental Care System exists. As described in Chapter 1, the Soldier is the focal point of the Operational Army and as such it is vitally important that he be in the best health possible, this includes his oral and dental fitness and health. The Army Dental Care System has a variety of dental service support assets available in the Generating Force. These assets—

- Augment the dental component capability of the Operating Force.
- Provide the requisite control and focus to promote dental health, to sustain and maintain dental operations, to enhance dental readiness, and to provide highly trained dental personnel to the deployed force through the Professional Filler System. See AR 601-142.
- Provide dental screening and treatment in support of the Soldier Readiness Program by ensuring that deploying Soldiers are fit to deploy and in the best possible dental condition prior to deployment. For additional information refer to AR 600-8-101.
- Provide dental capabilities to the Army and designated DOD activities; conduct medical/dental research, materiel development, and acquisition; educate and train personnel; and develop medical/dental concepts, doctrine, and systems to support Army dental care delivery.
- Provide dental support for deployment, sustainment, and demobilization of Army forces. The DENCOM will simultaneously maintain the capability to provide continuity of patient care, while ensuring it retains the capability to care for patients returning from the theater.

- Ensure that DTFs coordinate their support plans with the installations mobilization plan. Additionally, the DENCOM is responsible for the dental portion of Soldier readiness processing for the mobilized Army force.
- Provide individual AMEDD training and medical/dental materiel research and development to support the Army mobilization force. The DENCOM will expand the dental care base in CONUS to support the mobilizing Army force and casualties returning from theater.

ADDITIONAL GENERATING FORCE ENABLERS

COMBAT DENTAL RESEARCH PROGRAM

A-14. The U.S. military dental science and technology research laboratories, the U.S. Army Dental and Trauma Research Detachment and the Naval Institute for Dental and Biomedical Research are collocated at Great Lakes, Illinois. Their focus is on research and development of new technologies that reduce lost duty time caused by dental disease or trauma in military populations. Areas of research emphasis include methods to reduce disease causing dental plaque in conjunction with military rations; epidemiology of dental disease and trauma; rapid diagnostic aids; field-expedient preventive technologies; smaller, lighter, and less energy-consuming dental field equipment and sterilization; environment-insensitive dental materials; disposal of mercury contaminated water in deployed situations; and technologies to reduce the morbidity and mortality of oral and maxillofacial trauma, especially through the use of lightweight personal armor.

ARMY DENTAL LABORATORIES

A-15. Army dental laboratories provide a number of products and services which support Soldiers who require prosthodontic appliances. These products and services include—

- Fixed prosthodontics.
- Removable prosthodontics.
- Implant supported prostheses.
- Orthodontic services.
- Miscellaneous appliances.
- Modeling services (for clinics without laboratory support).
- Consultation and training.

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Appendix B

Department of Defense Oral Health and Readiness Classification System

DENTAL CLASSIFICATIONS

B-1. The oral health status of uniformed personnel is categorized using dental classes. These dental classes provide a method to easily identify dental conditions which could result in Soldiers becoming dental casualties when deployed.

DENTAL CLASS 1 (ORAL HEALTH)

B-2. Dental Class 1 includes patients with a current dental examination and who do not require dental treatment or reevaluation. Dental Class 1 patients are worldwide deployable.

DENTAL CLASS 2 (ORAL HEALTH)

B-3. Dental Class 2 includes patients with a current dental examination and who require nonurgent dental treatment or reevaluation for oral conditions, which are unlikely to result in dental emergencies within 12 months. Dental Class 2 patients are worldwide deployable. Patients in dental Class 2 may exhibit the following—

- Treatment or follow-up indicated for dental caries or minor defective restorations that can be maintained by the patient.
- Interim restorations or prostheses that can be maintained for a 12-month period. This includes teeth that have been restored with permanent restorative materials for which protective cuspal coverage is indicated.
- Edentulous areas requiring prostheses but not on an immediate basis.
- Periodontium that requires—
  - Oral prophylaxis.
  - Maintenance therapy.
  - Treatment for slight to moderate periodontitis and stable cases of more advanced periodontitis.
  - Removal of supragingival or mild to moderate subgingival calculus.
- Unerupted, partially erupted, or malposed teeth that are without historical, clinical, or x-ray signs or symptoms of pathosis, but which are recommended for prophylactic removal.
- Active orthodontic treatment. The provider should consider placing the patient in passive appliances for deployments up to six months. For longer periods of deployment, the provider should consider removing active appliances and placing the patient in passive retention.
- Temporomandibular disorder in remission. The provider anticipates the patient can perform duties while deployed without ongoing care and any medications or appliances required for maintenance will not interfere with duties.

DENTAL CLASS 3 (ORAL HEALTH)

B-4. Dental Class 3 includes patients who require urgent or emergent dental treatment. Dental Class 3 patients normally are not considered to be worldwide deployable.

- Treatment or follow-up indicated for dental caries, symptomatic tooth fracture, or defective restorations that cannot be maintained by the patient.
- Interim restorations or prostheses that cannot be maintained for a 12-month period.
- Patients requiring treatment for the following periodontal conditions that may result in dental emergencies within the next 12 months.
  - Acute gingivitis or pericoronitis.
  - Active progressive, moderate, or advanced periodontitis.
  - Periodontal abscess.
  - Progressive mucogingival condition.
  - Periodontal manifestations of systemic disease or hormonal disturbances.
  - Heavy subgingival calculus.
- Edentulous areas or teeth requiring immediate prosthodontic treatment for adequate mastication or communication or acceptable esthetics.
- Unerupted, partially erupted, or malposed teeth with historical, clinical, or x-ray signs or symptoms of pathosis that are recommended for removal.
- Chronic oral infections or other pathologic lesions including—
  - Pulpal, periapical, or resorptive pathology requiring treatment.
  - Lesions requiring biopsy or awaiting biopsy report.
  - Emergency situations requiring therapy to relieve pain, treat trauma, treat acute oral infections, or to provide timely follow-up care (for example, drain or suture removal) until resolved.
  - Acute temporomandibular disorders requiring active treatment that may interfere with duties.

DENTAL CLASS 4 (ORAL HEALTH)

B-5. Dental Class 4 includes patients who require periodic dental examinations or patients with unknown dental classifications. Dental Class 4 patients normally are not considered to be worldwide deployable.

Appendix C

Dental Equipment Sets

FIELD DENTAL SETS

C-1. Field dental sets provide the equipment necessary for Dental Corps personnel to deliver and provide forward dental service support in austere environments. The equipment is designed to be portable for easy transport and set up. The equipment is robust and requires very little electrical power to operate.

C-2. Each general and comprehensive dental officer in a field clinical position has the following DES assigned.

- Dental instrument and supply set, emergency care.
- Dental equipment set, comprehensive dentistry.
- Dental equipment set, dental support.
- Dental equipment set, emergency denture repair.
- Dental equipment set, dental x-ray, field.

C-3. The descriptions provided below are intended only to provide a brief description of the set and its intended purpose. For a list of the equipment contained in each of these sets go to the following Web site: http://www.usamma.army.mil/medical_equipment_handbooks.cfm or contact the following:

- United States Army Medical Materiel Agency, Customer Relations Management Office: Telephone: Defense Switched Network 343-4301/4316 or commercial (301) 619-4301/4316. The e-mail address is: USAMMACRM@amedd.army.mil.
- United States Army Medical Materiel Agency, Emergency Operations Center: Telephone: Defense Switched Network 343-4408 or commercial (301) 619-4408. The e-mail address is: USAMMAEOC@amedd.army.mil.

DENTAL INSTRUMENT AND SUPPLY SET, EMERGENCY CARE

C-4. The dental instrument and supply set is a small dental emergency kit that is contained in a hand carried medical aid bag. It contains the instruments and materials required for simple extractions and expedient temporary restorations. Essential in this kit is the battery-operated hand piece, which allows the dental officer to open an infected tooth, prepare a cavity for temporary restoration, or section a tooth for extraction. The dental instrument and supply set, emergency care, is intended for use when the situation does not permit the setup of the dental officer's standard equipment.

DENTAL EQUIPMENT SET, COMPREHENSIVE DENTISTRY

C-5. The DES, comprehensive dentistry is considered the primary dental equipment set for providing operational care. The field dental equipment contained in the DES is compact, rugged, and requires a limited power demand. This set provides the dental armamentarium used in the procedures to diagnosis and treat—

- Caries.
- Defective restorations.
- Occlusal trauma.
- Tooth luxation/evulsion.
- Gingivitis and early/moderate periodontitis.
- Periodontal abscess.
- Oral lesions that are traumatic or inflammatory.

- Routine endodontics.
- Postmortem examination.

C-6. Major items of equipment include one each, portable, field-type: dental chair and stool unit; dental operating and treatment unit; dental light set; and compressor.

DENTAL EQUIPMENT SET, DENTAL SUPPORT

C-7. The DES, dental support, is found in both the area support squad of medical companies, medical companies (dental service), and the dental companies (area support). It contains items which can be shared in a clinical environment and is issued to each forward treatment team. It provides necessary support items that include a curing light, composite resin, electric pulp tester, sterilizer, sink, and laboratory table.

DENTAL EQUIPMENT SET, EMERGENCY DENTURE REPAIR

C-8. The DES, emergency denture repair, provides basic materials for expedient denture repairs.

DENTAL EQUIPMENT SET, DENTAL X-RAY, FIELD

C-9. The DES, dental x-ray, field, provides a standard dental x-ray capability for the dental team.

DENTAL EQUIPMENT SET, MAINTAINING CARE

C-10. The DES, maintaining care, is only found in a medical company (dental services) or a dental company (area support). It contains a portable, light-weight fiber optic curing light system; ultrasonic endodontic equipment; and refrigerators critical to the comprehensive dental set.

SPECIALTY DENTAL SETS

C-11. General and comprehensive dental officers and dental specialists assigned to field clinical positions may have the following DES and specialty dental sets at their disposal.

- Dental equipment set, prosthodontic.
- Dental equipment sets, endodontic and periodontic.
- Oral and maxillofacial surgery set.
- Dental hygiene, field, DES.

DENTAL EQUIPMENT SET, PROSTHODONTIC

C-12. This set provides clinical and laboratory items necessary to support fixed and removable prosthodontic procedures. The prosthodontic DES must be used in conjunction with the DES, dental support.

DENTAL EQUIPMENT SETS, ENDODONTIC AND PERIODONTIC

C-13. These sets have recently been added to support the new endodontist and periodontist positions in the dental company (area support) now replacing the older, smaller dental companies. These sets are also used in conjunction with the DES, dental support.

ORAL AND MAXILLOFACIAL SURGERY SET

C-14. This set is also a new addition intended to support the oral and maxillofacial surgeon in the combat support hospital. This set contains modern bone drill and plating systems.

DENTAL HYGIENE, FIELD, DENTAL EQUIPMENT SET

C-15. This set includes those instruments and materials necessary for providing preventive dentistry services by the preventive dentistry specialist/sergeant.

Appendix D

Quality Assurance Plans

QUALITY ASSURANCE PLANS

D-1. Quality assurance plans provide a system of checks and balances that enable dental commanders and their staffs to objectively assess the quality of care being provided and the efficiency of the dental units. The objectives of the plan are to—

- Provide dental care consistent with the capabilities of the DTF and staff qualifications.
- Reduce risk-creating incidents for the patients treated.
- Improve provider-patient communication and patient satisfaction.
- Evaluate practitioner performance.

QUALITY ASSURANCE IN THE THEATER

D-2. The dental unit commander is responsible for the management of the unit's quality assurance plan. Policy and guidance on quality assurance matters comes through the technical/staff dental surgeon channels. As with other matters for which policy is stated in references directed at peacetime care and organizations, quality assurance policy in AR 40-68 must be modified to fit the tactical situation. In any case, the spirit of quality assurance must be addressed. The Soldier in the theater should have access to the highest possible quality of dental care, consistent with the tactical scenario, as he would receive in a garrison dental facility. Establishment of a sound quality assurance plan by dental commanders and staff dental surgeons at all levels helps to ensure the individual Soldier's accessibility.

PATIENT CARE EVALUATION

D-3. Patient care evaluations provide a tool to evaluate the quality and appropriateness of dental care being provided. These evaluations also provide a means to ensure that dental treatment records are established and maintained in accordance with regulatory guidance and established policies. Periodic audits also aid dental commanders and their staff in evaluating distribution of care and compliance with theater treatment policies regarding the type of care to be provided. Dental radiology, infection control, and barrier protection are areas of special command interest in field environments.

UTILIZATION MANAGEMENT

D-4. Access to and the effective utilization of dental services in theater is METT-TC driven. The goal of utilization management is to provide the highest quality dental care possible in the most efficient manner.

D-5. Utilization management is part of performance improvement data collected for the purpose of organizational improvement. For more information on this subject, see AR 40-68. Specific areas of interest include but are not limited to:

- Time management in patient care.
- Patient waiting time.
- Number of patients treated per unit of practitioner's time.
- Equipment and facility management.
- Logistics management.

D-6. Emergency and preventive care should be provided as close to supported troop populations as possible. The result is faster return to duty of Soldiers and fewer dental emergency evacuations. Preventive and operational dental care are provided at the convenience (location and time) of supported units.

RISK MANAGEMENT

D-7. The risk management program is concerned with the prevention of accident and injuries. For dental support in the theater, it encompasses the reduction of risk to patients, visitors, and unit personnel. For more information concerning risk management, see FM 5-19.

DENTAL RADIOLOGY

D-8. Quality assurance measures regarding dental radiology procedures include training personnel who operate dental x-ray equipment to recognize the risks associated with the use of this equipment. This training should include risk management and risk avoidance techniques which must be implemented. The following represent some of the techniques:

- X-ray equipment is set up and operated in accordance with the manufacturer's operational guidelines.
- Patient shielding and protection measures are implemented.
- Techniques of substituting distance for protective shielding during x-ray operations are used.
- Exclusion areas are clear of all personnel prior to putting x-ray equipment into operation.
- Dental personnel operating x-ray equipment are issued dosimeters and the dosimeters are handled and processed correctly.
- All x-ray information is entered in the patient's records.

Appendix E

Sample Clinical Standing Operating Procedure

E-1. The CSOP addresses only those issues relating to clinical policies, procedures, and operations. Procedures selected for inclusion in the CSOP are those which meet the unit's clinical mission. Paragraphs E-2 through E-7 of this appendix provide an outline and format.

PUBLICATION FORMAT

E-2. The most often used format for the CSOP is a loose-leaf binder arrangement. Clinical policies and procedures are subject to frequent change and a loose-leaf arrangement can be easily updated. It is also relatively inexpensive and easily produced in multiple copies at the unit level.

ORGANIZATION

E-3. Annexes with supporting appendixes and tabs are easy to change and update; therefore, maximum use of annexes in a CSOP is advisable. The CSOP should be organized as follows:

- Directive.
- Table of contents.
- Record of changes and corrections.
- Annexes, appendixes, and tabs.

DIRECTIVE

E-4. The commander's directive should be the first page of the CSOP. This directive is a letter order signed by the commander that directs implementation of the CSOP. The directive should be on unit letterhead and in memorandum format.

RECORD OF CHANGES AND CORRECTIONS

E-5. Since information in the CSOP is subject to frequent change, include a page in the front of the binder to record changes and corrections. This allows the user and the DTF officer in charge to easily audit that particular copy of the CSOP. A single page formatted as shown in Figure E-1 will serve this purpose.

RECORD OF CHANGES AND CORRECTIONS

Dental treatment facilities designation or unit designation CSOP

NUMBER	DESCRIPTION	AUTHORITY	DATE	ENTERED BY
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Figure E-1. Format for changes and corrections

ANNEXES

E-6. Information in the CSOP is incorporated into annexes dealing with general areas. Annexes are supported by appendixes and tabs that deal with more specific issues. Information in annexes and supporting appendixes and tabs should not be redundant, nor voluminous. However, there should be sufficient detail to ensure proper performance of the task addressed or compliance with the policy prescribed. As with the TSOP, annexes to the CSOP are directive and address *who, what, where, when,* and *how.* Annexes are attached in alphabetical order after the body of the table of contents, with appendixes (numerical) and tabs (alphabetical) following their supported annexes. Annexes are generally formatted in the same manner prescribed for the TSOP (see paragraph E-7); however, as a matter of expediency and economy, some material may be incorporated as an appendix or tab in its original form simply by adding a tab or appendix designator. Some examples of this method are manufacturer's instruction manuals, military technical manuals, or written policy directives from higher headquarters.

CONTENT

E-7. The information contained in annexes is variable and will depend on the type of unit and, of course, guidance and policy from the unit commander and his higher headquarters. The following is an outline of annexes, appendixes, and tabs recommended for inclusion in a generic CSOP.

E-8. Annex A—Organization. A general statement of the mission and organization of the unit.

- Appendix 1—Dental treatment facility layout. Line diagram of the suggested DTF layout.
  - Tab A—Vehicle load plans. Load plans for the DTF personnel and equipment.
- Appendix 2—Personnel. Organization of personnel assigned to the DTF and delineation of duties.
  - Tab A—Duty description. Detailed description of individual and special duties as necessary.

E-9. Annex B—Equipment. Listing of equipment assigned to the DTF.

- Appendix 1—Operation and maintenance. Statement of DTF policy for equipment operation and operator maintenance.
  - Tab A—Individual major items. Manufacturer's operator manual or service technical manual, if available, for each major item of equipment, to include vehicles and generators.
- Appendix 2—Maintenance support procedures. Prescribe procedure for obtaining maintenance support.

E-10. Annex C—Supply.

- Appendix 1—Class VIII medical supply. Statement of procedure for ordering, receiving, storing, and issuing Class VIII medical supplies.
- Appendix 2—Property control. Hand receipt procedure for maintaining accountability of the DTF's TOE and common tables of allowance property.
- Appendix 3—Precious metals control. Procedure for control of precious metals and finished fixed prosthodontic cases, if appropriate.
- Appendix 4—Medication control measures. Procedure for prescribing, issuing, storing, and disposing of schedule substances.

E-11. Annex D—Patient care operations.

- Appendix 1—Patient treatment policy. Statement of treatment policy to include priority of care, if appropriate.
  - Tab A—Policy letters from higher headquarters.
  - Tab B—Eligibility for care matrix.
- Appendix 2—Patient flow. Prescribe patient flow.
  - Tab A—Detainee dental operations. Provide information on security procedures.
- Appendix 3—Patient records. Prescribe procedure for preparation and maintenance of patient records.
- Appendix 4—Workload reporting. Prescribe procedure for workload data accountability and reporting.
- Appendix 5—Preventive dentistry. Describe and define responsibilities for the DTF's preventive dentistry program.
- Appendix 6—Referrals. Prescribe procedure for referral and evacuation of patients for treatment available at other DTFs.
- Appendix 7—Nutritional supplements. Provide guidance on providing patients undergoing lengthy treatment nutritional supplements prior to undergoing a dental procedure. (Refer to paragraph 1-59.)

E-12. Annex E—Immediate response situations.

- Appendix 1—Mass casualty scenarios.
- Appendix 2—Reaction to enemy action. Prescribe the DTF's response in the event of enemy action, to include handling of patients within the DTF.
  - Tab A—CBRN response.
  - Tab B—Ground attack.
  - Tab C—Air attack.
- Appendix 3—Mass casualty response. Prescribe the DTFs responsibilities in the event of mass casualties (alternate wartime role).

E-13. Annex F—Infection control. Statement of required infection control procedures.

- Appendix 1—Personal and patient protection. Prescribe procedure for protection of health care provider and patient.
- Appendix 2—Sterilization of instruments.
- Appendix 3—Disposal of medical waste.

E-14. Annex G—Relocation. Procedures for emplacement and displacement of the DTF.

- Appendix 1—Dental treatment facility setup.
- Appendix 2—Dental treatment facility takedown.
- Appendix 3—Provision of dental treatment during relocation. Prescribe procedure for provision of emergency dental treatment during relocation.

E-15. Annex H—Safety. Statement of safety policies and procedures.

- Appendix 1—X-ray operations.
- Appendix 2—Fire safety.
- Appendix 3—Hearing conservation.
- Appendix 4—Hazardous material handling.

E-16. Annex I—Physical security. Statement of physical security plan for the DTF.

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Glossary

ACRONYMS AND ABBREVIATIONS

AMEDD	Army Medical Department
AOC	area of concentration
AR	Army regulation
ASCC	Army Service component command
attn	attention
BCT	brigade combat team
CBRN	chemical, biological, radiological, and nuclear
CONUS	continental United States
CSOP	clinical standing operating procedure
DA	Department of the Army
DA Pam	Department of the Army pamphlet
DENCOM	Dental Command
DES	dental equipment set
DOD	Department of Defense
DTF	dental treatment facility
FM	field manual
G-9	Assistant Chief of Staff (Civil Affairs)
MEDBDE	medical brigade
MEDCOM (DS)	medical command (deployment support)
METT-TC	mission, enemy, terrain and weather, troops and support available, time available, civil considerations
MOS	military occupational specialty
MTF	medical treatment facility
NATO	North Atlantic Treaty Organization
NCO	noncommissioned officer
SF	standard form
SOP	standing operating procedure
STANAG	Standardization Agreement
TOE	table of organization and equipment
TSOP	tactical standing operating procedure
U.S.	United States
USAMEDDC&S	United States Army Medical Department Center and School

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DOCUMENTS NEEDED

Unless otherwise indicated, Standard Forms (SF) and Optional Forms (OF) are available on the GSA website (www.gsa.gov).

Standard Form 603, *Health Record—Dental*

Standard Form 603A, *Medical Record—Dental–Continuation*

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References are to paragraph numbers unless otherwise stated.

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31 July 2009

By Order of the Secretary of the Army:

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Official:

JOYCE E. MORROW
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