



From the Top

When I was recently reminded of the upcoming suspense for my “final” article in the Outlook, it served as a reality check regarding my forthcoming retirement. Pondering what my final words should be for our Army Medical Department (AMEDD) enlisted training newsletter, I thought about one of our greatest challenges in the training process – communication.

It continues to amaze me that despite our many technological advances, we continue to experience some of the same issues regarding dissemination of information about training opportunities, initiatives, and requirements as we did when I joined almost 31 years ago.

In March of this year, more than 1,800 medics failed to recertify in order to maintain their NREMT-B. Many reasons have been cited for this, to include the current OPTEMPO and Soldiers failing to meet the requirements for recertification. However, a large number were either unaware of the need to recertify, the requirements to recertify, and/or the consequences of not recertifying. Some were deployed and neither they, nor their chain of command, submitted waivers for extensions, since many were unaware of this option. Many were relying on their chain of command to “do the paperwork” and the commands were relying on the Soldier to take individual responsibility for this. Regardless, important information was not disseminated or conveyed to the Soldiers who needed it, which will result in additional training requirements in the AMEDD.

Earlier this year, the first Expert Field Medical Badge

(EFMB) tests were conducted under the revised guidelines. Under the new policy, the references for the written test and test procedures were changed. This information was put out through various avenues, but still some candidates arrived at the EFMB test sites, and leaders conducted train-ups, unaware of the changes that had been made. This contributed to lower than usual EFMB success rates. It is frustrating to Soldiers and their leaders to find out this type of information after the fact.



Sandra K. Townsend
CSM, USAMEDCOM

I encourage each of you to take on the challenge of working to improve the dissemination of information to Soldiers regarding training opportunities and requirements that affect their career and MOS development, as well as the Army and AMEDD’s training plan. We must also teach our Soldiers to be proactive and take the initiative to meet their training requirements. Leaders must maintain awareness of changing requirements and their Soldiers’ status. The future of the AMEDD depends on it.

As I close out my time on active duty, I want to personally thank each of you for your dedicated service to the country, the Army, and the AMEDD. I will change responsibility as MEDCOM CSM with CSM David Eddy on 27 August. Your support has been greatly appreciated and I wish each of you the best in your future endeavors.

New 8-page OUTLOOK begins with this issue

This issue of the Medical Soldiers OUTLOOK brings a new expanded format. A four-page publication distributed worldwide to Active and Reserve Component enlisted personnel since 1984, this Fall 2004 issue is the first of an eight-page format that will incorporate Lessons Learned issues. We will also continue to focus on training opportunities, doctrine revisions, and MOS changes and updates.

New procedures for requesting MOS reclassification or ASI training

Effective immediately, retention personnel assume a greater role in the processing of voluntary, mandatory, and medical reclassification. For voluntary reclassification actions, the following steps **must** be taken:

- (1) Soldier submits request for reclassification on DA Form 4187 through PAC.
- (2) PAC reviews latest Reenlistment/Reclassification In/Out calls for initial qualifications screening and eligibility to reclassify based on current PMOS strength and requested MOS strength. A request for reclassification will not be submitted if Soldier does not meet In/Out criteria to reclassify.
- (3) If Soldier meets the criteria to submit a voluntary reclassification, PAC will submit reclassification packet consisting of a copy of the In/Out calls (only the pages pertinent to Soldiers PMOS and requested MOS) used for initial pre-qualification of Soldiers requested action, DA Form 4187, and Soldier's ERB to the 1SG/Company Commander for review and recommendation.
- (4) If the Company Commander disapproves the request, the packet goes back to PAC for notification. If the Company Commander recommends approval of the action, he or she will forward packet to the S-1.
- (5) If Soldier has an unfavorable action, the packet will be returned without action. If otherwise qualified, the S-1 will then forward the complete packet, to include a memorandum stating Soldier has no unfavorable personnel actions pending, to the servicing Career Counselor.
- (6) The servicing Career Counselor checks packet for eligibility of requested PMOS and approves/disapproves the request based on eligibility. If it is determined the Soldier meets the eligibility requirements for requested PMOS, Soldier's request is processed in the Reenlistment/Reclassification System (RETAIN) through the Regional Career Counselor for submission to the HRC reclassification actions branch for approval/disapproval.
- (7) Once the approval/disapproval decision report is loaded into RETAIN by HRC, the servicing Career Counselor can review/retrieve the information pertaining to the requested action. It is imperative that the servicing Career Counselor continuously monitor the status of cases pending.
- (8) Medical reclassification actions are still processed through personnel channels. Retention processes reclassification actions upon receipt of MMRB IAW steps 6 and 7 above. The servicing Career Counselor must also fax a copy of the profile and MMRB results to the reclassification actions branch at DSN 221-9543 or (210) 221-9543.
- (9) Mandatory reclassification actions are still processed through personnel work centers to determine Soldier's retainability. Soldier's chain of command must initiate a chapter action IAW MILPER MSG 03-082 when a Soldier loses his or her security clearance through his or her own fault. Retention personnel will process the reclassification action upon receipt of memorandum stating Soldier will be "retained on active duty." Memorandums stating, "recommend retention" will not be processed. The servicing Career Counselor will process reclassification action IAW steps 6 and 7 above. The servicing Career Counselor must also fax a copy of board memorandum to reclassification actions branch at DSN 221-9543 or (210) 221-9543.

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LESSONS LEARNED

After Action Reports

The information contained in the following After Action Reports includes the views and opinions of the authors and does not necessarily reflect those of the AMEDDC&S or the Army Medical Department.

3d Armored Cavalry Regiment

1. **BACKGROUND:** This document is the 3d or 4th version of a medical AAR that I have completed for various requirements, having served in OIF with both the ACR and the 21st CSH. To understand this AAR, one must take a look at the unique organization of a cavalry regiment and its medical assets. The 3d ACR consists of 3 armored ground cavalry squadrons with around 1,000 troopers each. Also, an organic air cavalry squadron of around 800 troopers that fly or support AH-64, OH-58D, and UH-60 aircraft. A support squadron that is primarily wheeled has nearly 1,200 troops. Also, a separate MI, ADA, engineer, chemical and regimental headquarters troop/companies round out over 5,200 personnel.

a. *Organic medical:*

- i. Ground squadrons with one PA, 36 medics, use tracked vehicles. Each with one PROFIS doc.
- ii. Air squadron with flight surgeon, a PA, and 6 medics.
- iii. Medical Troop in SPT SQD. Similar to a FSB Charlie Med. Two PA's, one dentist, lab tech, x-ray tech, RN, an ambulance platoon, treatment platoon, and Regimental Medical supply. It has 6 tracked and 6 wheeled ambulances. PROFIS includes one PA and 3 docs.
- iv. Regimental Surgeon office consists of one doc. No PA, NCO, medic or MS corps officer.

b. *Attached/OPCON during OIF:*

- i. 2 Forward Surgical Teams-one with medical troop and the other in a remote area.
- ii. 1 PM detachment.
- iii. 1 wheeled ambulance platoon.
- iv. 1 Combat Stress Team.
- v. Habitual Air Ambulance Company (-).

c. During OIF1, the regiment also had attached an engineer battalion, artillery battalion, signal battalion, infantry battalion and numerous smaller units swelling to around 8,800 personnel. The regiment had responsibility for the largest AO in Iraq making communication and logistics a challenge. It is the reason that a second FST was obtained and placed in a remote area. The regimental headquarters and medical troop was an hour flight from one CSH and 1½ hours from a second CSH while the regiment extended up to another 2 hours flight time away. Ground travel was often dangerous and a significantly greater time distance away.

2. **ISSUE** (holding care at Level 1 and 2): The great distance and travel problems created many challenges, one of which was patient hold in non doctrinal locations (aid stations). **RECOMMENDATION:** Our approach is to create greater resources such as Propaq at the squadron level. Also, increase the training level to include ward rotations as a part of MPT programs for medics.

3. **ISSUE** (Evacuation): The distance also caused evacuation problems and over-use of air. Routine movement to the CSH was a great challenge and we often used LOGPAX convoys to move people. The addition of a FLA platoon allowed us to forward deploy wheeled assets at our multitude of FOBs. However, air assets continued to be relied upon heavily. One tragic episode includes the loss of an air ambulance, its crew and patients. **RECOMMENDATION:** If in a similar situation, we would continue to require additional ground support. Need to create SOP to allow the rapid formation of a ground security convoy rather than thrown together at time of evacuation.

OUTSTANDING: Need to reduce theater wide reliance on air travel. Safer ground travel. Need to change physician/physician assistant attitude on standards of medical care (i.e. high number of evacuations both to the CSH and out of theater for “convenient” care, chronic care, and “would get this test at home.”)

4. **ISSUE** (MEDEVAC Communications): While there was a standard FM frequency, there was both a security concern and severe range limitation of around 30 km. Units were frequently operating in large areas of operations and remote areas. These items bred a situation where command frequencies, phones (various), and other means were used to call for MEDEVAC. LOGPAX convoys were frequently out of communications range. **RECOMMENDATIONS:** Theater communications issue presented a need for a better-standardized, more useable MEDEVAC frequency. MTS system use standardized for long-range logistic convoys. The capabilities of an “enhanced 911 system” should be developed. Software upgrades that sent MEDEVAC request directly to centralized monitoring system at the theatre medical brigade who could, in turn, contact the nearest evacuation assets. As it stands now, MTS used in many convoys have communication monitoring only by their unit base station.

5. **ISSUE** (Point-of-Injury Care): Battlefield care is not properly taught to medics, combat lifesavers, and buddy aid. Medics are trained as civilian EMT and many (most) medics do little patient care in the garrison setting. **RECOMMENDATIONS:** 91W transition should continue as currently planned. Sustainment should include maintenance of EMT-B or above (NCO should eventually become EMT-I). More emphasis on Medical Proficiency Training. Drop SACMS-VT and develop a course on tactical medical care focused on what combat Soldiers frequently die from (airway, breathing, circulation). Re-tool CLS at the DA level. De-emphasize IV and NBC care and focus on tactical medical care. Secondary MOS identifier that encourages career long CLS with the option for more advanced training. First aid/buddy aid modified to reflect care of preventable battlefield deaths.

6. **ISSUE** (Combat Medical Badge): The regulation is vague and the interpretations vary widely. When the dust settles, there will be a number of medical personnel who deserved the badge and were never awarded it and yet another group who received it and never deserved it. I actually had air ambulance personnel verbose that the regulation states, “The sole (emphasis on sole) criteria for the badge is to be assigned to a particular type of unit.” The rumors of who got and who didn’t are abounding. . . a direct result of a poor regulation. Regulation needs to be re-written in a clear manner. When/if done so, realize that a cavalry regiment is not a brigade nor division. How should a regiment be treated?

7. **ISSUE** (Physician Assistant training): PAs need more trauma training. One solution is to make C4 mandatory as they come out of training prior to their first assignment. ATLS is excellent training for a PA.

8. **ISSUE** (Civil Military Affairs): There was an absence of nongovernmental organizations in Iraq during OIF. CA teams were overwhelmed and either voluntarily or command directed, medical section became responsible for CMO. For actions that we were equipped to handle (MEDCAPS), we weren’t allowed to do. We were supposed to manage infrastructure rebuilding of clinics, hospitals, etc. . . this is a full-time job and medical personnel aren’t trained and can’t support the force and be out doing full-time CMO. I don’t have a solution, however, medical personnel need to be consultants in CMO and not primary directors.

9. **ISSUE** (DNBI and other medical reports): While the medical channels insisted on these reports being done, and they may have some use, units moving around have a very difficult time completing and forwarding them. No command emphasis equals noncompliance and the medical sections did not have the connectivity (SIPR) to comply if they wanted them. That is fine because the medical brigade/corps surgeon’s office never gave feedback on the information. No injury or disease patterns. No support (a functional medical brigade would note disease patterns and investigate, support, or recommend).

10. **ISSUE** (Medical Enablers command and control): We had several medical teams operating in our AO; however, they were never OPCON, ADCON, or attached. It created the greatest difficulty for some of these units during re-deployment; some essentially forgotten by the parent unit. Technically, the regiment was not obligated to support them but the parent unit should have sent daily logpax to support them. A clear delineation for whom these sections work. A simple order to opcon a team for a certain period would clarify.

11. **ISSUE** (91W Sustainment): As I joined the regiment already deployed, it was poorly set up for any 91W sustainment. The ACR had planned for a short deployment, setting those who had yet to transition in a further hole. **RECOMMENDATION:** Maximize medical training in garrison. Commanders must realize this is an issue. All units, brigade size and larger, need to develop their own

EMT refresher, SACMS-VT, and BCLS programs. The theater is going to need a mobile EMT school with shortened programs of EMT-B, BTLS, and Trauma-AIMS. It is a harsh fact of the transition process and the multiple deployments.

12. **ISSUE (PROFIS):** Many don't want to be there. None want to deploy and do nothing. Their skills are at risk. Some PROFIS left Iraq for legitimate reasons (PCS, ETS, retire, fellowship training); others skated out permanently for temporary issues such as board exams. Some argue that continuity is needed, keeping the same PROFIS for training and duration of the deployments. For some positions that might be true, but in general, the units don't listen to the PROFIS anyway. It happened in the ACR and it happened when I was with the CSH. **RECOMMENDATION:** Establish a rotation program. PROFIS need to rotate at 180 days. Some specialties may need to rotate to/from the CSH. Year-plus rotations of physicians into positions in which they do little will cause more physicians to leave the service. Allow docs to leave, take boards and CME, and return.

13. **ISSUE (Casualty tracking):** The system is less than adequate. Personnel sections don't do it; if they do, they use TRAC2ES, which is not reliable. It thus falls on the medical sections. While we should be able to update commanders on conditions of the Soldier, tracking them isn't our responsibility nor is it cost-efficient to have a doc doing so. The one method I saw that worked is the 82d SSB put LNO(s) at the CSH, LRMC, and WRMC. While this is manpower intensive, it not only allowed for accurate tracking of Soldiers, it RTD Soldiers who otherwise would have skated to CONUS, and it also helped to support injured Soldiers and their needs. The LNO helped with personal issues and were appropriate getting family members orders to visit.

14. **ISSUE (Low threshold to evacuate):** It happened on all levels: Echelon I/II level docs would send people to the CSH b/c they wanted a MRI or to see a specialist. The CSH would send airevac Soldiers with chronic problems to LRMC b/c they couldn't hold them or thought they needed con-leave. LRMC would send them on to CONUS. One of the sources of the problem was no Echelon IV – no field hospital that rehab or con-leave could occur. **RECOMMENDATION:** Having unit LNO can help alleviate this problem. They could coordinate with the MTF and unit on whether a Soldier could con-leave in theatre s/p a minor procedure. Providers need to be educated on changing their way of thinking while deployed. MTFs need to change their policies. Kuwaiti Armed Forces Hospital for rehabilitation?

15. **ISSUE (Disease patterns and what you need to think about for Class VIII):** I knew that we'd see a lot of gastroenteritis and respiratory infections, but the large number of new renal stones, and new allergy or asthma-like problems surprised me. **RECOMMENDATION:** Outfit Echelon I and II to manage or increase assets for these diseases. Also, get your medics/PAs training in physical therapy to manage the back pain and sports-like injuries.

16. **ISSUE (Class VIII):** While I am sure that the Class VIII situation has and will continue to improve, chronic medications are a difficult issue. Deployment orders state to deploy with 180 day supply of medications. Home duty station MTF are very reluctant to support this action, mainly due to budget concerns. Once deployed, it is a tedious and time consuming process to get medications, and many have to come from a CSH or out of theatre. **RECOMMENDATION:** Support by home station MTF and the financial support for the MTF to follow the medicine deployment guidelines. A standard formulary of medications available in theatre that units have access to well in advance will allow the medical officer to adjust medications prior to deployment rather than during the deployment.

(Robert Westermeyer, MAJ, Regimental Surgeon, 29 Jul 04)

187th Infantry Regiment, 101st Airborne Division

1. The following items are issues that were addressed during the pre-deployment phase of Operation Enduring Freedom – Kuwait (when 101 ABN DIV was issued deployment order in FEB 2003).

2. Issue: PROFIS Assignments through DMOC

The PROFIS assignments were handled through the Division Medical Operations Center (DMOC). However, these assignments changed almost DAILY, and there seemed to be very little continuity in the DMOC on who was handling the assignments process. For example, the person coordinating PROFIS assignments in the DMOC changed 2-3 times in a matter of days. The final PROFIS POC

in the DMOC had little medical knowledge base of provider capability to make sound decisions on what kind of provider should be assigned (i.e. having a research-based aero-medical residency graduate who hadn't practiced primary care in over 7 years assigned to an FSB PROFIS position).

Recommendation: Brigade CHS Planners must be pro-active and contact daily (at least once to twice a day) the DMOC to get roll-up of who the PROFIS providers are. Furthermore, at the DMOC, a medical provider (i.e. surgeon or PA) should be directing the specific provider specialty requests for the division, and not someone who has no knowledge of medical specialties or competency. Finally, PROFIS providers should be no higher rank than Major, as rank tended to be an issue for the FSMC Commander (who is a CPT) who often had to "command" these not so willing assets.

3. Issue: CHSSO Integration

The Combat Health Service Support Officer assigned to the FSB can be invaluable in planning for pre-deployment (refer to pre-deployment planning in the Continuity Book). He can assist or take the initiative in any of the issues regarding pre-deployment medical planning. Currently, Force XXI transition has not occurred in the Division (i.e. a Brigade Surgeon Planning cell at Brigade consisting of Med Ops and Patient Holding planning cells).

Recommendation: Consolidating assets between the Brigade Surgeon and CHSSO during this phase can help compensate and pool resources until Force XXI transition takes place in the division.

4. Issue: MEB/ MMRB identification

When the deployment order was issued, BN providers were being "hit hard" from BN chain of command on profiles requiring either type of disqualification (i.e. MEB) or re-class (i.e. MMRB). These Soldiers should have been identified much earlier (i.e. prior to any deployment order) and this caused quite an administrative backlog for the BN and BDE providers as these Soldiers needed to be processed ASAP.

Recommendation: Should have BN providers identify boardable Soldiers ASAP to get the administrative process initiated.

5. Issue: Medical Portion of SRP (i.e. immunizations, HIV, G-6-PD Testing)

The above process is a continuing source of frustration as this seems to be done at large only once or twice a year. If done on a more frequent basis, the massive "cattle call" for the above would not need to occur. Organic infantry BNs actually do this process relatively well; however, FSB and Slice Elements are somewhat concerned. In addition, medical supplies for these SRPs need to be ordered ASAP through the LaPointe Health Clinic (i.e. in this case, the NCOIC is the POC).

Recommendation: The Medical "SRP" process should be initiated as soon as the Soldier in-processes to the unit. Furthermore, if possible, SRP should be done at BN level by Birth Month to capture as many Soldiers as possible more frequently.

6. Issue: Ordering of R&Q/Controlled Substances and other medications

Once the alert/deployment order is issued, the above items may become scarce as division requirements increase and supply cannot meet demand. Furthermore, if ordering these items too late, then they may not be able to be used while en-route and may eventually be sent weeks later when in-theater.

Recommendation: The R&Q/Controlled Substance requests need to be ordered through the DMSO ASAP once the deployment order has been issued.

7. Point of contact is the undersigned at (270) 956-0301.

(Don J. Sarmiento, CPT(P), Brigade Surgeon, 2 Mar 03)

FBCB2 Training

Force XXI Battle Command Brigade and Below (FBCB2) is an element of the Army Battle Command System. It is a digital battle command information system that provides on-the-move, real time, and near real time command and control tactical combat. This is the system that Soldiers are using in Kuwait, Afghanistan, and Iraq. The next two classes, open to all AMEDD Soldiers, will be held 18-21 Oct 04 and 8-10 Nov 04 at Fort Sam Houston's AMEDDC&S. If interested, **contact:** Mr. Danzy, DSN 471-4361, (210) 221-4361, e-mail marvin.danzy@amedd.army.mil, or visit the FBCB2 website at <http://fbcd2.monmouth.army.mil>.

91E ASI N5/X2 Training Available

Training seats are available through the Department of Dental Science, AMEDD Center and School for training as a Dental Laboratory Specialist (ASI N5) and Preventive Dentistry Specialist (ASI X2). The N5 course is trained at Sheppard AFB, TX, and X2 training is held at Fort Sam Houston, TX.

For more information or questions, contact the Department of Dental Science, DSN 471-8055 or (210) 221-8055.

New Website now available

You may now access the much improved website for the Army e-Learning program. The new address is <http://usarmy.skillport.com>.

If you were registered in the MySmartForce system, your ID and password are already in the new system. If you were not registered in the MySmartForce system, follow the link to "register" found on the new site.

The new site contains all new courseware – especially the courseware for Windows 2003 Server, the .NET development environment, and Microsoft Office 2003. Also, notice the new Catalog grouping of "Certification View" that will be of special interest to those desiring mentoring and quickly getting at all of the content related to a specific certification series or certification exam.

Several new customized curricula are also included in the new Catalog grouping of Army Customized Curricula.

If you have been using SkillSoft Playable CDs created in 2004, you may now log into the new system (provided you are registered) and your completions will be uploaded into the database. E-mail juliegueller@us.army.mil or call DSN 471-4359 or (210) 221-4359 for more information.

2004 Expert Field Medical

Badge (EFMB) Program

The CONUS and OCONUS test dates have been announced and can be found on the EFMB Test Control Office (TCO) website at www.cs.amedd.army.mil/dts/efmbhome.htm or call DSN 421-9567/9453/9051 or (210) 295-9567/9453/9051.

The schedule is not inclusive of all EFMB tests conducted annually, but only those the EMB TCO has received as official notification and approved.

Training Record available

Students can now access their Army training record through Army Knowledge Online (AKO). The record includes SkillPort courses that have been completed. Go to AKO: <https://www.us.army.mil> and click on either "My Education" or "My Training." Scroll down to the ATRRS block and click on "Go to ATRRS On-Line."

Useful Links

- For assistance with AKO, access the website FAQs/Help at www.us.army.mil or call 1-877-256-8737 (DSN 654-3791).

- For assistance with any difficulty in ATRRS, logon to www.atrrs.army.mil/help or call 703-695-2060 (DSN 225-2060).

- For assistance with the Army e-Learning program or contract management, contact the Army COR at [cibtcor@secbmail.belvoir.army.mil](mailto:cbtcor@secbmail.belvoir.army.mil) (703-806-3671 or DSN 656-3671).



New Reserve Advisor Points of Contact

The AMEDDC&S has had a “changing of the guard” in the USAR Reserve Advisor’s office:

MAJ Bradley T. Richardson (replacing LTC Joy Ream) – Senior Reserve Advisor – (210) 221-6342, toll free 1-800-531-1114, ext 1-6342, or e-mail bradley.richardson@amedd.army.mil.

SGM Eugene Huckaby (replacing SGM Alan Caudell) – Senior Enlisted Reserve Advisor- (210) 221-6271, toll free 1-800-531-1114, ext 1-6271, or e-mail eugene.huckaby@amedd.army.mil.

MSG Jose Torres – Fort Sam Houston USAR Liaison NCO – DSN 471-4864, (210) 221-4864, FAX (210) 221-4866, or e-mail jose.torres@cen.amedd.army.mil. Mailing address is: USAR Liaison, MSG Jose A. Torres, 3061 Garden Ave, Bldg 1290, Fort Sam Houston, TX 78234. The RC Liaison NCO is the central POC for NGB, OCAR, State/Territory AGs, USAREC MUSARC, and the ARNG/USAR Soldier’s parent unit on matters pertaining to ARNG/USAR Soldiers on IADT/ADT. As the central POC, the USAR Liaison NCO provides feedback information on these areas to recruiting and training managers, as well as the Soldier’s unit.

MSG Michelle Betz – AMEDD Personnel Proponent RC Representative – (210) 221-9929, FAX (210) 221-9927, or e-mail michelle.betz@cen.amedd.army.mil. Mailing address is: AMEDDC&S, ATTN MCCS-DE (MSG Betz), 1400 E. Grayson St, Fort Sam Houston, TX 78234-5052. MSG Betz is the Reserve Component POC for requests for waivers of course prerequisites.

AMEDD Correspondence Course Program Update

Enrollment – All Soldiers who wish to enroll in self-development courses or subcourses of the AMEDD Correspondence Course Program **must** submit an application over the Internet. The website is <https://atrrs.army.mil>.

Web-based Instruction – AMEDD subcourses continue to be added to the General Dennis J. Reimer Training and Doctrine Digital Library. The subcourses below were added recently. Visit the website at <http://atiam.train.army.mil> to view the complete list. To receive credit hours, students must enroll through the Army Training Requirements and Resources System (ATRRS) as mentioned above.

MD0033 – Tort Law, The Federal Tort Claims, and the Geneva Convention

MD0171 – Arthropod Control

MD0705 – Inspection Documents

MD0802 – Pharmaceutical Calculations

MD0837 – Laboratory Mathematics

MD0902 – Basic Electricity

MD0916 – Nursing Care Related to the Musculoskeletal System

New Courses – the following courses have been added to the ATRRS catalog this past year and will be found in the updated FY 05 DA PAM 350-59, Army Correspondence Course Program:

081-18DSCOM – Special Operations Combat Medic Prep Course

6H-F20(DL) – Fundamentals of Occupational Medicine

6H-F9/322-F9 – Sexually Transmitted Disease Intervention (DL)

For more information, **contact:** Nonresident Instruction Section, DSN 471-5877, (210) 221-5877 or toll free 1-800-344-2380.