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Training

MEDCOM TRAINING AND LEADER DEVELOPMENT

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*This regulation supersedes MEDCOM Regulation 350-4, 12 February 1998.

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Chapter 1 Introduction

1-1. History. This publication is a major revision. The portions unaffected by this major revision are not listed in a summary of change sheet.

1-2. Purpose

a. This regulation prescribes policy, procedures, and responsibilities for developing, managing, and conducting Army training, and leader development within the Office of The Surgeon General (OTSG) and the U.S. Army Medical Command (MEDCOM).

b. This regulation is applicable to all MEDCOM units, installations, activities, and reserve component (RC) units attached for training.

c. This regulation does not address Army Medical Department (AMEDD) numbered courses or the Professional Postgraduate Short Course Program. The U.S. Army Medical Department Center and School (AMEDDC&S) is responsible for the control and oversight of these courses. Utilize the Army Training and Resource System (ATRRS) for more information on AMEDD numbered courses.

d. This regulation does not address long-term health education or graduate medical education (GME). Army Regulation 351-3 sets policies and procedures for internships, residencies, and fellowships.

e. Masculine pronouns address both genders unless specifically stated otherwise.

f. All references to Professional Filler System (PROFIS) include all categories (Active Army (AA), RC and multi-compo) unless otherwise stated.

1-3. References. Required and related publications and prescribed referenced forms are listed in appendix A.

1-4. Explanation of abbreviations and terms. Abbreviations and special terms used in this regulation are explained in the glossary.

1-5. Applicability. This regulation applies to all MEDCOM units, its major subordinate commands (MSCs), medical treatment facilities (MTFs), and RC units attached for training.

1-6. Responsibilities. Responsibilities assigned by this regulation are contained within the narrative of each chapter.

1-7. MEDCOM Mission

- a. Promote, sustain and enhance Soldier health.
- b. Train, develop and equip a medical force that supports full spectrum operations (FSO).
- c. Deliver leading edge health services to our Warriors and military Family to optimize outcomes.

1-8. Training philosophy. During long-range planning, the MEDCOM Commander and subordinate commanders will publish training philosophies as part of command training and leader development guidance. This provides a guide for the development of subordinate training programs. The commander's training guidance emphasizes areas that are essential for success of the unit's mission. The philosophy also emphasizes training methods or programs the unit needs to improve. These include collective training events, occupation/specialty, physical, combatives, leader development, warrior tasks, emergency personnel requirements for chemical, biological, radiological, nuclear, and high yield explosives (CBRNE), weapons, mobilization, resiliency for warrior transition unit (WTU) and community based warrior transition unit (CBWTU) cadre or other medical specialties, risk assessment and safety.

1-9. Army Training System - training domains. The Army Training System focuses on the Army's training efforts within the three domains in which training occurs: institutional, operational, and self-development. Each training domain complements the other two. All the domains have an important role in training Soldiers and Army civilians for leader development and deployment preparation.

1-10. Establishing and validating of MEDCOM-wide training requirements

a. MEDCOM-wide training consists of topics, tasks and courses approved by HQ MEDCOM for all personnel or personnel in a particular category such as:

- (1) All military, or just the officers, noncommissioned officers (NCOs), or junior enlisted.
- (2) Army civilians.
- (3) Contractors.
- (4) Volunteers.
- (5) Supervisors (military, civilian, or both).
- (6) Host nation personnel.

(7) Area of concentration (AOC), military occupational specialty (MOS), and civilian job series.

(8) Age-based requirements.

(9) Training required for additional/appointed duties (example: Secret Internet Protocol Router Network (SIPRNET) user, Safety NCO, or commander).

(10) Training required for special duty pay (example: WTU/CBWTU squad leader/platoon sergeant duties).

b. Department of Defense (DOD), Department of the Army (DA) and other government agencies through their regulations and policies routinely direct Army commands to implement mandatory training for the entire command, or command-wide for selected MOS/AOCs or duties. In order to provide consistency and standardization, MEDCOM-wide training requirements are established and implemented. This paragraph outlines the process for establishing, validating and managing training requirements.

c. G3, MEDCOM is responsible for maintaining the MEDCOM consolidated training document and will ensure training requirements, regardless of source, are staffed with the appropriate OTSG or MEDCOM proponent prior to command-wide implementation. New training requirements in which the AMEDD is the proponent will be staffed with the AMEDDC&S for validation and or situational awareness. All OTSG/MEDCOM directorates are designated as training policy proponents for their functional area. Training proponents will validate/re-validate training and develop training policy. The G3, MEDCOM will be included in that staffing process and the approval authority of policies that direct MEDCOM personnel to train.

d. The G-3, MEDCOM will ensure all MEDCOM-wide training requirements are initially validated and re-validated at least every three years. The validation process will include:

(1) Mission supported efficacy and impact of training.

(2) Recommendation on the knowledge and skills degradation period.

(3) Delivery method (face-to-face or distributed Learning (dL)).

(4) Resource impact: number of hours, equipment and automation cost.

(5) Recommendation to continue or discontinue or make the training optional or self development.

1-11. Training Standardization Program

a. Standardization. The management principle which fosters the development and sustainment of a high state of proficiency and readiness among Soldiers and units throughout an organization. Standardization is accomplished through the universal application of uniform practices and procedures. Standardization policies, procedures and management must be set at the highest level in order to achieve the greatest benefit without stifling initiative.

b. Training standardization is a MEDCOM-wide special emphasis area for the command's Inspector General, and will be included in all organizational inspection programs (OIPs). MEDCOM training standardization will meet the objectives of AR 34-4.

c. The objectives of the command's training standardization program are to improve and sustain readiness and proficiency of Soldiers and units.

d. Standardization of training is not an end in itself. Standardization will be considered whenever operational, training, tactical, logistical, automation, or administrative programs are developed or changed.

e. Each regional medical command regional medical command (RMC) and MSC will designate a training standardization officer responsible for coordinating regional standardization issues and providing input to the AMEDDC&S/MEDCOM training standardization working group.

f. The Commander AMEDDC&S is the AMEDD proponent for standardization matters pertaining to healthcare education and training (E&T) (except for GME). He is responsible for coordinating training standardization issues presented by MEDCOM RMCs/MSCs. All AMEDD MOS/AOC/civilian job series training standardization issues will be documented and shared with AMEDD teaching proponents and MEDCOM Healthcare Operations Staff. Unresolved AMEDD standardization issues will be reported to MEDCOM Healthcare Operations for tracking and resolution. The proponent for MEDCOM-wide non-AMEDD training E&T is the OTSG/MEDCOM staff responsible for policy in the functional area. Unresolved non-AMEDD training standardization issues will be reported to the appropriate Army proponent.

g. The AMEDDC&S Commander will appoint the chairman of the MEDCOM E&T Work Group (WG) (E&T WG) which is comprised of training standardization officers appointed by each MEDCOM RMC/MSC. The MEDCOM E&T WG will identify, validate and recommend face-to-face and dL courses for command-wide standardization. The E&T WG will also assist the Center for distributed Learning (CdL) in validating new distributed learning issues.

h. MEDCOM units will use Digital Training Management System (DTMS) to assist in standardization of unit level training tasks and courses. The following task management procedures will be used:

(1) DOD, Headquarters, Department of the Army HQDA and MEDCOM directed training will not be created in DTMS by MEDCOM units.

(2) In order to avoid duplication and make new DOD, HQDA tasks/courses immediately available for tracking the tasks/courses will be temporarily made available for tracking in DTMS using a MEDCOM task number. MEDCOM will notify units when DOD and HQDA tasks are available for documentation in DTMS. MEDCOM will ensure training completion data from the temporary task are merged into the DOD/HQDA task.

(3) Commanders will establish internal processes that ensure MOS/AOC, civilian job series, job specific and additional duty training documentation is not duplicated in DTMS.

1-12. Mission essential task (MET), and mission essential task list (METL) development

a. FSO METL consists of the Chief of Staff, Army (CSA) approved standardized missions for brigade and above. The FSO METL represents those fundamental doctrinal tasks a unit is designed to perform. If a unit is assigned a mission outside of the core functions/designed capabilities, commanders will analyze the assigned mission, identify mission essential tasks and if necessary, add additional (“Out of Design”) METs to the units FSO METL. Out of design METs are used as temporary modifications to the FSO METL in order to accommodate the current operational environment.

b. Procedures for RMC/MSC METL development are:

(1) MEDCOM RMCs/MSCs are designated as medical commands for training management and unit status reporting purposes.

(2) RMCs/MSCs will train, evaluate and report unit proficiency using the Army approved FSO METL.

(3) Training and reporting of an “out of design” mission will be at the direction of MEDCOM.

(4) The FSO METL entered in DTMS and Defense Readiness Reporting System-Army (DRRS-A) will match the missions evaluated on the commander’s unit status report (CUSR).

(5) DTMS will be used to assist commanders in determining individual and collective skill proficiency for assessing unit overall training.

(6) Commanders will create local collective tasks (LCTs) when no Army universal task list (AUTL) task exists for missions assigned to the unit.

(7) LCTs will be created in DTMS and will contain the following elements:

(a) Task number.

(b) Task title.

(c) Task proponent.

(d) Conditions, standards, descriptions, purpose, outcome, guidance, evaluation criteria, and task steps.

c. Procedures for METL development for units below the RMC/MSC are:

(1) The next higher unit commander will approve the subordinate unit METL within 45 days of the change of command.

(2) Commanders will train on and evaluate their unit's proficiency based on their approved METL.

(3) Commanders will use AUTL tasks, and only create LCTs when no AUTL task exists for missions assigned to the unit. LCTs are appropriate for non-standard training, new equipment training, and out of design missions.

(4) LCTs will be created in DTMS and will contain:

(a) Task number.

(b) Task title.

(c) Task proponent.

(d) Conditions, standards, descriptions, purpose, outcome, guidance, evaluation criteria, and task steps.

Chapter 2 Responsibilities

2-1. Commander, MEDCOM

a. Exercise HQDA responsibility on matters pertaining to medical training.

b. Establish training requirements and develops products to support training collective tasks in accordance with AR 350-1 in medical units for Soldiers, civilians and assigned contractors.

c. Provide MEDCOM Training and Leader Development Guidance (MTLDG).

d. Monitor, evaluate, and provide guidance for improving the status of medical readiness as reflected in the modified table of organization and equipment (MTOE) and table of distribution and allowances (TDA).

e. Receive training briefings.

f. Approve RMC/MSC METs and METL.

g. Approve the charter and review the minutes of the MEDCOM E&T WG.

h. Ensure the following management tools are understood and used at the appropriate levels:

(1) MEDCOM MTLDG.

(2) AMEDD Balanced Scorecard (BSC).

(3) DTMS.

(4) Medical Operational Data System (MODS).

(5) Army Learning Management System (ALMS).

(6) Military Health System Learn (MHSLearn).

(7) Army Training Network (ATN).

(8) Range Facility Management System (RFMSS).

(9) Training Ammunition Management Information System-Redesigned (TAMIS-R).

(10) Defense Medical Human Resource System – Internet (DMHRSi).

(11) Joint Knowledge Development and Distribution Capability (JKDDC).

2-2. Chief of Staff, MEDCOM

a. Approve training analysis and skills degradation criteria for training repeated 24 months or less.

b. Approve the business process and provide funding for the MEDCOM dL Program and enterprise dL training products/programs.

2-3. All OTSG/MEDCOM directorates

a. Act as the MEDCOM training proponents for staffing of policy and guidance for training programs and topics listed in the MTLDG.

b. Monitor AMEDD and MEDCOM readiness and training reports for programs in which the directorate is the MEDCOM proponent.

c. Ensure documents containing training requirements for MEDCOM personnel are staffed with Healthcare Operations (HCO) directorate prior to seeking approval from the Chief of Staff, the Deputy Surgeon General, or the MEDCOM Commander.

d. Staff documents containing dL and face-to-face training with G3, MEDCOM.

e. Utilize DTMS to analyze training trends and document staff training as outlined in the MTLDG.

f. Update the MEDCOM Consolidated Training Requirements Matrix (MCTRM) for training in which the directorate is the proponent.

g. Conduct analysis of training in which the directorate is the proponent to develop task description, conditions, standards, method of training, target audience, length of training, frequency and skills degradation periods.

h. Provide timely and sufficiently detailed information on major events so subordinate units can lock in their training plans.

i. Maintain long-range planning calendars in DTMS.

j. Where applicable, allocate resources and/or coordinate resources to support implementation of training.

k. Each directorate/staff agency is responsible for documenting training in DTMS.

2-4. G3, MEDCOM

a. Provide supervision, coordinate, direct and support the staff in development of individual and collective training policy.

b. Coordinate training functions within the MEDCOM.

c. Establish priorities for the allocation, distribution, construction of resources and facilities to support the effort for training of MEDCOM units.

d. Approve MEDCOM-wide mandatory training requirements that require retraining over 24 months.

e. Convene and chair the Joint Medical Nuclear Biological and Chemical (NBC) Training Oversight Group, composed of military service and DOD representatives, acting within the scope of the Army as executive agent for NBC Defense.

f. Provide representatives and monitor progress of the Army training management process led by DA through the Training General Officer Steering Committee (TGOSC) and the supporting Council of Colonels (COC) and WG.

g. Ensure the MEDCOM has representation on the Institutional Training COC, Distributed Learning COC, Home Station/Deployed Training COC, Combat Training Centers COC, Munitions Requirements COC (for training munitions issues), and the Training Support and Training Transformation WGs.

h. Provide a MEDCOM voting member for the Army METL Review Board (AMRB).

i. As required, support the United States Army Forces Command (FORSCOM) as supported command for Army Force Generation (ARFORGEN).

j. Serve as the Army readiness functional proponent for the DMHRS-i.

k. Publish and provide updates to the MEDCOM Training and Leader Development Guidance.

l. Publish and maintain the MEDCOM Mission, METs, and METL.

m. Monitor training trends and readiness reports submitted to the MEDCOM.

n. Maintain the MCTRM in DTMS.

o. Maintain the MEDCOM long-range calendar in DTMS.

p. Approve all PROFIS training requests.

2-5. Commanders, MSCs

a. Train and evaluate assigned personnel in accordance with this regulation and AR 350-1.

b. Use the military decision-making process (MDMP) to develop METs, task groups (TGs), unit and staff METL, critical collective and supporting individual tasks. Utilize the following in developing of METs/METLs:

(1) MEDCOM BSC.

- (2) Applicable DOD, Army and MEDCOM regulations and policies.
 - (3) The Joint Commission (TJC) and other accreditation standards.
 - (4) Combined Arms Training Strategy (CATS).
- c. Enter and assess approved METs, in the DRRS-A.
 - d. Enter and maintain approved TGs, METL, critical collective tasks and supporting individual tasks in DTMS.
 - e. Provide a quarterly assessment of units unclassified METL as indicated in DTMS.
 - f. Submit changes to unit METLs to MEDCOM as they occur using DTMS.
 - g. Use DTMS as the authoritative system for assessment of approved METL and collective training events.
 - h. Approve subordinate unit METL.
 - i. Provide timely and sufficiently detailed information on major events so that subordinate units can make long range plans.
 - j. Use the MTLDG in the development, planning and implementation of training.
 - k. Publish and provide updates to the RMC/MSC training and leader development guidance.
 - l. Protect training time by eliminating training distractions and ensure necessary resources are readily available.
 - m. Conduct after action review (AAR) for training events and ensure subordinate leaders document unclassified AARs in DTMS Nonsecure Internet Protocol Router Network (NIPRNET) and document classified AARs in DTMS using SIPRNET where available.
 - n. Ensure the following management tools are understood and used at the appropriate levels:
 - (1) DTMS.
 - (2) MODS, 68W Module and the Medical Protection System (MEDPROS).
 - (3) AMEDD BSC.
 - (4) ALMS.

- (5) MHSLearn.
- (6) Army Training Network (ATN).
- (7) RFMSS.
- (8) TAMIS-R.
- (9) DMHRSi.
- (10) AMEDD Resource Tracking System (ARTS).
- (11) JKDDC learning management system (LMS).
 - o.* Establish standing operating procedures (SOPs) on the use of DTMS.
 - p.* Require each unit commander to maintain a DTMS SOP.
 - q.* Ensure the MSC has a trained primary and alternate DTMS master trainer.
 - r.* Train DTMS users and provide DTMS access down to the first line leader where applicable.
 - s.* Set the standard for safety, provide guidance for risk acceptance decisions, and conduct risk assessment for all training events.
 - t.* Document individual training in the DTMS Individual Training Record (ITR) and collective training in DTMS training manager/unit manager modules as follows:
 - (1) Use CATS tasks to document collective training and only create LCTs when no applicable CATS or MEDCOM LCT exist.
 - (2) Use individual tasks developed by the AMEDDC&S to document AOC, MOS and civilian job series training prior to creating new dL or face-to-face training tasks.
 - (3) Obtain MEDCOM approval prior to creating mandatory training tasks directed by DOD, DA or MEDCOM.
 - (4) Identify personnel performing additional duties in the DTMS ITR additional duty tab.
 - (5) Identify personnel performing special duties and receiving special duty pay in the DTMS ITR special duty tab.

2-6. Commander, AMEDDC&S

a. Train and evaluate medical personnel for worldwide deployment in accordance with this regulation, AR 350-1 and AR 10-87.

b. Establish AMEDD training requirements and develop products to support collective and individual training for military and civilian personnel in MTOE and TDA medical units.

c. Ensure collective and individual tasks contain standards of practice applicable to both MTOE and TDA organizations.

d. Support overseas deployment training (ODT) within funding constraints and in support of unit, METL based, collective training opportunities in accordance with AR 350-9.

e. Execute the systematic and progressive education of MEDCOM Soldiers and Army civilian personnel in the health services field and:

(1) Establish Noncommissioned Officer Education System (NCOES) courses to provide job proficiency training to all MEDCOM enlisted Soldiers.

(2) Monitor Advanced Leaders Course (ALC) and Senior Leader Course (SLC) quota utilization (class input) for courses conducted at MEDCOM schools.

(3) Monitor class input for courses for which The Surgeon General (TSG) is the proponent and ensure:

(a) Appropriate prerequisites for enrollment are established.

(b) Nonresident MEDCOM NCOES courses are established and maintained.

(4) Conduct Noncommissioned Officer Academy (NCOA) instructional programs at the AMEDDC&S under TSG approved program of instruction (POI).

f. Program and budget for temporary duty (TDY) travel related to MEDCOM basic NCOES. The U.S. Army Health Professional Support Agency will program and budget for MEDCOM personnel to attend the Warrior Leader Course (WLC).

g. Act as the Army's material developer (MATDEV), combat developer (CBTDEV), and training developer (TNGDEV) for medical materiel systems.

h. As required, support FORSCOM as supported command for ARFORGEN.

- i.* Provide a representative to the FORSCOM biennial ARFORGEN Training Template and Event Menu Matrix (EMM) WG to review/revise templates and EMMs to ensure continued synchronization with FSO METL and combined arms strategy tasks.
- j.* Serve as the Army training E&T functional proponent for the DMHRSi.
- k.* Execute AMEDD responsibilities for collection and analysis of medical lessons learned and implement appropriate changes to doctrinal manuals and training programs.
- l.* Provide MEDCOM updated listings of all AMEDD dL training developed by the CdL.
- m.* Ensure training requests for subject matter experts (SMEs) and training product requests are staffed through HCO prior to implementation.
- n.* Provide proponent points of contact (POC) and SMEs for all AMEDD dL and face-to-face training as requested by MEDCOM.

2-7. Commanders below the RMC and MSC level

- a.* Publish METL and associated conditions and standards for the unit.
- b.* Conduct training to Army standards and evaluate training proficiency.
- c.* Publish short range training and leader development guidance.
- d.* Use DTMS as the authoritative system for managing unit training.
- e.* Commanders will develop and sign training schedules.
- f.* MTF commanders or appropriate next higher commanders will approve training schedules.
- g.* Protect subordinate units from training distracters and implement training as listed on signed training schedule.
- h.* Train DTMS users and provide DTMS access down to first line leader where applicable.

Chapter 3 Training in Units and Organizations

3-1. AA planning. MEDCOM units will conduct the following planning procedures in accordance with filed manual (FM) 7-0. Training plans translates the commander's

training and leader development guidance and training strategy into a series of interconnected requirements and events to achieve the commander's training objectives. Planning documents include the frequency and duration of each training event and the resources required. Required resources and events drive planning considerations. The three types of training plans are long-range, short-range, and near-term. A long-range training plan consists of training and leader development guidance and the long-range planning calendar. Senior commanders publish training and leader development guidance early enough to give their units enough time to plan, both during operations and in peacetime. Guidance from senior command echelons is critical to developing and integrating subordinate AA and RC long-range training plans. Therefore, long lead times, consistent with the ARFORGEN cycles, are normal. Each headquarters follows an established timeline so subordinates have time to prepare their plans. Higher headquarters should give subordinate units more planning time than they keep for themselves.

3-2. Mandatory training overview. The Army mandatory training requirements are listed in AR 350-1. Mandatory training consists of Army senior leader selected general training requirements considered essential to individual or unit readiness for all Soldiers and Army civilians. This training is common to all Soldiers and Army civilians, regardless of component (unless otherwise noted), branch/career field, or rank/grade. Mandatory training will be incorporated into unit or institutional training programs as specified in AR 350-1 and other governing reference as listed in appendix A of this regulation. HQDA, Deputy Chief of Staff (DCS) G-3/5/7 approves and validates training strategies used to address Army mandatory training requirements.

3-3. MEDCOM Consolidated Training Requirements Matrix (MCTRM)

a. The MCTRM consists of command-wide training requirements that are validated by training proponents and approved by the MEDCOM Commander or designated approval authority. The MCTRM provides a single document that lists the information needed to provide standardization, management, and execution of training by units and individuals within the command.

b. The MCTRM is published within the MTLDG and is updated as changes occur.

c. The G3, MEDCOM will maintain the MCTRM.

d. Training proponents will develop, staff, and coordinate DOD, DA, and MEDCOM training requirements with the G3, MEDCOM prior to seeking MEDCOM Commander's approval to implement command-wide training.

e. Training proponents will request SME from the AMEDDC&S for AOC. MOS and civilian job series training in which the AMEDDC&S is the Army proponent.

3-4. PROFIS and individual augmentee (IA) training and readiness

a. Orientation to the operational unit is applicable to all PROFIS personnel and will be done within 3 months of PROFIS designation/assignment. The PROFIS orientation will include an initial brief by the operational unit or the MEDCOM Unit Operations Staff. The brief will include the unit mission, METL, task organization, and the PROFIS individual's responsibilities and duties.

b. PROFIS personnel will be assigned to PROFIS positions until their status changes (for example: non-deployable, PCS, ETS, etc.).

c. Commanders will provide PROFIS personnel for collective and individual training with their assigned PROFIS or like unit in support of the ARFORGEN Cycle when requested by FORSCOM and approved by the G3, MEDCOM.

d. All PROFIS will qualify with an individual weapon every 3 years.

e. MSC/RMC commanders will plan for and provide personnel identified in the PROFIS Deployment System (PDS) to deploying units in accordance with the deploying commands ARFORGEN training cycle, planned mission rehearsal exercise (MRE) or culminating training event (CTE). The goal is to provide training in support of the ARFORGEN cycle for personnel to train in the environment and with the type of equipment that the member will use in the deploying unit.

f. Commanders will support training requests received 90 days in advance for personnel identified in the PDS.

g. Personnel training requests received less than 90 days prior to training execution will be supported in accordance with MEDCOM mission analysis.

h. IA and PROFIS personnel will meet Army Soldier readiness processing (SRP) qualifications NLT 30 days of designation as PROFIS and within 15 days of notification to deploy for IA personnel.

3-5. Health Care Specialist (68W) Training Program. The accuracy of individual training records is a critical part of ensuring 68W Soldiers are MOS sustained. The MODS 68W tracking module will be used to track and input 68W sustainment training requirements. All organizations will use the individual training module of DTMS to track 68W training.

3-6. Medical proficiency training (MPT). MPT is conducted at MEDCOM facilities in accordance with MOU established between MEDCOM and organizations such as FORSCOM, U.S. Army Training and Doctrine Command (TRADOC). The overall purpose of MPT is to ensure AMEDD table of organization and equipment (TOE) personnel sustain necessary skills in peacetime required for medical readiness in the event of overseas contingency operations, and special consideration should be given to

low density military occupational specialties (for example, 68R and 68S and their respective ASIs). MEDCOM commanders will ensure skills and tasks completed during MPT are documented in Soldiers' DTMS ITR.

3-7. Soldier and Team Training (STT) Program. STT training time and tasks are not prescriptive. The training is intended to increase Soldier and civilian proficiency in skills and knowledge required of their current work site, MOS, AOC, and civilian job series. Commanders and civilian leaders must establish contracts with their military and civilian trainers during training/planning meetings to properly resource STT, approve the selected tasks, provide time to prepare, and to monitor the training. The topics selected for STT must fit into the unit's overall training program and be based on small unit leader training assessment. The STT Program requires dedicated time on the unit training schedule and will be clearly identified using the event name of "STT". The actual tasks trained will be linked to the STT event and documented in their individual training record. Senior NCOs and senior civilians must train, teach, coach and mentor Soldiers and assist in the training and leader development of civilians. Where appropriate, all officers and civilian leaders will participate in the planning and execution of STT training and ensure training is conducted. STT AARs will be documented in DTMS and used to improve the program. Soldier and team training in the MEDCOM will meet the requirements of AR 350-1 Sergeant's Time Training.

Chapter 4 Ammunition Management

4-1. Training ammunition management overview. This chapter prescribes policies and procedures for managing training ammunition. Commanders must plan the use of training ammunition. The training ammunition management objective is to accurately establish training ammunition requirements based on approved munitions training strategies. The TAMIS-R contains the Army and MEDCOM guide to manage ammunition. The web site for TAMIS-R is: <https://tamis.army.mil/>. ERM and PRMC are exempt from the MEDCOM training ammunition management requirements and are managed through their respective Army Service Component Command.

4.2. Training munitions strategies

a. TDA Soldiers that are not assigned a weapon are exempt from weapons qualification in accordance with AR 350-1 and DA PAM 350-38.

b. MEDCOM priorities are:

(1) Army civilian guards.

(2) PROFIS. All PROFIS will qualify with an individual weapon every three years.

(3) MEDCOM Soldiers that need to qualify for official purposes such as Noncommissioned Officer of the Year and Soldier of the Year competition, expert field medical badge (EFMB) testing, expert field medical competition (EFMC) and SGT/SSG promotion boards.

(4) Commanders will use training devices and simulators when available.

4-3. Training ammunition management

a. Ammunition forecasts will be submitted during the first three quarters of the fiscal year. The last quarter is used for re-fires and newly assigned personnel training.

b. Turn back of excess munitions to MEDCOM will be done prior to the end of the 3rd quarter each fiscal year. HQDA will not accept fourth quarter turn backs. Units with excess munitions at the end of the fourth quarter have to respond by memorandum to HQ, MEDCOM ATTN: MCOP-O-RT and state the reasons why ammunition was not expended. Ammunition cannot be moved to the next fiscal year.

4-4. Requirements

a. MTFs will include ammunition requirements of co-located dental, veterinary, and public health activities in their forecast.

b. MEDCOM Ammunition Manager will enter requirements into TAMIS-R.

c. MSCs will forward their estimated forecast to HQ, MEDCOM, ATTN: MCOP-O-RT, not later than 15 December (or as requested).

4-5. Authorizations

a. MEDCOM is responsible for distributing ammunition authorizations to units using TAMIS-R.

b. The MEDCOM ammunition authorizations can be changed by HQDA, and in turn the MEDCOM Ammunition Manager will make changes to MSC authorizations as required.

c. MSCs are responsible for sub-authorizations of ammunition to their subordinate units.

Chapter 5

MEDCOM distributed Learning Program (MdLP)

5-1. General

a. Distributed learning dL is an instructional methodology that leverages various technologies to expand E&T access to enhance learning. This MdLP establishes dL governance for the development, management, registration, and delivery of dL products and services. AMEDDC&S CdL is the MEDCOM proponent for dL.

b. The dL products and services include all instructional media, synchronous, asynchronous, and blended learning that use the following methods:

(1) Computer-based instruction—E&T delivered via computer.

(2) Computer-managed or web-managed instruction—E&T managed via computer or online using a LMS. Management may include: course delivery, course catalogs, course certificates, test scoring, pass or fail documentation, and training completion tracking.

(3) Correspondence courses—involve the exchange of teaching materials between departments and students. They are usually paper-based products distributed via mail or electronically in Adobe Acrobat or Microsoft Word formats. Exams are either proctored by an instructor or taken online for electronic grading and tracking purposes.

(4) Discussion forums—Virtual social communities where students can discuss training E&T topics and share information.

(5) Digital graphical training aids (GTAs)—Various digital formats of graphics that assist students with mastery of training E&T objectives. GTAs are usually intended for printing and mass distribution, such as pocket reference cards.

(6) Electronic guides—Digitized documents such as study guides, text books, or e-books.

(7) Electronic testing—A digitized testing environment in which students take exams online or in a computer based environment. With these systems, scores are usually calculated electronically, students often receive immediate pass or fail results, and some systems also include remediation components. Some electronic systems have the ability to generate multiple test versions by selecting test questions randomly.

(8) Electronic job aids—Printable, digitized, job related information or mini programs that assist with job performance (for example, a mobile, mini application that calculates medication dosage amounts for specific patients). These job aids are designed for use on the job to provide guidance on performing specific tasks/processes or as a reference guide.

(9) Electronic performance support systems (EPSSs)—An electronic environment that contains tools, software and information to assist with job performance. For example, many pharmacists use online medication information sources to verify drug interactions. EPSSs are typically much larger in scope than electronic job aids.

(10) Interactive electronic technical manuals (IETMs)—Digitized technical manuals containing text, diagrams, and graphics. Some may also contain branching or low level simulation components for troubleshooting purposes.

(11) Interactive multimedia instruction (IMI)—Digital training E&T components that include a variety of media such as text, audio, graphics, animation, and video and may be delivered via WEB, CD, or learning management systems.

(12) Interactive video—Video-based training E&T courseware providing interactive scenarios and/or exercises that require student decisions to progress, provide branching opportunities, and include decision feedback.

(13) Mobile learning (M-learning) applications—E&T videos, study aids, IMI designed for use on MP3 & MP4 players, netbooks and ebooks.

(14) Desktop gaming & simulations—A complex, interactive environment where students apply theories and principles and practice performance components. These environments typically enact events, situations, equipment, people, places, or things as close to real world as possible to allow for safe exposure and practice.

(15) Satellite broadcast (SAT)—Offers live or recorded one-way audio and video delivery and is primarily used to view information, training, or historical events that do not require two-way communications, such as high level command briefings.

(16) Video-based courseware—E&T courseware that utilizes video to deliver instructional components.

(17) Video Tele-Training (VTT)—Provides live, two-way audio and video communication via a central distribution network or bridge. VTT is primarily used to offer students or faculty training and information from geographically separated SMEs or for educational workshops that require coordination with geographically separated stakeholders. This format allows participants to ask questions and interact with geographically separated presenters or participants.

c. The dL products and services include synchronous, asynchronous, and blended learning activities.

(1) The dL products and services may replace, supplement, or enhance traditional classroom instruction.

(2) Depending on the type of dL products and services, delivery may be self-paced or involve interaction with the instructor, other students, or both through the utilization of digital training facilities (DTFs), SAT, Defense Connect Online (DCO), content management systems such as Blackboard, ALMS, or other emerging technologies.

(3) The dL products and services are commonly used throughout the Army to provide training for the knowledge components of task performance and for knowledge-based training objectives. Some examples of dL products are mandatory training, prerequisite training, phase training, quota managed training, RC needs, refresher or sustainment training and self-development courses.

(4) The dL courseware benefits MEDCOM E&T initiatives by:

(a) Providing training opportunities to students who unavoidably miss scheduled training.

(b) Providing sustainment and other up-to-date E&T for previous graduates.

(c) Expanding access to SME information.

(d) Providing alternates to and supplementing classroom training.

(e) Distributing standardized training.

(f) Overcoming logistical challenges.

(g) Providing prerequisite training.

(h) Reducing travel expenses.

(5) Blended learning dL products and services supplement classroom E&T and training by combining dL components and classroom instruction to maximize training and education effectiveness. By expanding student exposure to various delivery mechanisms, instructional sources, and SMEs, blended learning components offer several benefits to both instructors and students. These benefits include:

(a) Increased student interest.

(b) Increased quality of training.

(c) Increased study opportunities.

(d) Reduced instructional load of faculty.

(e) Increased access to educational and training experiences students might otherwise miss.

(f) Student and instructor exposure to and awareness of technologies that may potentially increase their future job performance.

(6) Examples of blended learning uses:

(a) IMI or video scenarios for classroom discussion points, projects, or student response papers.

(b) Videos or IMI components that draw students interest to training material or motivate students to learn training material.

(c) IMI review games or instructional games.

(d) Video capture of SME lectures.

(e) Graphical training aids.

(f) Student feedback outlets.

(g) M-learning study aids.

(h) Electronic testing.

(i) Realistic videos.

(j) Simulations.

5-2. Purpose

a. The purpose of this program is to:

(1) Leverage multiple dL technologies and training design efficiencies to enhance and sustain MEDCOM readiness by delivering standardized training to Soldiers and units, while minimizing traditional geographical constraints and maximizing the effectiveness of classroom training.

(2) Streamline the development, management, coordination, and registration process of dL products and services to reduce duplication of effort, ensure conformance with dL standards, improve cost effectiveness, promote standardization of dL courseware, and maximize the use of the approved Enterprise Learning Management System (ELMS), such as the ALMS.

5-3. MEDCOM Executive Agent

a. AMEDDC&S CdL serves as the executive agent for the development, management, registration, and delivery of all existing and new dL products and services within the MEDCOM.

b. AMEDDC&S CdL serves as a consultant to the MEDCOM assisting with the identification of dL requirements, emerging dL technologies, and dL best practices.

c. AMEDDC&S CdL also provides dL product design, development, delivery services, and customer support.

d. dL product requests:

(1) All dL product requests must be submitted to AMEDDC&S CdL via cdl@amedd.army.mil. Those requests originating from sources external to AMEDDC&S require approval from MEDCOM HCO.

(2) CdL will review all dL courseware, product, and service requests and determine approval requirements. The approval process may include but is not limited to a front end analysis, a needs assessment, and/or a business analysis.

(a) E&T dL products not requiring development resource requests (such as webinars or digital training aides) do not require approval and will be submitted for registration purposes.

(b) The use of the ALMS for collaboration or informational purposes does not require submission for approval or registration.

(3) CdL will advise and assist the proponent with selecting the appropriate dL product(s) and delivery method(s).

e. dL product development.

(1) Upon approval, AMEDDC&S CdL will coordinate the development of the dL product(s) based upon AMEDDC&S CdL business practices.

(2) dL product development may be achieved internally by the CdL or externally depending on the CdL analysis and recommendations.

f. Hosting of Army-owned dL products.

(1) All MEDCOM dL products will be hosted on the approved ELMS, such as the ALMS. AMEDDC&S CdL will coordinate hosting and advise proponents as to which system within the ELMS is most appropriate for their specific course(s).

(2) All dL products not hosted on the ELMS must have a TRADOC approved waiver.

g. Commercial off-the-shelf (COTS) dL products.

(1) In order to reduce redundancy and increase purchase efficiencies, all COTS product requests must be submitted to CdL.

(2) AMEDDC&S CdL will evaluate COTS product requests and coordinate TRADOC approval based on internal business practices.

(3) Once the proponent is approved to purchase the COTS product, the proponents must register the COTS product with CdL.

f. dL Subscriptions, including but not limited to, continuing education (CE) and continuing medical education (CME) subscriptions.

(1) In order to reduce duplication of effort and increase purchase efficiencies, all CE/CME subscription requirements, must be submitted to CdL for coordination of TRADOC approval.

(2) To assist CdL with reducing duplication of effort and identify purchasing efficiencies, proponents are required to register subscriptions with CdL and to provide CdL courtesy copies of all subscription contracts, scopes, and specifications.

(3) AMEDDC&S CdL will manage the current, approved, enterprise CE/CME web-based, subscription solutions.

g. Standardization of dL training.

(1) Under the guidance of the Dean, Academy of Health Sciences (AHS) and MEDCOM HCO, the MEDCOM E&T WG is tasked with providing recommendations to AMEDDC&S CdL related to dL requirements and standardization.

(2) Members of the MEDCOM E&T WG represent their respective RMCs/MSCs and have voting authority as it relates to dL standardization and dL requirements throughout the MEDCOM.

(3) AMEDDC&S CdL will coordinate with the MEDCOM E&T WG for decisions to reduce redundancy of dL courseware when migrating courses from organizational systems to the ELMS, such as the ALMS.

(4) AMEDDC&S CdL will coordinate with the MEDCOM E&T WG for decisions when possible redundancies are identified with new dL courseware requests.

(5) This standardization initiative includes all dL products and services applicable to MEDCOM including TJC, CE/CME, hospital educator courses, and MEDCOM subject matter areas.

Chapter 6

Hospital Education and Staff Development (HESD)

6-1. General. The purpose of this chapter is to describe the core functions, services, and activities of the hospital education and staff development. Functions, services and activities described in this chapter are not inclusive of the entire body of HESD work. The HESD provides medical treatment facilities with a broad range of training, education, and learning opportunities that support competency development and assessment. The HESD serves as the MTF learning resource center and promotes a culture that supports multi-disciplinary teaching and learning.

6-2. Purpose

a. The mission of hospital education and staff development is to:

(1) Provide E&T support for clinical and administrative functions performed by the hospital staff.

(2) Support E&T for co-located dental and veterinary training.

(3) Serve as the proponent for competency based documentation.

(4) Conduct learning need assessments and surveys.

(5) Coordinate and develop plans for implementation of new equipment training.

(6) Plan and synchronize training and education for organization compliance programs.

(7) Serve as the functional proponent for training standardization and coordinate standardization functions with other members of the organization.

(8) Identify training and education activities and tasks that should be performed in the same manner and to the same standard throughout the organization.

b. Execute oversight and management of hospital-based training and education by:

(1) Ensure all formal (military and civilian) clinical and non-clinical training is monitored, tracked, and reported.

(2) Coordinate classroom instructors, class location and travel arrangements.

(3) Provide oversight for phase 2 programs (except for GME) under guidance of the AMEDDC&S, Dean, AHS.

(4) Provide oversight of Reserve Officer Training Corps programs, and training support to other military civilian teaching programs.

(5) Enforce standardization of the Hospital Orientation Course and monitor annual updates for training.

(6) Conduct life support training for Basic Life Support, Advanced Cardiac Life Support, Pediatric Advanced Life Support and Trauma Nurse Core Course.

(7) Provide staff memorandums of agreement (MOAs) for medical proficiency training.

(8) Manage and monitor continuing education requirements.

(9) Manage and monitor new equipment training.

(10) Develop implementation plans for emerging training programs and other educational requirements.

Appendix A References

Section I Required Publications

AR 10-87

Army Commands, Army Service Component Commands, and Direct Reporting Units

AR 190-13

The Army Physical Security Program

AR 220-1

Army Unit Status Reporting and Force Registration – Consolidated Policies

AR 350-1

Army Training and Leader Development

AR 351-3

Professional E&T Programs of the Army Medical Department

AR 385-10

The Army Safety Program

AR 525-13

Antiterrorism

AR 530-1

Operations Security (OPSEC)

AR 600-8-101

Personnel Processing (In-, Out-, Soldier Readiness, Mobilization and Deployment Processing)

AR 600-9

The Army Weight Control Program

AR 600-20

Army Command Policy

AR 601-142

Army Medical Department Professional Filler System

DA PAM 350-38

Standards in Training Commission

MEDCOM Regulation 10-1

Organization and Functions Policy

Section II

Related Publications

AR 40-13

Medical Support - Nuclear/Chemical Accidents and Incidents

AR 190-11

Physical Security of Arms, Ammunition, and Explosives

AR 190-30

Military Police Investigations

AR 190-56

The Army Civilian Police and Security Guard Program

TRADOC Pamphlet 350-70-12

Distributed Learning - Managing Courseware Production and Implementation

DoD Directive 1322.18

Military Training

DoD Instruction 1322.20

Development and Management of Interactive Courseware for Military Training

DoD Instruction 1322.24

Medical Readiness Training

DoD Instruction 1322.26

Development, Management, and Delivery of Distributed Learning

FM 7-0

Training for Full Spectrum Operations

Section III

Referenced Forms

There are no entries in this section.

Glossary

Section I Abbreviations

AA

Active Army

AAR

after action review

ALC

Advanced Leaders Course

AHS

Academy of Health Sciences

ALMS

Army Learning Management System

AMEDD

Army Medical Department

AMEDDC&S

United States Army Medical Department Center and School

AMEDDC&S CdL

United States Army Medical Department Center and School, Center for distributed Learning

AOC

area of concentration

ARFORGEN

Army Force Generation

AUTL

Army universal task list

AMRB

Army METL Review Board

ARTS

AMEDD Resource Tracking System

ATN

Army Training Network

ATRRS

Army Training and Resource System

BSC

balanced scorecard

CATS

Combined Arms Training Strategy

CE

continuing education

CBRNE

chemical, biological, chemical, nuclear, and high-yield explosives

CBTDEV

combat developer

CBWTU

community based warrior transition unit

CdL

Center for distributed Learning

COC

Council of Colonels

COTS

commercial off-the-shelf

CME

continuing medical education

CSA

Chief of Staff, Army

CTE

culminating training event

DA

Department of the Army

DCO

Defense Connect Online

*MEDCOM Reg 350-4

DCS

Deputy Chief of Staff

dL

distributed Learning

DMHRSi

Defense Medical Human Resource System – Internet

DOD

Department of Defense

DRRS-A

Defense Readiness Reporting System-Army

DTF

digital training facility

DTMS

Digital Training Management System

E&T WG

education and training work group

EFMC

expert field medic competition

EFMB

expert field medical badge

ELMS

Enterprise Learning Management System

EMM

event menu matrix

EPSS

Electronic Performance Support System

ETS

end of time in service

FM

field manual

FORSCOM

United States Army Forces Command

GME

graduate medical education

GTA

graphical training aid

HESD

hospital education and staff development

HCO

healthcare operations

HQDA

Headquarters, Department of the Army

IA

individual augmentee

IETM

interactive electronic technical manual

IMI

interactive multimedia instruction

ITR

individual training record

JKDDC

Joint Knowledge Development and Distribution Capability

LCT

local collective task

LMS

Learning Management System

MATDEV

materiel developer

MCTRM

MEDCOM Consolidated Training Requirements Matrix

*MEDCOM Reg 350-4

MdLP

MEDCOM distributed Learning Program

MDMP

military decision-making process

MEDCOM

United States Army Medical Command

MEDPROS

Medical Protection System

MOA

memorandum of agreement

MET

mission essential task

METL

mission essential task list

MHSLearn

Military Health System Learn

M-learning

mobile learning

MODS

Medical Operational Data System

MOS

military occupational specialty

MOU

memorandum of understanding

MPT

medical proficiency training

MRE

mission rehearsal exercise

MSC

major subordinate command

MTF

medical treatment facility

MTLDG

MEDCOM Training and Leader Development Guidance

MTOE

modified table of organization and equipment

NBC

nuclear, biological, and chemical

NCO

noncommissioned officer

NCOA

Noncommissioned Officer Academy

NCOES

Noncommissioned Officer Education System

NIPRNET

Nonsecure Internet Protocol Router Network

ODT

overseas deployment training

OIP

Organization Inspection Program

OTSG

Office of the Surgeon General

PCS

permanent change of station

PDS

PROFIS Deployment System

POI

program of instruction

PROFIS

Professional Filler System

*MEDCOM Reg 350-4

RC

reserve component

RFMSS

Range Facility Management Support System

SAT

satellite broadcast

SIPRNET

Secret Internet Protocol Router Network

SLC

Senior Leader Course

SME

subject matter expert

SOP

standing operating procedure

SRP

Soldier readiness processing

STT

Soldier and Team Training Program

TAMIS-R

Training Ammunition Management Information System-Redesigned

TDA

table of distribution and allowances

TDY

temporary duty

TG

task group

TNGDEV

training developer

TOE

table of organization and equipment

TRADOC

United States Army Training and Doctrine Command

TSG

The Surgeon General

VTT

video tele-training

WG

work group

WLC

Warrior Leader Course

WTU

warrior transition unit

Section II

Terms

This section contains no entries.

Section III

Special Abbreviations and Terms

This section contains no entries.

*MEDCOM Reg 350-4

The proponent of this publication is the U.S. Medical Command Readiness and Training Branch. Users are invited to send comments or suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to the Deputy Chief of Staff, Health Care Operations, Attn: MEDCOM Operations Division, Fort Sam Houston, Texas, 78234-6000.

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