
DENTAL SERVICES

JULY 2026

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DENTAL SERVICES

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Preface

Army Techniques Publication (ATP) 4-02.19 provides discussion about dental services as one of the ten medical functions, as well as tactics, techniques, and procedures to plan and employ dental organizations within an area of operation. This publication was also developed to address dental services across the spectrum of violence and the operational categories—from security cooperation to large-scale ground combat as described in Field Manual (FM) 3-0.

The principal audience for ATP 4-02.19 is commanders, staff, surgeons, surgeon sections at echelon, Army Health System (AHS) planners, and Army Medical Department personnel and units. Commanders, staffs, and subordinates ensure that their decisions and actions comply with applicable United States, international, and in some cases host-nation laws and regulations. Commanders at all levels ensure that their Soldiers operate in accordance with the law of war and the rules of engagement (refer to FM 6-27).

This publication implements or is in consonance with the following North Atlantic Treaty Organization (NATO) Standardization Agreement (STANAG) and the standards of the American, British, Canadian, Australian, and New Zealand (ABCANZ) Armies program. NATO STANAGs are accessible online at the NATO Standardization Office (NSO) public website. ABCANZ standards are accessible online at the Protected Internet eXchange (PiX) – ABCANZ product library website. All referenced websites are listed in the rear matter of this publication.

TITLE	NATO STANAG	ABCANZ
Coalition Health Support Handbook, Edition 4		256
Requirement for Training in Casualty Care for All Military Personnel (Edition 5)—AMedP-8.15 (Edition B)	2122	
Medical and Dental Supply Procedures (Edition 6)—AMedP-1.12 (Edition A)	2128	
Allied Joint Doctrine for Medical Support—AJP-4.10 Edition C	2228	
Military Forensic Dental Identification—AMedP-3.1 (Edition B)	2464	
Dental Fitness Standards for Military Personnel and the NATO Dental Fitness Classification System (Edition 4)—AMedP-4.4 (Edition B)	2466	
Allied Joint Civil-Military Medical Interface Doctrine (Edition A)—AJMedP-6 (Edition 2)	2563	
The Civil-Military Planning Process on Oral Health Care and Deployment of Dental Capabilities in all Operations with a Humanitarian Component (Edition 1)—AMedP-6.1 (Edition A)	2584	
Allied Joint Medical Doctrine for Military Health Care (MHC), Edition 1 AJMedP-8 (Edition A)	2598	
Orders for the Camouflage of Protective Medical Emblems on Land in Tactical Operations. (Edition 4)—ATP-79 (Edition B)	2931	

ATP 4-02.19 uses joint terms where applicable. Selected joint and Army terms and definitions appear in both the glossary and the text. Terms for which ATP 4-02.19 is the proponent publication (the authority) are **bold italics** in the text and are marked with an asterisk (*) in the glossary. For other definitions shown in the text, the term is italicized, and the number of the proponent publication follows the definition.

This publication applies to the Regular Army, the Army National Guard/Army National Guard of the United States, the United States Army Reserve, Army Civilian Corps, and Army contracted medical providers, unless otherwise stated.

This publication supersedes ATP 4-02.19 dated 14 August 2020. Throughout this publication, as appropriate, reference is made to the major policy guidance affecting each specific topic. These references should not be considered as the only policy guidance available. When issues arise that require consideration of policy guidance, the issue should be thoroughly researched and, as appropriate, coordinated with the supporting staff judge advocate, governmental or nongovernmental agency involved.

The proponent and preparing agency of ATP 4-02.19 is the United States Army Medical Center of Excellence. Send comments and recommendations on Department of Army (DA) Form 2028 (*Recommended Changes to Publications and Blank Forms*) to Commander, United States Army Medical Center of Excellence, ATTN: ATMC-DTC-F (ATP 4--02.19), Building 4011, Suite B, 2377 Greeley Road, JBSA Fort Sam Houston, TX 78234-7731; or by e-mail to usarmy.jbsa.medical-coe.mbx.ameddcs-medical-doctrine@army.mil. All recommended changes should be keyed to the specific page and paragraph number. A rationale for each proposed change is required to aid in the evaluation and adjudication of each comment.

Introduction

The content of this publication remains generally consistent with the 2020 publication on key topics, while incorporating updated terminology and concepts as necessary and integrating the Army's adoption of the multidomain operations operational concept into this publication. Although the primary focus of this publication is the dental services provided in theater, it is important to understand that the emphasis on a Soldier's oral health begins at the time that they enter the Army and continues throughout their service commitment.

Summary of changes include:

- Aligning this publication with Army hierarchy publications, including ADP 3-37, FM 3-0, FM 4-0, and FM 4-02.
- Introduction of expeditionary dental care.
- Removal of Levels of Dental care.

ATP 4-02.19 consists of four chapters and seven appendixes as follows:

- **Chapter 1** introduces the role of dental services within the Army Health System (AHS) highlighting their contributions to force health protection (FHP), health service support (HSS), and operational readiness. It explains how dental services enable return to duty (RTD), reduce evacuations, and align with Army operational principles across all phases of operations.
- **Chapter 2** explains how Army dental services is vital to the success of military operations and keeping Soldiers healthy and ready to fight. It discusses how to effectively plan and deliver dental support across different types of military operations and adapt to the unique challenges each presents.
- **Chapter 3** details how dental assets are positioned and supported at each role of care, including—brigade, division, corps, and theater levels. It emphasizes the importance of mobility, expeditionary teams, and deliberate coordination with medical units.
- **Chapter 4** provides commanders and planners with methodologies to forecast dental support requirements and integrate them into the comprehensive medical plan.
- **Appendix A** details the responsibilities of unit commanders, dental activities, and clinic personnel in supporting and managing dental readiness efforts.
- **Appendix B** outlines potential dental services activities that align with the Army's strategic contexts of competition below armed conflict, crisis, and armed conflict.
- **Appendix C** is a guide for Geneva Conventions and medical ethics compliance.
- **Appendix D** provides details on the dental equipment sets.
- **Appendix E** outlines the framework and essential components of quality assurance plans for dental service operations in military settings.
- **Appendix F** provides a sample Format for Tab C (Dental Services) of Appendix 9 (Force Health Protection), to Annex E (Protection) of an Operation Plan or Order.
- **Appendix G** provides an outline for standard operating procedures (SOPs) and clinical standard operating procedures (CSOP).

The United States Army Medical Center of Excellence is reorganizing the placement of terms and definitions found in proponent publications within the Army Medicine's FM 4-02 series doctrine manuals. It was determined that some of the terms are best suited in other publications within this series.

Based on current doctrinal changes, certain terms for which ATP 4-02.19 is the proponent have been added, rescinded, or modified for purposes of this publication. The glossary contains acronyms and defined terms. See Introductory table-1 on page viii for specific term changes.

Introductory table-1. New Army terms

<i>Term</i>	<i>Remarks</i>
comprehensive dental care	updates the term definition
dental care	updates the term definition
emergency dental care	updates the term definition
essential dental care	updates the term definition
expeditionary dentistry	establishes term definition and proponent publication
operational dental care	updates the term definition

Chapter 1

Dental Services Overview

The Army's dental services play a crucial role in maintaining the health and readiness of Soldiers, directly impacting their ability to perform missions effectively. Beyond ensuring oral health, these services support the Army's operational goals by keeping Soldiers deployable and mission ready. This chapter provides a detailed overview of dental services as a medical function and highlights their operational capabilities within the Army Health System (AHS). It also emphasizes the significance of dental readiness, operational care, and the strategic coordination required to optimize dental support across all echelons of care.

Additionally, this chapter describes how dental care contributes to the broader healthcare system, ensuring Soldiers receive timely treatment to minimize downtime. It also outlines the categories of dental care—preventive, operational, and comprehensive, and their role in supporting unit readiness. By detailing the structure of dental services during military operations, this chapter underscores the importance of dental professionals in enhancing the Army's overall combat effectiveness and ability to sustain operations.

SECTION I – DENTAL SERVICES AS A MEDICAL FUNCTION

1-1. The *Army Health System* is the component of the Military Health system that is responsible for operational management of the health service support and force health protection missions for training, predeployment, deployment, and postdeployment operations. The Army Health System includes all mission support services performed, provided, or arranged by the Army Medicine to support health service support and force health protection mission requirements for the Army and as Directed, for joint, intergovernmental agencies, coalition, and multinational forces. (FM 4-02). This system includes all mission support services performed, provided, or arranged by Army Medicine to meet force health protection (FHP) and health service support (HSS) mission requirements for the Army and as directed, for joint, intergovernmental agencies, Army Forces, and multinational forces.

1-2. Dental services is one of the medical functions in the FHP mission component of the AHS. The mission of the dental services is to promote dental health; prevent and treat oral and dental disease; provide far forward dental treatment; and provide early treatment of severe oral and maxillofacial injuries. Prior to and during military operations, ensuring the dental health and readiness of personnel is critical for maintaining a capable and effective fighting force. For more information on AHS, FHP, and the other medical functions, refer to FM 4-02.

1-3. *Force health protection* are measures that promote, improve, or conserve the behavioral and physical well-being of Soldiers comprised of preventive and treatment aspects of medical functions that include: combat and operational stress control, dental services, operational public health, and laboratory services. Enabling a healthy and fit force, prevent injury and illness, and protect the force from health hazards. (FM 4-02). Most dental service tasks support FHP by ensuring medical readiness before deployment and by delivering preventive care in theaters. These efforts reduce the number of casualties from dental disease, lower the need for evacuation, and minimize lost duty time due to oral health issues.

1-4. While the majority of dental activities fall under FHP, some tasks contribute directly to HSS. Dental services provide emergency dental care, manage dental trauma, and support return-to-duty care functions that involve treatment and evacuation. These activities are considered part of HSS because they involve direct patient care, movement of patients, and medical regulation. When dental units perform these tasks in response to illness, injury, or battlefield trauma, they operate as part of the broader HSS framework to support operational effectiveness. *Health service support* is the support and services performed, provided, and arranged by the Army Medicine to promote, improve, conserve, or restore the behavioral and physical well-being of personnel by providing direct patient care that include medical treatment (organic and area support)

and hospitalization, medical evacuation to include medical regulating, and medical logistics to include blood management. (FM 4-02).

1-5. Dental care plays a critical role in sustaining the health and readiness of Soldiers. Oral health directly affects a Soldier's ability to perform their duties, especially in austere or combat environments. Operational dental planning focuses on maximizing return to duty (RTD) outcomes by preventing dental emergencies and ensuring that Soldiers receive treatment as far forward as possible.

1-6. Dental services include the personnel, equipment, training, policies, and planning required to deliver care across all phases of military operations. These services are integrated into the AHS at every echelon and contribute to both FHP and HSS. Comprehensive planning ensures that dental services coordinate with other medical functions, align with the operational plan, and meet the oral health needs of the force.

1-7. At the strategic level, dental leaders use trends in oral disease, non-battle injuries, and readiness indicators to inform resourcing and policy decisions. By identifying risk patterns early and allocating assets effectively, planners help protect the force from preventable dental problems. A well-integrated dental strategy ensures that care is available when and where it is needed, sustaining both health and combat effectiveness.

1-8. Dental services should be included early in the operational planning process. This includes not only the restoration and treatment of oral health conditions but also the proactive maintenance of dental readiness before deployment. Early integration helps reduce avoidable dental emergencies and ensures that dental issues do not interfere with mission execution. Whether focused on prevention or treatment, dental services are essential to preserving the fighting strength of the force.

SECTION II – STRUCTURE OF DENTAL SERVICES

1-9. Lessons learned and published literature show that even when dental readiness approach policy levels, actual treatment needs in theater often exceed the accepted risk. For example, although dental readiness levels reached nearly 95 percent in 2010, emergency dental care still accounted for more than 15 percent of reported cases during deployments. These emergencies are most common during early entry operations, when units are establishing initial positions and resources are limited.

1-10. Reviews of past deployments confirm that the longer Soldiers are deployed, the greater the risk of experiencing a dental emergency. In austere environments, Soldiers have fewer opportunities to maintain or improve their oral health, and access to comprehensive care is limited. These findings highlight the operational need for dental services to be organic to maneuver units. Having dental assets embedded ensures timely care, reduces the need for evacuation, and preserves combat effectiveness. The vignette on page 3, *The Impact of Dental Health on Combat Effectiveness*, illustrates how dental readiness influences mission success.

The Impact of Dental Health on Combat Effectiveness

Dental readiness and surveillance programs are essential for maintaining the oral health of military personnel and directly impacting operational effectiveness. Dental emergencies, which often require evacuation and treatment, are a persistent issue in deployed environments and can significantly impair a unit's combat readiness. Ensuring that dental teams are fit and ready to provide care in forward-deployed locations is critical. Historical examples from World War II, the Korean War, and the Vietnam War demonstrate the importance of dental health in military effectiveness, with significant dental emergencies disrupting Soldier readiness and incapacitating them for extended periods.

Dental health challenges were evident in both World War II and later conflicts. In the European Theater (1942-1943), over 650,000 patient encounters included 250,000 restorations and 62,000 extractions. By the end of WWII, the United States (U.S.) Army had completed 12.6 million restorations and 2.5 million extractions. During the Korean War, 15 percent of Soldiers in 1951 and 23 percent in 1952 were classified as Class III, requiring immediate dental treatment. In 1968, commanders in Vietnam reported that dental emergencies incapacitated Soldiers for up to seven days, impacting combat effectiveness. During Operation Desert Storm, 19 percent of Army Reserve and 27 percent of National Guard Soldiers were classified as Class III, requiring treatment before deployment.

Dental emergencies have remained a critical issue in recent deployments. In Bosnia, NATO-led Stabilization Force VIII saw a dental emergency rate of 170 per 1,000 Soldiers per year, with common issues like defective restorations and wisdom tooth problems. During Operation Iraqi Freedom, dental emergencies made up 19 percent of patient encounters, with many requiring restorations, extractions, and root canals. From 2001 to 2011 the Joint Trauma Registry showed that 42 percent of evacuations from Iraq and Afghanistan involved oral-maxillofacial injuries. From 2001 to 2014, the Department of Defense (DOD) Trauma Registry reported a total of 6,180 oral-maxillofacial injuries in Operation Enduring Freedom and Operation Iraqi Freedom, with the Army accounting for over 72 percent of these casualties. Dental emergencies also led to significant time loss, with evacuations and treatments averaging three days lost per Soldier, depending on treatment and evacuation logistics.

Dental readiness was notably lower in the Army Reserve and National Guard during both Operation Iraqi Freedom and Operation Enduring Freedom. In 2010, the Reserve experienced a dental emergency rate of 184 dental emergencies per 1,000 Soldiers, compared to 136 in the active-duty Army, highlighting the need for adequate dental care across all military components. Similarly, in 2013, French forces deployed to Mali saw 16 percent of medical evacuations due to dental emergencies, with Soldiers absent from units for an average of 10.5 days due to lack of dental support and long transport distances. These examples underline the ongoing impact of dental health on combat readiness and the need for effective dental care in all military branches.

In large scale combat operations, the dental health of the force will be just as relevant. To increase the rate of RTD, skilled dental providers must be appropriately collocated with medical assets and operational forces to reduce the need for evacuation in an environment where airspace and communications will be contested. Prior to mobilization and deployment, units should prioritize preventative, routine, and acute care to decrease the potential for emergency dental conditions and injury.

CATEGORIES OF DENTAL CARE

1-11. **Dental care is the preventive, restorative, and surgical treatment of the orofacial hard and soft tissues, which is comprised of comprehensive dental care and operational dental care.** Planning for dental services in military operations must consider both categories, especially in joint and multinational missions.

COMPREHENSIVE DENTAL CARE

1-12. **Comprehensive dental care is the dental treatment to restore or maintain a Soldier's optimal oral health, function, and aesthetics.** Comprehensive dental care is a holistic approach to oral health that includes a wide range of preventive, diagnostic, and therapeutic services. This type of care addresses both immediate dental concerns and long-term oral health goals, focusing on personalized treatment plans, thorough examinations, and ongoing care. By taking a multidisciplinary approach, comprehensive dental care ensures that individuals receive tailored support to achieve and maintain optimal oral health and overall, well-being.

1-13. This category of care represents the highest level of dental capability within the AHS, encompassing services such as preventive care, restorative treatments, cosmetic dentistry, oral pathology, and orthodontics. Typically provided at a Role 4 medical treatment facility (MTF), comprehensive dental care is reserved for medical support plans involving extended periods of reception and training in theater. While most comprehensive care is delivered in fixed facilities located outside of the theater—such as joint security or strategic support areas, within the theater it is limited to treatments that maximize FHP and RTD. This approach ensures that Soldiers receive complete, patient-centered care, even in a challenging operational environment (OE).

OPERATIONAL DENTAL CARE

1-14. **Operational dental care is the dental care provided for deployed Soldiers consisting of expeditionary dentistry, emergency dental care and essential dental care.** Operational dental care addresses the health threats of dental disease and non-battle injuries (DNBI) and dental trauma to RTD far forward to sustain the force. The Army places a high priority on ensuring Soldiers have access to quality dental care during peacetime and in OEs. Leaders should be aware of the specific considerations, challenges, and strategies involved in providing operational dental care for the Army and ensure that immediate dental support is provided at or near the point of need. To accomplish this, dental units must leverage mobility within the OE provide expeditionary dentistry to reduce the impact of dental DNBI and dental trauma casualties.

1-15. Operational dental care is designed to maximize and maintain dental readiness, minimize incidents of dental emergencies, and minimize evacuations needed. Operational dental care provides the capability to prevent or treat dental emergencies as far forward as possible. The treatment provided should maintain a patient's oral health to avoid retreatment during the deployment.

Expeditionary Dentistry

1-16. **Expeditionary dentistry is the provision of immediate and responsive dental care in a dynamic or developing operational environment.** This type of dental care is crucial in ensuring that Soldiers maintain optimal dental health during military operations, where access to dental facilities and resources may be limited. Expeditionary dentistry enables the Army to provide effective, mobile dental support in austere conditions, helping sustain dental readiness and keeping Soldiers in the fight without being sidelined by dental problems. This is the most austere form of dental care provided to deployed Soldiers who are engaged in tactical operations.

1-17. An example of expeditionary dentistry can be seen in United States military operations in remote regions like Africa. During these missions, Army dental teams are deployed alongside other medical units to support troops stationed in isolated bases with limited infrastructure. These teams use portable dental equipment to perform procedures such as emergency tooth extractions, treatment of dental infections, and preventive care like cleanings and cavity fillings.

1-18. During humanitarian and counter-terrorism missions in areas like Djibouti or Somalia, Army dentists set up mobile clinics in tents or other temporary structures. This allows them to deliver essential dental care while troops are engaged in tactical operations or providing support to local populations. These efforts not only enhance Soldier readiness but also demonstrate the versatility of expeditionary dentistry in addressing both military and humanitarian needs. This modern application of expeditionary dentistry continues the legacy established in historical operations, ensuring that dental health remains a priority even in the most challenging environments.

Emergency Dental Care

1-19. **Emergency dental care is the care given to relieve oral pain; diagnosis and treat infections; control of life-threatening oral conditions; and manage injuries to the teeth, jaws (maxilla/mandible), and associated facial structures.** Common examples of emergency dental treatments include:

- Airway management.
- Hemorrhage control.
- Stabilization of maxillofacial injuries (fracture stabilization, soft tissue injury/laceration repair).
- Non-restorable or symptomatic extractions.
- Management of maxillofacial infection (antibiotics, incision, and drainage).
- Interim pulp therapy.
- Pain medication.
- Temporary restorations.

Essential Dental Care

1-20. **Essential dental care is the treatment provided to prevent potential dental emergencies that could affect a Soldier's health or ability to perform duties.** The essential dental care performed may include:

- Simple extractions.
- Basic restorations.
- Definitive pulp therapy (pulpectomy, obturation).
- Treatment of periodontal conditions.
- Simple prosthetic repairs.

1-21. Essential dental care is the highest category of operational dental care available in a deployed environment. It 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 Class 2 (untreated oral disease) or Class 3 (potential dental emergencies) should receive essential care as soon as the tactical situation and availability of dental resources permit.

PREVENTIVE DENTISTRY

1-22. Preventive dentistry is essential for maintaining the dental readiness of Soldiers by promoting good oral health, overall wellness, and physical fitness. By focusing on prevention, Soldiers are less likely to develop tooth decay or other oral diseases that could affect their ability to perform during deployments. Key preventive measures such as professional dental cleanings (prophylaxis), fluoride treatments, and dental sealants help prevent tooth decay. Soldiers who practice good dental hygiene are less likely to experience dental problems while deployed, reducing the need for evacuation or treatment due to dental issues.

1-23. The goal of the Army Dental Readiness Program is to reduce oral disease and injury among Soldiers, ensuring they are ready for their assigned missions. This program uses evidence-based preventive techniques to minimize dental problems, including dental DNBI that could arise during deployments. By focusing on preventive care, the program helps keep Soldiers healthy and combat-ready, reducing the need for dental evacuations, and treatment during operations.

1-24. Community oral health protection programs aim to improve the general wellness and fitness of all authorized beneficiaries by optimizing their oral health. These programs include initiatives like water fluoridation in installation water systems, and school-based education programs that teach proper dental hygiene. By promoting better oral health in the community, these efforts help ensure that Soldiers and their families maintain strong dental health, contributing to overall well-being.

1-25. For more detailed information on dental services and related programs, refer to Department of Defense instruction (DODI) 1010.10, Army Regulation (AR) 40–3, AR 40–5, AR 40-35, and AR 600-63.

TYPES OF DENTAL CARE

1-26. Army dental care falls into three main groupings: comprehensive care, preventive care, and diagnostic support. Comprehensive care includes both general and specialty service that restore or maintain oral health. Table 1-1 outlines these groups and their subtypes, along with common examples and descriptions of each.

Table 1-1. Common types of dental care

Category or Type	Level	Description
Comprehensive Dental Care	Primary Category	Combines general and specialty dental care to restore and maintain full oral function. This care supports readiness by addressing both routine and complex dental needs.
General Dental Care	Subcategory of Comprehensive	Includes fillings, extractions, basic restorations, and some limited specialty care. General dentists trained through Army programs provide this level of care.
Specialty Dental Care	Subcategory of Comprehensive	Delivered by trained specialists or experienced general dentists. It covers advanced care in specific areas like root canals, gum treatment, dentures, and oral surgery.
Endodontic Care	Specialty	Treats diseases and injuries inside the tooth. Includes root canals, retreatments, and surgical procedures to save natural teeth.
Periodontal Care	Specialty	Focuses on gum health and the structures that support teeth. Includes deep cleanings, gum surgery, and bone support treatment.
Prosthodontic Care	Specialty	Restores missing teeth with dentures, bridges, or implants. Aims to improve function and appearance.
Oral Surgery	Specialty	Involves surgical treatment of the teeth, jaws, and soft tissues. Includes extractions, implants, jaw surgery, and treatment of oral injuries.
Oral Pathology	Specialty	Identifies and helps manage oral diseases such as cancer. Involves lab testing, diagnosis, and coordination with medical providers.
Orthodontics	Specialty	Aligns teeth and corrects bite problems. Includes braces and retainers. Typically provided at Role 4 facilities due to resource needs.
Preventive Dental Care	Primary Category	Focuses on preventing disease and keeping Soldiers healthy. It includes regular exams, cleanings, fluoride treatments, sealants, oral hygiene education, and nutrition counseling. This care helps reduce dental injuries and non-battle injuries (DNBI) during operations.
Diagnostic Dental Care	Supporting Function	Help identify dental problems and plan treatment. Includes exams, x-rays, cancer screenings, impressions, and dental imaging. Supports all types of care by guiding diagnosis and planning.

SECTION III – DENTAL READINESS

1-27. Individual Soldier readiness directly affects unit readiness and the ability to meet combatant commander requirements. Dental disease is one of the most common causes of DNBI, and Soldiers with uncorrected, severe dental deficiencies are at a higher risk of experiencing a dental emergency during the deployment. For more information on dental readiness see Chapter 1, Appendix A.

1-28. Soldiers are deployable unless they have a Service-determined reason that prevents them from deploying in accordance with DODI 1332.45. To be deployable, Soldiers must meet the criteria established in Army Directive 2018-22.

PREDEPLOYMENT PREPARATION

1-29. Dental services facilitate FHP by maximizing pre-deployment dental readiness. Maximizing and maintaining dental readiness reduces lost duty time, minimizes medical evacuation (MEDEVAC), and reduces the requirement for resources to provide HSS during operations. Soldiers must undergo oral examinations to identify any oral health threats. A dental team conducts a dental exam. This exam includes an inspection inside and outside the mouth. It may also involve taking x-rays and asking other health questions. These examinations diagnose dental diseases and conditions, assess dental readiness, identify treatment needs, and provide dental health surveillance information to inform Commanders on the dental readiness of the Soldier and organization. Oral examinations are conducted at the Soldier's—

- Advanced Individual Training to identify and assess dental health, determine dental readiness and inform dental healthcare requirements for Soldiers prior to assignment at their first unit. The First Term Dental Readiness program provides examination and, if needed, dental treatment requirements to achieve 95 percent dental readiness for Soldiers at graduation.
- Duty station through comprehensive or periodic oral examinations as a health surveillance function for dental healthcare planning and Commander's medical readiness assessments. U.S. Army Medical Command monitors monthly dental readiness of the force as a component of medical readiness.
- Remote location through the Reserve Health Readiness Program or at Defense Health Agency (DHA) dental treatment facilities. Dental readiness assessments are conducted by civilian providers and documented on DD Form 2813 (*Department of Defense Active Duty/Reserve/Guard/Civilian Forces Dental Examination*).
- Soldier Readiness Processing site and validates that the Soldier has completed the required dental readiness assessment. Dental readiness validation occurs at Mobilization Force Generating Installations. Dental care is not programmed into this process. Units and Soldiers must arrive with all necessary dental care completed prior to soldier readiness processing.

1-30. Pre-deployment dental care includes two main types: preventive dentistry and comprehensive dental care. These types of care are scheduled ahead of time to help improve dental readiness prior to deployment. DODI 6025.19 reaffirms the military health system's goal of 90 percent fully or partially medically ready. To meet this goal, service members must be in Dental Readiness Class 1, 2, or 4. Personnel in Class 3 are considered not mission-ready, as they have an existing dental condition that is likely to cause an emergency. Reaching this goal can be difficult, but it highlights the importance of oral health for a ready force and health affairs' commitment to its pursuit. For additional information on the dental readiness class see paragraph 1-32.

Note. All dental readiness classifications can be made deployable by the commander.

1-31. Dental Readiness information is captured by the electronic health record. The electronic health record transfers data to the readiness system of records. Refer to AR 40-502 and Department of the Army Pamphlet (DA PAM) 40-502 for additional information.

This section is in consensus with STANAG 2466

DENTAL READINESS CLASSIFICATION SYSTEM

1-32. A dental readiness classification is assigned to every Soldier based on the results of a thorough dental examination. The classification is a dentist's best judgment of the state of a Soldier's oral health and is used to determine the likelihood that a patient will experience a dental emergency during a deployment. For more information on dental classification criteria refer to AR 40-3 and Health Affairs Policy 02-011.

1-33. The dental readiness classification system is a standardized system used by the Military Health System to assess and classify the oral health and dental readiness of Soldiers. It helps determine the dental treatment needs of individuals and ensures that Soldiers are fit for deployment and can perform their duties without oral health-related limitations. The dental readiness classification system consists of several categories that reflect different levels of dental health and treatment requirements. The specific classification system may

vary slightly between different branches of the military, but the general principles remain similar. The following is an overview of the dental readiness classification system commonly used in the Army.

1-34. The dental readiness classification system is a comprehensive evaluation process that helps Army dental professionals and commanders assess Soldiers' dental health status, prioritize treatment needs, and allocate appropriate resources for dental care. By identifying dental conditions and providing treatment plans, the system enhances Soldiers' dental fitness and overall well-being and contributes to mission readiness. The following classifications—Class 1 through Class 4—describe the dental health categories used to determine a Soldier's readiness.

CLASS 1- NO DENTAL TREATMENT NEEDED.

1-35. Soldiers in Class 1 have undergone an annual dental examination or comprehensive dental examination, and they have no outstanding dental treatment needs. Their oral health status is within normal limits. These Soldiers are considered fully dental ready and can perform their duties without dental-related restrictions. Soldiers in Class 1 are worldwide deployable.

CLASS 2 – DENTAL TREATMENT NEEDED

1-36. Soldiers in Class 2 have identified dental treatment needs that require intervention but do not pose an immediate threat to their health or operational readiness within 12 months. They may require non-urgent dental procedures such as restorative work (fillings), periodontal care, prosthodontics, or preventive treatments. Soldiers are usually deployable but may need dental treatment before deployment.

CLASS 3 – DENTAL TREATMENT URGENTLY NEEDED

1-37. Soldiers in Class 3 have dental conditions that need urgent attention. These issues can affect their ability to perform duties and threaten their overall oral health. Common examples include severe toothaches, infections, and abscesses. Because of the seriousness of their dental problems, these Soldiers are not medically ready for deployment. Their conditions often require complex procedures and extensive restorative work. They must receive timely dental treatment to restore their oral health and reach an acceptable level of readiness. Soldiers in Class 3 are generally not considered worldwide deployable until their dental conditions are addressed. If left untreated, these conditions may result in a dental emergency within the next 12 months, which could lead to complications during deployment. Therefore, it is crucial to resolve these dental issues promptly to ensure Soldiers can deploy and perform their duties without interruption.

CLASS 4 – DENTAL EXAMINATION REQUIRED

1-38. Soldiers are placed in Dental Class 4 when they have not completed their required annual (every 12 months) dental examination or when their dental classification is unknown. This also includes Soldiers who are missing a digital panoramic image in their electronic health record. Class 4 status shows that a Soldier's dental readiness cannot be verified. For additional information on the specific requirements for dental examinations and classifications, refer to AR 40-3, AR 40-501, Health Affairs Policy 98-021, and Health Affairs Policy 07-017.

1-39. Soldiers in Class 4 are generally not considered deployable worldwide. Until they complete the exam needed and their classification is updated, their readiness status may limit their ability to support missions.

DENTAL HEALTHCARE DELIVERY

1-40. The U.S. Army Medical Command provides personnel to staff Army dental units and dental treatment facilities. These facilities support Soldier readiness and training by delivering timely dental care. The DHA holds authority, direction, and control over these facilities and ensures they meet operational and healthcare needs. By offering essential dental treatment, these facilities help maintain oral health and support the Army's overall mission.

1-41. The DHA also expands access to care through contracted dental programs. The Active-Duty Dental Program and dental insurance contracts allow Soldiers to receive treatment from civilian dentists. For Army National Guard and Army Reserves Soldiers, the Reserve Health Readiness Program helps them complete exams and treatments needed to stay ready for deployment or activation.

POST-DEPLOYMENT DENTAL CARE AND REHABILITATION

1-42. After deployment, many Soldiers need follow-up dental care to address any dental issues that may have developed during their deployment and are not addressed in theater. Post-deployment dental examinations are conducted to identify and treat these issues early. This care supports long-term oral health and helps Soldiers stay ready for continued service.

1-43. Dental professionals provide treatments like fillings, root canals, or dental prosthetics to restore function and relieve pain. These efforts help Soldiers return to full duty with optimal oral health and support their ability to complete future assignments or missions without dental interruptions.

The following topic implements STANAG 2122 and in consonance with STANAG 2598

SECTION IV – TRAINING AND MULTINATIONAL READINESS OF DENTAL PERSONNEL

1-44. Dental services contribute not only to operational patient care, but also to the readiness and professional development of dental personnel. The U.S. Army Transformation and Training Command develops, maintains, and executes training programs that prepare dental officers and enlisted Soldiers to support missions in garrison and deployed environments. Training emphasizes clinical proficiency, survivability, and integration with broader HSS activities.

1-45. Dental treatment facilities serve as both health readiness platforms and training centers. They provide a controlled environment where dental teams conduct hands-on training to reinforce operational and clinical tasks. Training is guided by Individual Critical Task Lists and directed under Army Directive 2021-08. These standards ensure that dental personnel remain ready to deploy and contribute effectively to operational health support.

1-46. In alignment with STANAG 2122, all military personnel, including dental personnel, must be trained in basic life-saving procedures and FHP. The ability to perform initial hemorrhage control, and airway management, significantly improves survival rates in combat. Additionally, implementing basic hygiene measures, including dental hygiene practices, reduces the spread of disease in austere environments. Tactical Combat Casualty Care training, Combat Lifesaver, and field sanitation instruction should be conducted prior to deployment and refreshed regularly, as outlined in Training Circulars (TC) 4-02.3.

1-47. For those participating in multinational operations, STANAG 2598 serves as the baseline for standardized pre-deployment training. Dental personnel assigned to joint and combined medical task organizations must complete training modules that include tactical trauma care, multinational relations, medical ethics, stress management, and mission-oriented readiness. Language proficiency, environmental risk awareness, and interoperability in disaster relief and casualty evacuation are essential components of NATO-aligned readiness.

1-48. These standardized training programs, coordinated through the NATO Centre of Excellence for Military Medicine and Allied Command Transformation, ensure that dental personnel can operate effectively alongside allied and partner nation forces. Whether contributing to dental care delivery, supporting trauma teams, or assisting in public health missions, dental professionals must meet internationally accepted standards to ensure mission success and preserve multinational trust.

SECTION V – DENTAL PRIMARY TASKS AND PURPOSES

1-49. The task and purpose of dental services cover a wide range of responsibilities, from preventive care to specialized treatments, all with the aim of achieving and maintaining optimal oral health for patients. Dental professionals diligently diagnose and treat dental conditions, educate patients on oral hygiene practices, and support the overall healthcare team. Table 1-2 discusses the primary tasks and purposes of dental services.

Table 1-2. Primary tasks and purposes of dental services

Tasks	Purpose
Conduct oral examinations	• Diagnose oral disease or conditions and determine Soldier dental health.
Conduct dental health surveillance	• Monitor dental readiness, identify health risks, and inform commanders to plan preventive and corrective actions.
Provide preventive dentistry	• Deliver oral hygiene training and preventive care to reduce disease and preserve dental readiness.
Provide expeditionary dentistry	• Deliver mobile, effective dental services in austere settings to maintain oral health and readiness.
Provide operational dental care	• Deliver dental care near the point of need (Such as Role 2), including exams, extractions, and urgent treatment.
Perform emergency dental care	• Relieve pain, treat infection or trauma, and stabilize oral injuries affecting mission performance.
Perform essential dental care	• Provide dental interventions to prevent lost duty time and preserve combat effectiveness.
Provide comprehensive dental care	• Restore or maintain optimal oral function, health, and aesthetics.
Triage of combat casualties	• Augments medical teams during mass casualty incidents to manage dental injuries.
Assist with dental treatment for military working dogs	• Support veterinary teams by delivering emergency and routine dental care to military working dogs.
Perform forensics dentistry	• Identify remains through post-mortem dental analysis.

Chapter 2

Dental Services Support to Army Operations

The success of military operations relies on the readiness and resilience of the force, and dental services are essential in maintaining that capability. This chapter explores the principles of dental support in operations and discusses the specific considerations for effectively using dental resources in different operational environments. By understanding the commander's goals and key tasks, dental leaders can align their services with mission needs, ensuring that Soldiers remain healthy and ready for action in constantly changing and often difficult conditions.

The following sections focus on the role of dental support during offensive, defensive, stability operations and defense, of civil authorities. Each type of operation presents unique challenges and requires careful planning to incorporate dental services into the overall mission. Whether responding to mass casualty (MASCAL) situations, adjusting to environmental conditions, or coordinating with local healthcare systems, dental leaders must be adaptable and resourceful. With proper planning and execution, dental services can improve the overall health and effectiveness of the force, playing a key role in achieving mission success in all types of operations.

SECTION I – OVERVIEW OF DENTAL SERVICE SUPPORT TO ARMY OPERATIONS

2-1. The Army's primary mission is to organize, train, and equip its forces to conduct prompt and sustained land combat to defeat enemy ground forces and seize, occupy, and defend land areas. It supports four strategic roles for the joint force. Army forces shape operational environments, counter aggression during crisis, prevail during large-scale ground combat, and consolidate gains. The Army accomplishes its strategic roles by providing forces for joint campaigns that enable integrated deterrence of adversaries outside of conflict and the defeat of enemies during conflict or war.

2-2. The dental service's medical function supports the Army's primary mission by synchronizing and coordinating Army dental services across all echelons, as well as integrating with joint services. This support conserves fighting strength and avoids the loss of trained manpower due to dental disease or injury.

2-3. *Multidomain operations* are the combined arms employment of joint and Army capabilities to create and exploit relative advantages to achieve objectives, defeat enemy forces, and consolidate gains on behalf of joint force commanders (ADP 3-0). Multidomain operations is the Army's operational concept. The Army is capable of supporting operations across the spectrum of violence across the operational categories—from large-scale combat operations, limited contingency operations, crisis response, and support to security cooperation. The Army dental service medical function enables multidomain operations through the preservation, restoration and sustainment of oral health and function by providing emergency and essential dental care and assisting in the emergency medical management of combat casualties that support maneuver forces at echelon. For additional information on the strategic context, tenets, and imperatives, refer to FM 3-0.

2-4. Figure 2-1 on page 12 depicts operational medicine's contribution to multidomain operations. It shows where the AHS, operational medicine capabilities and the medical functions support the OE within each domain. All ten medical functions are performed within multidomain operations. The land, maritime, air, and space domains are defined by their physical characteristics. Cyberspace, a manmade network of networks, transits and connects the other domains as represented by the dots. For more information on the ten medical functions refer to FM 4-02.

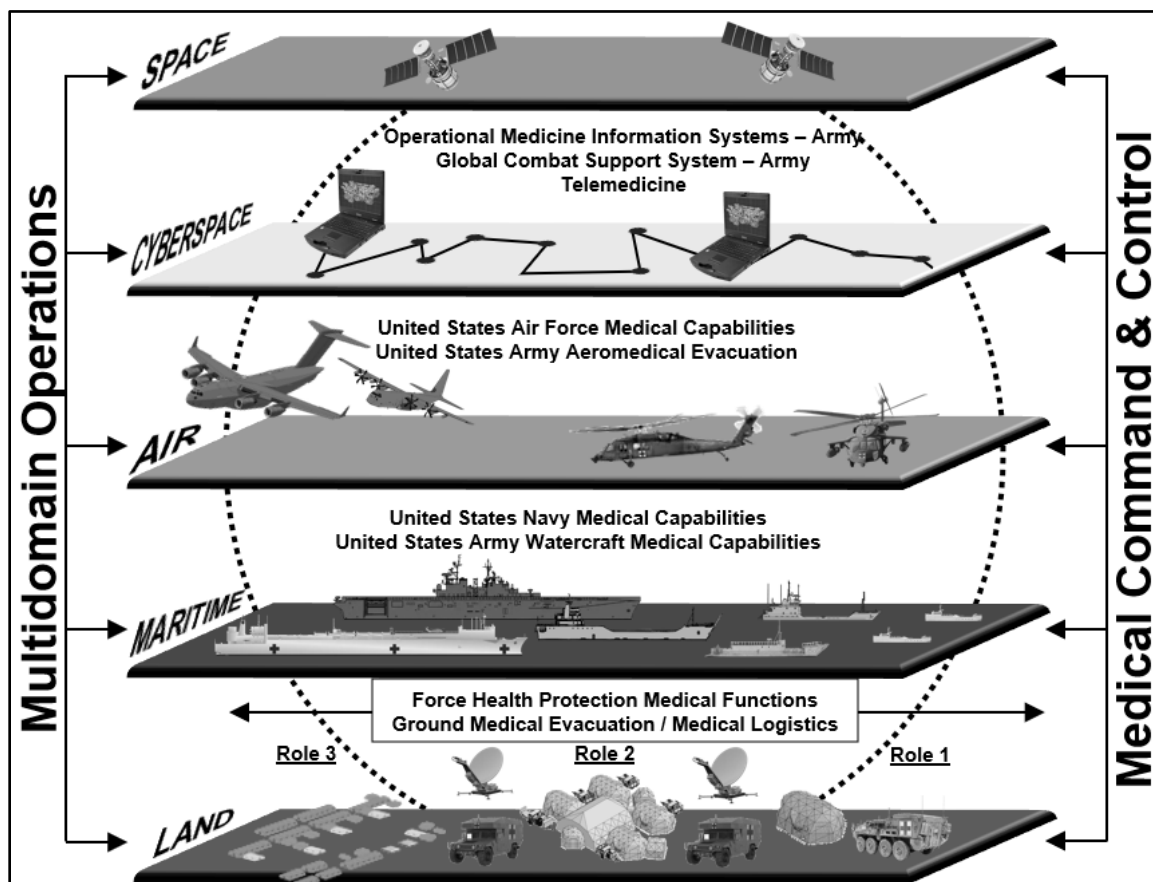


Figure 2-1. Medical functions in support of multidomain operations

DENTAL SUPPORT TO THE ARMY STRATEGIC CONTEXTS

2-5. Army dental capabilities support multidomain operations across the competition continuum. Dental readiness helps preserve the fighting force, reduce noncombat losses, and maintain operational momentum. Army dental services must be prepared to support operations in any strategic context—competition, crisis, or armed conflict—at any echelon and in any theater.

2-6. Army doctrine uses three strategic contexts to describe the environment in which Army forces operate: competition below armed conflict, crisis, and armed conflict. While these contexts may overlap, Army tactical formations typically operate in one context at a time. Dental forces must remain flexible to shift support across contexts as the situation changes. Dental planners adjust operations based on theater requirements, force structure, and population at risk. Figure 2-2 on page 13 shows how Army strategic contexts aligns with operational categories.

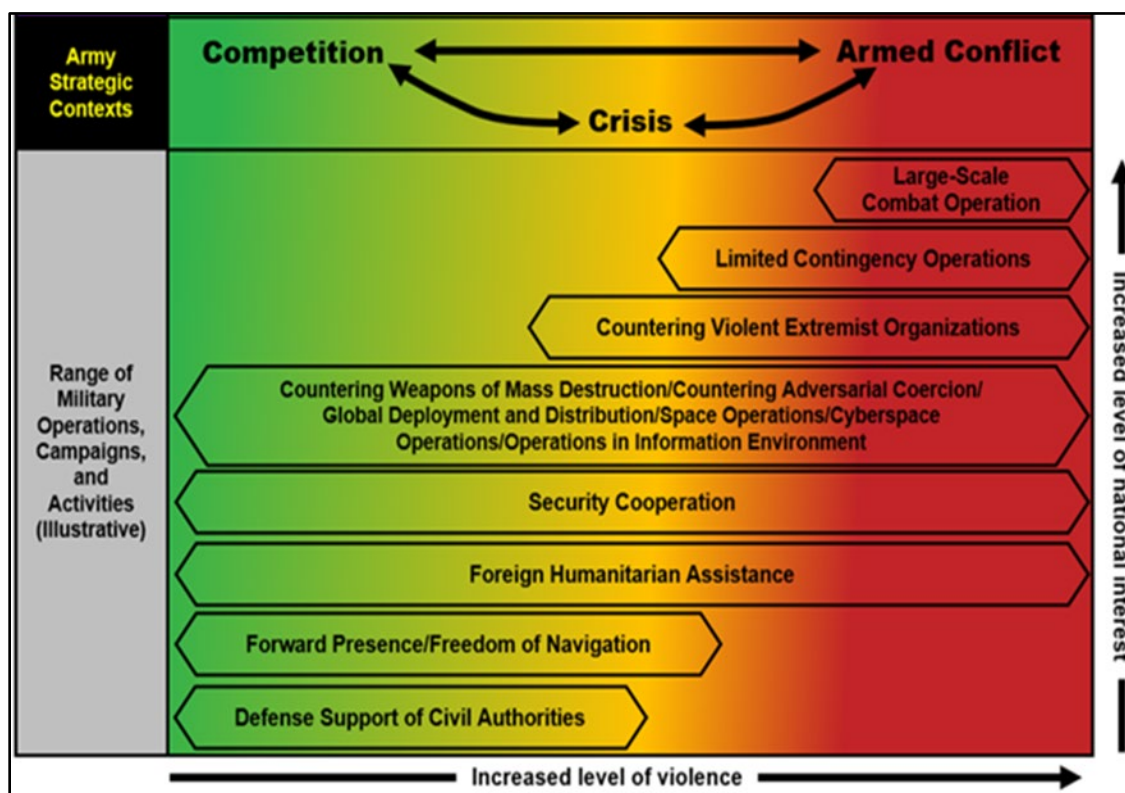


Figure 2-2. The Army strategic contexts and operational categories

2-7. Dental support requirements vary by context. During competition, the focus is on preventive and emergency care to maintain readiness and ensure medical deployability. In crisis, dental services support expeditionary operations, often under austere conditions, and in direct coordination with maneuver forces. In armed conflict, dental personnel may augment medical units during MASCAL events, while continuing to provide essential care and specialty support.

2-8. Dental support also contributes to strategic shaping activities such as security cooperation, multinational exercises, and humanitarian operations. These efforts build partner capacity, support civil-military engagement, and improve interoperability. U.S. dental assets may work with allied and host-nation partners during all phases of operations.

2-9. Dental teams must be trained, equipped, and organized to support operations at all echelons. At the tactical level, dental assets are embedded in a brigade support medical company (BSMC) to deliver emergency and preventive care. At the operational level, the dental company (area support) (DCAS) provides scalable support for corps and division formations. At the strategic level, theater medical commands (TMCs) and medical brigades (MEDBDEs) coordinate employment, readiness, and resourcing of dental forces.

2-10. Chapter 1, Appendix B provides detailed guidance on how dental services are employed at echelon within each strategic context. It outlines the key tasks, support relationships, and considerations for planners. The appendix builds upon this chapter's overview and reflects how Army dental capabilities enable FHP and mission success across the range of military operations.

APPLICATION OF THE TENETS OF ARMY OPERATIONS TO DENTAL SERVICE OPERATIONS

2-11. The tenets of Army operations— agility, convergence, endurance, and depth are essential attributes that shape how operations are planned and executed. Dental services apply these tenets to their own operations to remain responsive, resilient, and mission focused. By using the tenets to guide planning, dental

leaders improve their ability to position resources, adapt to changing conditions, and provide timely support across the operational framework.

AGILITY

2-12. *Agility* is the ability to move forces and adjust their dispositions and activities more rapidly than the enemy (ADP 3-0). Agility allows commanders to seize the initiative, respond to changing conditions, and remain unpredictable in the eyes of the enemy. Agility is tied to the mobility AHS principle.

2-13. Dental services apply agility by adapting quickly to changing operational conditions, especially during large-scale combat operations. Dental units train to rapidly set up, break down, and relocate treatment facilities, including tents, equipment, and mobile shelters. These actions help maintain continuity of care and support dispersed operations. Dental leaders plan and task organize so that teams can adjust priorities, change locations, or reassign capabilities as the mission evolves. Practicing these tasks under field conditions builds confidence and enables dental teams to stay close to supported units across all phases of the operation.

CONVERGENCE

2-14. *Convergence* is an outcome created by the concerted employment of capabilities against combinations of decisive points in any domain to create effects against a system, formation, or decision maker, or in a specific geographic area (ADP 3-0). Convergence balances the principles of mass, objective, and economy of force by combining actions across domains for maximum cumulative effect.

2-15. Dental services apply convergence by integrating specialties such as oral surgery, periodontics, and prosthodontics across echelons and operational areas. This integration allows dental leaders to deliver the right care at the right place and time, supporting decisive points, and maintaining combat power. By preventing and treating dental non-battle injuries, dental teams help keep Soldiers in the fight. This gives commanders the ready forces they need to apply combat power where it matters most. In joint and multinational environments, dental planners work with partner nations to coordinate resources, reduce redundancy, and improve access to care. These actions support convergence by ensuring the force remains healthy, mobile, and able to operate across domains.

ENDURANCE

2-16. *Endurance* is the ability to persevere over time throughout the depth of an operational environment (ADP 3-0). It reflects the capacity to apply combat power for extended periods, even under difficult conditions such as degraded communications, chemical, biological, radiological, and nuclear (CBRN) threats, and high casualty rates.

2-17. Dental services contribute to endurance by maintaining Soldier readiness and reducing the risk of dental emergencies. By treating dental conditions early and promoting preventive care, dental teams help keep personnel healthy and mission-capable throughout long operations. Soldiers with good oral health are less likely to become non-deployable or require evacuation for dental reasons. Dental services also support resilience by helping Soldiers recover from injuries more quickly and continue operating under stress. Through sustained care delivery, dental units support the force's ability to maintain tempo across all phases of conflict.

DEPTH

2-18. *Depth* is the extension of operations in time, space, or purpose to achieve definitive results (ADP 3-0). Commanders create depth by understanding enemy strengths and weaknesses and applying pressure in both simultaneous and sequential actions.

2-19. Dental services apply depth through force structure and the continuum of care. The Army positions organic dental teams with special forces groups, civil affairs units, brigade combat teams (BCTs), multidomain task forces, hospital centers, and medical augmentation detachments. When required, the DCAS can deploy forward teams, sections, or the full unit based on mission needs. Dental capabilities also follow the continuum of care, from point of injury through Role 1 to Role 3 and beyond, to provide consistent support across time, space, and operational purpose.

2-20. This layered approach gives commanders flexibility while ensuring dental readiness across the force. By preventing minor issues from becoming major problems, dental services preserve combat power over the long term. Dental care complements broader medical operations by reinforcing the depth of health services available to Soldiers in diverse environments. Through deliberate planning and forward positioning, dental services strengthen the Army's ability to operate in depth and sustain operations to their intended conclusion.

APPLICATION OF THE ARMY IMPERATIVES TO DENTAL SERVICES OPERATIONS

2-21. Army imperatives are actions that units take to defeat enemy forces and achieve objectives at acceptable cost. These imperatives are shaped by the operational environment and the capabilities of the most dangerous threats the Army may face. The Army imperatives include—

- See yourself, see the enemy, and understand the operational environment.
- Protect against constant observation and all forms of enemy contact.
- Own the electromagnetic spectrum.
- Create and exploit relative physical, information, and human advantages.
- Make initial contact with sensors, unmanned systems, or the smallest element possible.
- Impose multiple dilemmas on the enemy.
- Anticipate, plan, and execute transitions.
- Designate, weight, and sustain the main effort.
- Consolidate gains continuously.
- Understand and manage the effects of operations on units and Soldiers.

2-22. Dental services apply the Army imperatives by aligning their operations with the challenges and demands of the battlefield. Dental leaders use the imperatives to assess how their units deliver care, maintain readiness, and support the force under combat conditions. For example, dental planners contribute to situational understanding by tracking the dental status of supported units and monitoring operational environments for threats that could impact care delivery. They train and operate with the expectation of enemy observation, maintain communication discipline, and support electromagnetic emission control measures. Dental teams exploit human advantages by preserving Soldier health, which improves decision-making and resilience at all levels.

2-23. Dental operations are also shaped by transitions between roles of care, phases of operations, and shifts in support priorities. Dental leaders plan for these changes to ensure continuity of care. During consolidation of gains, dental teams maintain readiness and provide essential care to stabilize the force. Finally, by managing the physical and psychological effects of operations on Soldiers, especially through pain relief and preventive services, dental personnel support long-term readiness and reinforce the Army's ability to sustain operations. Table 2-1 on pages 16 through 18 lists the Army imperatives and includes how each applies to the dental medical function.

Table 2-1. Application of Army Imperatives by dental services

<i>Imperatives</i>	<i>Dental Services Application</i>
See yourself, see the enemy, and understand the operational environment	Dental leaders assess their unit's capabilities, resource status, and readiness while identifying threats that could disrupt dental operations. • Evaluate dental unit readiness, equipment status, and Class VIII availability. • Conduct dental surveillance to assess oral health threats and potential emergency risks. • Analyze climate, terrain, and elevation impacts on dental operations. • Adjust plans based on updated casualty estimates and enemy actions. • Use terrain, protection, and dispersion to reduce vulnerability.
Protect against constant observation and all forms of enemy contact	Dental units operate with the understanding that they are observable and targetable by enemy sensors or fires. • Select treatment locations with cover, concealment, and defensible approaches. • Train for operations under direct, indirect, and cyber threat conditions. • Reduce electromagnetic signature through comms discipline and alternate transmission methods. • Maintain redundant analog systems for continuity when digital systems fail. • Enforce information discipline, including on social media and public messaging.

Table 2-1. Application of Army Imperatives by dental services (continued)

<i>Imperatives</i>	<i>Dental Services Application</i>
Own the electromagnetic spectrum	Dental leaders reduce electromagnetic signatures to avoid detection while sustaining secure communications. • Set dental equipment to the lowest effective power settings. • Use burst transmissions and minimize radio usage. • Reposition mobile command posts and dental assets to reduce predictability. • Coordinate with signal units to support spectrum management and interference mitigation.
Create and exploit relative physical, information, and human advantages	Dental services enhance operational advantage by maintaining force health and exploiting medical intelligence. • Track oral health trends and anticipate disease and nonbattle injury risks through surveillance. • Align treatment and evacuation to support the commander's decision cycle. • Develop predictive dental capabilities and support medical readiness assessments. • Invest in medical technologies that improve access, diagnosis, and care delivery.
Make initial contact with sensors, unmanned systems, or the smallest element possible	Dental leaders use small, mobile teams to preserve survivability and maintain proximity to supported forces. • Deploy minimal dental teams forward to reduce exposure and increase mobility. • Support early-entry forces with scalable emergency care capabilities. • Plan for emergency Class VIII support in austere environments. • Remain flexible to support detainee and displaced personnel if required.
Impose multiple dilemmas on the enemy	Dental services maintain Soldier readiness, reducing medical-related vulnerabilities that the enemy could exploit. • Return Soldiers to duty quickly, minimizing evacuation burden. • Prevent disease-related degradation through hygiene and early treatment. • Provide care forward to extend operational reach and support dispersed operations. • Harden dental sites against disruption through integrated security and mobility.
Anticipate, plan, and execute transitions	Dental leaders prepare to support operational shifts, changes in mission phase, or evolving casualty flows. • Align capabilities with changes in tempo, force posture, or geography. • Maintain the continuum of care across mobilization, deployment, and redeployment. • Plan for transitions involving boundary crossings or shifts in supported units. • Reassign or reconstitute units as needed to maintain momentum.

Table 2-1. Application of Army Imperatives by dental services (continued)

<i>Imperatives</i>	<i>Dental Services Application</i>
Designate, weight, and sustain the main effort	Dental planners allocate resources based on priority of effort and mission phase. • Position dental assets in support of the main effort across echelons. • Shift capabilities as needed to reinforce critical operations. • Provide emergency Class VIII support to sustain operations. • Emphasize return-to-duty care over non-urgent procedures during high-intensity phases.
Consolidate gains continuously	Dental services help sustain control and stability during transitions between combat and post-conflict phases. • Plan for dental support during stabilization, security, and civil support tasks. • Coordinate with host nation and unified action partners to support the population. • Rebuild or reinforce capabilities through reconstitution of staff and supplies. • Identify requirements to support dental care in occupied or transitioned areas.
Understand and manage the effects of operations on units and Soldiers	Dental personnel support force health, morale, and resilience through continuous care and internal unit monitoring. • Monitor and manage the psychological and physical stress of dental personnel. • Rotate workloads and allow for rest when possible. • Maintain clean, safe treatment areas to prevent illness. • Offer morale and wellness support to both patients and staff. • Conduct behavioral health checks on dental teams in prolonged operations.

THREATS

2-24. A *threat* is any combination of actors, entities, or forces that have the capability and intent to harm United States forces, United States national interests, or the homeland (ADP 3-0). Army forces encounter threats that are typically hybrid in nature. These threats can include individuals, groups, paramilitary or military forces, criminal organizations, nation-states, or alliances. Generally, threats are classified as either enemies or adversaries. For more information about enemies and adversaries refer to ADP 3-0.

2-25. Threats can influence plans and ongoing operations within the operational environment. During operations, commanders and their staff use integrated information collection to evaluate the situation and make adjustments. These adjustments might include shifting priorities, reorganizing tasks, or requesting additional capabilities. Such actions aim to create advantages, extend operational reach, preserve combat power, and achieve mission objectives.

2-26. Dental leaders should view threats from the perspective of health threats and enemy threats. Although operational medicine's primary concern is that of the health threat, the enemy threat should also be fully considered as it influences the—

- Character, types, and severity of wounds and injuries to which our forces may be exposed.
- Enemy's ability and willingness to disrupt AHS operations and to respect the conditions of the Geneva Conventions regarding the protection of dental personnel while engaged in their humanitarian mission.

ORAL HEALTH THREAT

2-27. A Soldier's oral health can be affected by a range of issues, including facial injuries and various oral conditions. These conditions may include dental cavities, complications with tooth roots, gum infections, swelling around partially erupted teeth, and diseases affecting the gums or surrounding bone. Factors like fatigue, poor nutrition, high sugar intake, inadequate oral hygiene, and physical or mental stress can make these issues worse. Additionally, the breakage or loss of dental prosthetics can lead to pain and discomfort, which may reduce a Soldier's ability to stay focused and effective.

2-28. Injuries to the mouth and jaw, known as oral and maxillofacial injuries, can occur during both combat and non-combat situations. If not properly treated, these injuries may result in severe and potentially life-threatening complications.

ENEMY THREAT

2-29. Warfare has evolved significantly from World War II to recent conflicts in Iraq and Afghanistan. During World War II, combat was highly lethal, and every domain was contested. In contrast, recent conflicts have been lower intensity, with U.S. forces benefiting from air and maritime superiority that allowed freedom of movement. The growing use of drones and other emerging technologies presents a constant threat of surveillance and attack. Dental units need to maintain vigilance by managing noise, light, sound, and electronic signatures to reduce detection. While dispersing operations can provide some protection, dental units are not designed to maintain dispersion without losing effectiveness. Instead, they should explore alternative methods of cover and concealment.

2-30. The threats to dental units vary depending on the intensity and location of a conflict. In a European conflict, operations are likely to involve large, contiguous battle areas with massed artillery and contested airspace. In contrast, conflicts in the Indo-Pacific region may be non-contiguous, requiring dental units to adapt to extended lines of communication and develop flexible solutions for operations. A maritime conflict, likely led by the United States Navy, would demand greater integration of joint capabilities to support Army dental services. Intratheater aeromedical evacuation might be limited, forcing dental units to manage patients during delayed evacuation operations until they can be moved farther from enemy areas.

2-31. Dental units operating in a theater of operations face a range of threats, including:

- Drones or unmanned vehicles.
- Artillery.
- Armored combat vehicles.
- Fixed- and rotary-wing aircraft.
- CBRN.
- Anti-ship missiles.
- Cyber threats.
- Irregular warfare.

2-32. Long-range fire systems, such as tube artillery and multiple rocket launchers, pose significant risks to dental units at the division, corps, and theater levels. These threats may result in dental units being directly targeted or affected by proximity to high-value assets. Drones further increase the risk by enabling observation and attack, potentially targeting command posts or sustainment assets near dental units. To mitigate these risks, dental units should maintain a primary, alternate, contingency, and emergency (also known as PACE) communication plan. This redundancy ensures reliable communication and data management, including analog systems, which have minimal or no electromagnetic signatures and can be used when electronic systems are disrupted by enemy action.

SECTION II – DENTAL SERVICES SUPPORT TO DEFENSIVE, OFFENSIVE, AND STABILITY OPERATIONS

2-33. Dental services support Army operations across the full spectrum of large-scale combat operations. These include defensive, offensive, stability, and defense support of civil authorities (DSCA) missions. Dental units help maintain Soldier readiness by delivering preventive, emergency, and deployment-related care during complex missions such as reconstitution, CBRN response, urban and subterranean operations,

MASCAL events, prolonged care scenarios, and detainee operations. This section highlights the role of dental personnel in sustaining the force and supporting commanders across the operational environment. For additional detail on operational context, refer to ADP 3-0, ADP 3-90, ATP 3-91, ATP 3-92, ATP 3-93, FM 3-0, FM 3-94, and other applicable OE or operational 3-series publications.

DENTAL SUPPORT TO DEFENSIVE OPERATIONS

2-34. A *defensive operation* is an operation to defeat an enemy attack, gain time, and develop conditions favorable for offensive or stability operations (ADP 3-0). These operations include area defense, mobile defense, and retrograde. Although the defense is not typically decisive on its own, it creates the opportunity to regain the initiative. For detailed discussion of the defensive, refer to ADP 3-90.

2-35. Dental services are essential to maintaining combat effectiveness during defensive operations. When positioned forward and properly integrated, dental teams reduce the number of Soldiers evacuated for treatable dental conditions. By preserving the health of the force and enabling Soldiers to RTD quickly, dental services directly support the commander's ability to sustain combat power under pressure.

2-36. Dental units should be placed in locations that support the defensive scheme of maneuver and ensure access to care without exposing personnel or equipment to unnecessary risk. This often means collocating with Role 2 medical elements in brigade support areas or maintaining mobile dental teams that can reposition as the tactical situation evolves. Integration with Role 1 and Role 2 providers ensures a seamless flow of patients and supports triage and stabilization efforts.

2-37. Planning for dental support in the defense should be included in the unit's tactical standard operating procedures (TACSOPs) and operations orders. Dental leaders must consider mission duration, expected casualty rates, evacuation routes, and resupply timelines. This includes planning for mobility, power, equipment maintenance, and survivability measures such as dispersion or camouflage, especially when operating in contested areas. Refer to ATP 3-37.34 for more information on survivability measures.

2-38. Dental services must also be ready to augment MASCAL response, particularly during enemy attacks involving CBRN incidents. In these cases, dental personnel may assist with triage, treatment of maxillofacial injuries, and stabilization of casualties prior to evacuation. Their role should be clearly defined in rehearsals and operational plans.

2-39. Dental support enhances unit resilience during defensive operations by reducing non-battle injuries, enabling RTD, and reinforcing medical capacity. When fully integrated into planning and execution, dental teams contribute to preserving combat power across the depth and duration of the defense.

DENTAL SUPPORT TO OFFENSIVE OPERATIONS

2-40. An *offensive operation* is an operation to defeat or destroy enemy forces and gain control of terrain, resources, and population centers (ADP 3-0). They are the primary means by which commanders impose their will and regain the initiative. Offenses rely on speed, surprise, and aggressive action to disrupt and dislocate enemy forces. For a complete discussion of the offense and its types, refer to ADP 3-0 and ADP 3-90.

2-41. Dental services play a critical role in maintaining the combat power required for sustained offensive action. The physical intensity, pace, and unpredictability of offensive operations increase the risk of dental injuries and oral health issues that can remove Soldiers from the fight. By providing emergency and essential dental care forward in the operational environment, dental teams help return Soldiers to duty quickly and reduce unnecessary MEDEVAC.

2-42. To support maneuver effectively, dental units must be positioned to align with the commander's phasing and task organization. This includes providing coverage during movement to contact, attacks, and exploitation phases, as well as during consolidation and transitions. Mobile dental teams or forward treatment sections may be attached to brigade or division support areas to ensure care is available without delaying momentum.

2-43. Dental leaders must participate in operational planning to synchronize support with the scheme of maneuver. They should prepare TACSOPs and fragmentary orders (known as FRAGORDs) that allow for rapid adjustments during execution. Plans should account for resupply of Class VIII dental materials, power

and maintenance needs, and casualty reporting procedures. Contingency planning should also address how to support MASCAL events and extended operations in austere conditions.

2-44. Offensive operations often extend into deep areas and may involve rapid displacement over great distances. Dental support must remain flexible and mobile to keep pace with maneuver elements. Evacuation coordination and situational awareness are key to ensuring dental teams can reposition as needed and continue providing care where it is most needed. Close coordination with Role 1 and Role 2 facilities, as well as with medical planners, enables a seamless patient flow and supports effective RTD decisions.

2-45. In the offense, dental services also contribute to consolidating gains by preventing dental emergencies that would otherwise disrupt operations or reduce unit strength. As units transition from combat to stability tasks or prepare for further operations, continued access to dental care sustains readiness. Effective dental support during offensive operations not only preserves fighting strength, it enables commanders to maintain tempo and exploit tactical opportunities without losing momentum.

DENTAL SUPPORT TO STABILITY OPERATIONS

2-46. A *stability operation* is an operation conducted outside the United States in coordination with other instruments of national power, to establish or maintain a secure environment and provide essential governmental services, emergency infrastructure reconstruction, and humanitarian relief (ADP 3-0). These operations are often executed alongside unified action partners. Stability activities blend coercive and constructive efforts to achieve enduring outcomes. For more detail on the doctrine and tasks of stability operations, refer to ADP 3-07 and ATP 4-02.42.

2-47. Dental support plays an important role in promoting health and resilience during stability operations. Oral disease is among the most common global health burdens, and poor dental health negatively impacts quality of life, work capacity, and school attendance. In many operational environments, host-nation populations face widespread, untreated dental conditions. Providing dental care, through support to local systems, can improve civilian well-being and when executed carefully, helps bolster the legitimacy of the host-nation government and builds goodwill.

This section is in consensus with STANAG 2563 and 2584

2-48. Dental services may be tasked to support humanitarian assistance, forensic identification, security cooperation, or capacity-building efforts. These missions require dental leaders to integrate early with medical planners, civil affairs elements, and unified action partners. Support must be aligned with the combatant commander's theater campaign plan and synchronized with the broader health engagement strategy. In addition to treating urgent conditions, dental assets may assist with public health messaging, preventive services, and partner-nation training initiatives. They provide guidelines for dental (oral health) involvement in missions with a humanitarian character as described in STANAG 2563 and STANAG 2584. For additional information on forensic identification see paragraph 4-73.

2-49. To ensure effective and ethical support, planners must consider the eligibility of recipients, the local population's dental needs, and the existing infrastructure. Stability missions often involve dislocated civilians, former combatants, and other vulnerable groups whose needs may differ from U.S. forces. Dental leaders should coordinate with planning teams, theater civil military operations planners, the U.S. Embassy Country Team and unified action partners to deconflict areas of responsibility to avoid duplicate efforts.

2-50. When planning dental support to stability operations, several operational questions must be addressed. Leaders should determine the optimal location for dental facilities based on mission variables and the population at risk (PAR). They must also verify the rules of eligibility in the HSS annex, assess the host nation's supply and maintenance capacity, and ensure interpreter support is available. Financial considerations, such as cost reimbursement and transfer of medical equipment, should be included in the TACSOP or operation plan (OPLAN) if support extends beyond minimal-cost humanitarian assistance.

2-51. Dental teams operating in these environments must remain flexible and culturally aware. They may be called upon to provide basic services during initial response efforts, especially for populations displaced by conflict. Where possible, care should be designed to build local capacity, not create long-term dependency.

Training, advising, or equipping local dental personnel can have a lasting impact and strengthen strategic relationships with partner nations.

2-52. Dental support during stability operations helps shape the environment, build trust, and reinforce host-nation health systems. When carefully planned and coordinated, these efforts contribute to long-term stability by addressing urgent oral health needs and enabling broader health cooperation in the area of operations.

DENTAL SUPPORT TO DEFENSE SUPPORT OF CIVIL AUTHORITIES

2-53. *Defense support of civil authorities* is the support provided by U.S. Federal military forces, Department of Defense civilians, Department of Defense contract personnel, Department of Defense Component assets, and National Guard forces (when the Secretary of Defense, in coordination with the Governors of the affected States, elects and requests to use those forces in Title 32, United States Code status) in response to requests for assistance from civil authorities for domestic emergencies, law enforcement support, and other domestic activities, or from qualifying entities for special events. Also called DCSA or civil support (DODD 3025.18). These operations are governed by federal law, including the *Posse Comitatus Act* and *Stafford Act*, and are coordinated with lead federal agencies such as the Department of Homeland Security or the Federal Emergency Management Agency. For a detailed discussion of DSCA roles and legal authorities, refer to ADP 3-28.

2-54. While dental services are not typically a primary response asset during DSCA, they may be tasked to provide emergency care, FHP, or humanitarian assistance in support of civil authorities. Their participation must align with mission assignments approved by higher headquarters and coordinated through the Defense Coordinating Officer and Joint Field Office. Dental teams operating under DSCA authorities remain under military command but work in close coordination with civilian agencies.

2-55. Dental personnel may contribute to DSCA missions in several ways. They can provide emergency dental care to Service members, first responders, and potentially affected civilians when authorized. In large-scale disaster response, they may also assist in casualty management and mass fatality identification through forensic dental capabilities, in coordination with the Armed Forces Medical Examiner System or local authorities.

2-56. Dental teams supporting DSCA must be prepared to operate in austere and degraded environments. They must bring self-sustaining capabilities, including mobile equipment, power generation, infection control supplies, and secure communication systems. Coordination with preventive medicine teams is essential to manage public health threats such as waterborne illness, poor sanitation, or disease transmission in temporary shelters or damaged infrastructure.

2-57. DSCA operations require strict compliance with legal and policy restrictions on the use of military medical capabilities in domestic environments. Dental leaders must ensure that any care provided to civilians is authorized under appropriate mission assignments and that documentation, consent, and reporting procedures comply with Department of Defense and host-state regulations.

2-58. In planning for DSCA, dental services should be included in medical annexes and supporting FHP plans. Dental assets can enhance the resilience of responding military and civilian personnel, especially during prolonged response efforts. They may also support health surveillance, triage, or screening operations, contributing to a broader unified effort to stabilize affected communities and restore essential services.

2-59. While dental support to DSCA missions is situational and limited in scope, it remains an important component of the AHS's capability to respond to domestic crises. When integrated into interagency planning and executed in accordance with policy, dental services can reinforce readiness, support public health, and assist civil authorities in times of national need.

SECTION III – APPLICATION OF THE ARMY HEALTH SYSTEM PRINCIPLES AND DENTAL SERVICES OPERATIONS

2-60. The principles of the AHS are closely aligned with the operational variables, key tenets, imperatives, and mission variables. These principles serve as the foundation for delivering healthcare in deployed settings and guide medical planners in developing OPLANs that are effective, efficient, adaptable, and feasible. AHS support plans are tailored to integrate with the operational commander's movements and strategies, while maintaining a strong focus on providing healthcare.

2-61. AHS principles apply to all medical functions and are coordinated by medical commanders through the medical command and control function, which operates within the broader command and control system. Surgeon sections at each echelon coordinate, synchronize, and integrate medical resources through technical medical channels. The six principles of the AHS are conformity, proximity, flexibility, mobility, continuity, and control. These principles complement and support the Army's operational tenets and imperatives. This section explains how these principles apply specifically to dental services. For a more detailed discussion on how AHS principles relate to FHP and HSS missions, refer to FM 4-02.

CONFORMITY

2-62. Conformity is the alignment of AHS support with the operation order (OPORD). Effective conformity ensures that medical support directly enables the commander's intent. To build a coherent concept of support, medical commanders work closely with operational commanders throughout the planning process. Early involvement of AHS planners allows integration of medical considerations into the scheme of maneuver. Rehearsals with supported units help refine the concept, identify risks, and ensure AHS support remains synchronized as the operation progresses.

2-63. Dental services apply the principle of conformity by aligning their support plan with the scheme of maneuver and commander's priorities. Dental planners take part in mission analysis and course of action development to determine where and when support is most needed. They tailor capabilities based on the mission type, anticipated casualty load, and operational tempo. At each echelon, the positioning of dental units is determined through the orders process and integrated with medical and operational planning. During large-scale combat operations, where casualty rates and resupply challenges are higher, conformity becomes even more critical. In these environments, dental leaders work with maneuver and hospital planners to ensure resources are prioritized and directed to support mission execution without delay.

PROXIMITY

2-64. Proximity ensures that AHS support is available close enough to the fight to reduce morbidity and mortality, while remaining far enough to avoid disrupting operations. Medical assets are placed within supporting distances of maneuver forces to locate, treat, stabilize, and evacuate casualties in line with the operational plan. This placement becomes especially critical during periods of high-intensity combat, when demands on medical resources are greatest.

2-65. Dental services apply the principle of proximity by positioning treatment capabilities close to the units they support. This enables dental teams to receive and treat Soldiers quickly, reducing the impact of dental emergencies and DNBI on operational readiness. During large-scale combat operations, casualty rates and dental emergencies can affect a significant portion of the force. To manage this demand, planners allocate both organic dental teams and modular area support assets throughout the battlespace. Expeditionary dental teams provide care forward of Role 2 and Role 3 facilities, especially for units that are isolated or moving rapidly. By staying close to supported forces, dental units help maintain momentum and return Soldiers to duty without delay.

FLEXIBILITY

2-66. Flexibility allows the AHS to adjust resources and operations in response to changing mission requirements. This principle is essential when transitioning between levels of conflict or shifting across the

competition continuum. Flexibility is built into the OPLAN so medical support can remain aligned with the maneuver commander's intent, even as conditions change.

2-67. Dental services apply flexibility by organizing and deploying capabilities based on mission demands. Dental leaders use command and control to reassign teams, prioritize care, and adapt to offensive, defensive, or stability tasks as needed. The modular structure of the DCAS provides options to send a single team or the full unit, depending on the size and urgency of the requirement. Dental systems and equipment must also function under expeditionary conditions, including in remote or network-degraded environments. By maintaining the ability to shift resources and deliver care under challenging conditions, dental services ensure continuity of support and responsiveness to the commander's operational needs.

MOBILITY

2-68. Mobility allows AHS units to maintain proximity within supporting distance of maneuver forces. Mobile AHS assets must match the movement, survivability, and sustainability of the formations they support. One of the most effective ways to maintain mobility is by evacuating stabilized patients before a unit displaces. When anticipating large casualty flows, medical teams prepare by clearing current patients or using alternative evacuation routes to prevent delays and maintain continuous support. Without mobility, dental units cannot maintain proximity to supported forces, which limits their ability to deliver timely care and return Soldiers to duty.

2-69. Dental services apply mobility by equipping units with portable systems and trained teams that can move quickly to meet operational demands. Dental leaders ensure their units are capable of rapid setup and teardown, allowing them to provide care close to maneuver forces, even in austere, temporary, or high-threat areas. The modular structure of dental companies supports this by allowing flexible task organization and employment. Dental planners assess transportation requirements, sustainment dependencies, and tactical movement timelines when developing courses of action. By maintaining mobility, dental units can follow supported formations, deliver expeditionary care, and remain responsive across combat, humanitarian, and contingency operations.

CONTINUITY

2-70. *Continuity of care* is the attempt to maintain the role of care during movement at least equal to the care provided at the preceding facility (FM 4-02). Continuity of care ensures that medical treatment remains consistent and progressive as patients move through the roles of care. Each AHS unit is expected to deliver care equal to or better than the level provided at the previous role, from the point of injury through evacuation to the support base in the continental United States. This seamless progression improves outcomes and reduces gaps in treatment during complex operations.

2-71. Dental services apply the principle of continuity by providing consistent care across all echelons and phases of operations. In previous conflicts, aeromedical evacuation often allowed patients to bypass intermediate roles of care. In large-scale combat operations, however, high casualty rates, contested airspace, extended distances, and indirect fire threats will likely require dental patients to be treated at multiple roles before reaching a definitive care facility. Dental teams must be prepared to sustain care at each stage, ensuring patients remain stable and mission-capable whenever possible.

2-72. In ongoing and emerging conflicts are already challenging the ability to evacuate patients quickly. Conditions such as enemy drone surveillance, contested airspace, and degraded transportation routes can delay movement from forward areas. These realities may force dental patients to remain at MTFs longer than anticipated. When evacuation is delayed, dental teams may need to provide prolonged care, including pain management, infection control, and emergency interventions. Planners must ensure that capabilities are positioned along the continuum of care to maintain treatment quality and support the health and readiness of the force.

2-73. Maintaining continuity also requires effective coordination between dental teams, medical units, and supported commands. Dental personnel use tools such as digital imaging, intraoral scanning, and adaptive manufacturing to preserve treatment records, improve diagnostics, and reduce delays. These technologies help ensure that patients receive consistent care as they move through the roles. By prioritizing

communication, documentation, and interoperability, dental leaders support continuous care and contribute to overall force readiness, even in austere or high-risk environments.

CONTROL

2-74. Control ensures that AHS resources are used effectively and in accordance with the operation plan, professional standards, and legal requirements. Medical commanders and surgeon cells manage this function across echelons, using their training and expertise to align medical support with the commander's objectives. Control allows planners to track performance, adjust resources, and maintain accountability in complex operational environments.

2-75. Dental services apply control by enforcing standards, managing resources, and ensuring compliance with medical policy and law. Dental leaders supervise the delivery of care to ensure it meets clinical, ethical, and legal expectations. They oversee unit readiness, monitor performance, and adjust resource allocation to meet mission demands. Through coordination with surgeon cells and higher headquarters, dental leaders help synchronize care across the operational area. By balancing quality, efficiency, and accountability, dental control measures support operational success and maintain trust in Army medical capabilities.

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Chapter 3

Dental Services Organizations

Dental services are essential to sustaining Soldier readiness and operational success in any environment. This chapter explains how dental care is integrated across the AHS and aligned with the roles of care. It describes the categories of dental treatment, unit capabilities, and how those units are employed throughout the operational framework. The chapter also describes how dental assets are positioned and supported at each role of care, including brigade, division, corps, and theater levels. It emphasizes the importance of mobility, expeditionary teams, and deliberate coordination with medical units.

The chapter concludes by outlining the key considerations for establishing a field dental treatment facility, including security, sheltering, camouflage under STANAG 2931, and compliance with the Geneva Conventions. Together, these sections provide a clear picture of how Army dental services protect the health of the force and contribute to mission endurance across large-scale and sustained operations.

SECTION I – DENTAL SERVICES AT ROLES OF CARE

3-1. Dental care categories align with the Army’s medical roles of care. This alignment supports readiness by improving coordination, promoting whole-health planning, using resources wisely, and ensuring smooth care transitions. Table 3-1 shows the types of dental care provided at each medical role of care.

Table 3-1. Dental support provided at medical roles of care

<i>Task/Category</i>	<i>Role 1</i>	<i>Role 2</i>	<i>Role 3</i>	<i>Role 4</i>
Emergency Dental Care	Non-dentist-limited Only if dental team is deployed forward to the battalion aid station	Yes	Yes	Yes
Essential Dental Care	No	Limited	Yes	Yes
Comprehensive Dental Care	No	No	No	Yes

DENTAL CARE AT A MEDICAL ROLE 1

3-2. Role 1 care begins at the battalion aid station (BAS) and provides basic emergency care. Medical providers, such as battalion surgeons, physician assistants, or combat medics, may offer limited dental support. Treatments may include tooth extractions, temporary fillings, pain control, and antibiotics for infections. Providers may also stabilize dental injuries like fractures or dislodged teeth before referring patients for further care.

3-3. Role 1 medical staff receive basic dental emergency training, but they are not dental personnel. Their focus is to manage urgent conditions that affect readiness. When requested and feasible, dental teams with expeditionary capabilities may circulate forward to treat Soldiers at Role 1 MTFs. These mobile efforts help maintain readiness in austere or high-risk environments.

DENTAL CARE AT A MEDICAL ROLE 2

3-4. Role 2 is the first role of care with assigned dental personnel. Dental teams provide emergency and essential dental care and may also move forward to provide expeditionary dental care. Available services depend on Class VIII supplies and operational priorities. Typical capabilities include:

- Limited preventive care: Patient education on oral health practices, including brushing, diet, and oral hygiene. Supplies are limited to toothbrushes and toothpaste.
- Basic Restorative Care: Fillings to treat dental decay and prevent dental emergencies.
- Dental imaging: X-rays taken by trained specialist and interpreted by dentist to support diagnosis.
- Limited endodontic care: Pulpectomy to manage pain and infection; full root canal treatment when conditions and time allow.
- Limited periodontal care: Treatment for acute gum infections. Regular maintenance and hygiene care are not available.
- Limited prosthodontic care: Temporary crowns and denture repairs to support the deployment duration.

3-5. Role 2 provides a wider range of dental care than Role 1, but complex procedures still require referral. Soldiers needing oral surgery or specialty care will need to be evacuated to Role 3 or the supporting DCAS.

DENTAL CARE AT A MEDICAL ROLE 3

3-6. Role 3 facilities provide hospitalization and surgical capabilities, including care for more complex injuries and illnesses. Dental care at a Role 3 hospital includes emergency and essential services provided by an organic dental section. This section supports hospital staff and patients and provides services such as limited oral surgery, endodontics, and preventive care. A preventive dentistry specialist or sergeant may also be assigned, along with associated equipment, to deliver dental hygiene services.

3-7. While the Role 3 hospital houses a core dental team, much of the dental capability at this echelon resides within the DCAS, which operates outside the hospital structure. The DCAS is a modular, stand-alone unit that provides operational dental care across the theater and supports Role 3 operations by delivering expanded capabilities. This includes comprehensive treatment planning, enhanced dental specialties, and expeditionary dental teams that can maneuver as needed to support corps and division-level forces.

3-8. The DCAS includes dental officers who are trained across multiple dental disciplines. These providers enhance care beyond what is available from the dental section in the Role 3 hospital, offering advanced services such as root canal therapy, periodontal interventions, prosthetic fabrication and repair, and minor oral surgeries. Though distinct from the hospital, the DCAS works closely with medical planners and hospital staff to ensure dental operations are synchronized with the broader mission and support medical regulating, referrals, and RTD efforts.

DENTAL CARE AT A MEDICAL ROLE 4

3-9. Role 4 facilities deliver definitive medical and surgical care, including complex procedures not available in the theater. From a dental standpoint, this includes access to oral-maxillofacial surgical support typically located within Role 4 hospitals. These hospitals are equipped to manage severe maxillofacial trauma, fractures, and infections requiring inpatient care, or coordinated surgical teams.

3-10. Most other dental services at Role 4 are delivered through fixed dental treatment facilities, which may or may not be collocated with Role 4 hospitals. These facilities fall under the DHA and provide the full range of dental specialties, preventive, diagnostic, restorative, prosthodontic, endodontic, periodontic, and orthodontic care. These clinics ensure that Soldiers complete treatment initiated during deployment and receive care that supports dental readiness and long-term health.

3-11. While Role 4 hospitals provide critical surgical support for emergency oral health conditions, the dental treatment facilities serve as the primary site for routine and comprehensive dental care. Coordination between the hospital and the dental treatment facility ensures continuity of care, particularly for Soldiers transitioning from theater or being medically evaluated for retention, redeployment, or separation. This division of responsibilities reflects the broader structure of the DHA system and its support of medical readiness.

SECTION II – EMPLOYMENT OF DENTAL CAPABILITIES

3-12. Dental assets are positioned with medical companies or troops in brigade combat teams, armored cavalry regiments, sustainment brigades, and special forces groups (SFGs) to provide timely treatment. Civil

affairs units usually receive dental care from theater-level assets. However, in austere or isolated environments, civil affairs dental officers may provide dental care directly to support the unit's mission.

3-13. Dental capabilities must be synchronized across the OE to support mission success at every echelon. Leaders and planners must understand where dental capabilities are located and how they are distributed across the OE. This includes the strategic support area, joint security area, and extended deep area, as well as the rear, close, and deep operational zones. Refer to FM 3-0 for more information on the operational framework.

3-14. Positioning dental assets deliberately across operational areas improves both readiness and operational endurance. First, it allows Soldiers to receive care and RTD quickly, reducing the time they are separated from their units. Second, it minimizes the need to evacuate Soldiers for routine dental treatment, preserving manpower forward, and improving the commander's ability to sustain operations.

DENTAL CAPABILITIES IN THE DEEP AND CLOSE AREA

3-15. Dental capabilities in the deep and close areas are positioned to support maneuver forces and specialized units operating in contested or austere environments. These capabilities deliver timely operational dental care, helping reduce evacuations, and preserve combat power.

SPECIAL OPERATIONS FORCES AND CIVIL AFFAIRS BRIGADE

3-16. Special operations forces (known as SOF), including SFGs and civil affairs brigades, typically operate in the deep and close area. Their command surgeon sections coordinate dental support based on mission requirements. For more information, refer to ATP 3-05.40 and ATP 4-02.43.

BATTALION AID STATION

3-17. BAS do not include assigned dental personnel. When emergency dental care is needed, the battalion surgeon or physician assistant may manage the condition if trained and equipped, focusing on stabilization until referral is possible.

3-18. High patient volumes during sustained operations may exceed the BAS's capacity. When this occurs, the BAS can coordinate with the BSMC or request additional support to manage patient care demands.

3-19. The DCAS forward dental treatment section is equipped to deploy and augment the BAS with expeditionary dental teams. This support relieves pressure on medical personnel and ensures timely care for Soldiers in the forward area.

BRIGADE SUPPORT MEDICAL COMPANY

3-20. Dental services are part of the area support squad within the BSMC of the brigade support battalion. These teams provide Role 2 dental care in the brigade area and can also conduct battlefield circulation to support Role 1 sites. When a patient's needs exceed available resources, the BSMC may request DCAS augmentation.

FORWARD DENTAL TREATMENT SECTION OF THE DENTAL COMPANY AREA SUPPORT

3-21. The forward dental treatment section of the DCAS consists of semi-mobile treatment teams trained and equipped to provide expeditionary dental care. These teams can deploy to support BASs, BSMCs, or small and forward deployed troop concentrations, improving access to care, maintaining Soldier readiness, and minimizing the need for evacuation.

DENTAL CAPABILITIES IN THE REAR AREA

3-22. Rear area operations provide essential support to forward forces, including sustained dental care. Dental capabilities in the rear area focus on reducing the risk of dental emergencies, restoring oral function, and returning Soldiers to duty. These capabilities are delivered by units such as the DCAS, Medical Company (Area Support) (MCAS), and hospital augmentation detachments. Positioned to support large troop concentrations, these assets complement forward dental elements and help maintain readiness across the theater.

DENTAL COMPANY AREA SUPPORT

3-23. The DCAS provides operational dental care across the corps support area and other designated areas in theater. This unit supports readiness by delivering emergency and essential dental treatment designed to eliminate potential dental emergencies before they degrade combat power. While primarily employed in the corps support area, DCAS elements may also be forward deployed to the brigade support area or joint security area to provide Role 2 or Role 3 dental support based on mission variables. The DCAS mission, capabilities, and functions should be reflected in the unit's TACSOP.

3-24. The DCAS is assigned to the TMC or MEDBDE and relies on support from various elements to perform its mission. These include theater-level support for religious, legal, FHP, finance, personnel, and administrative services; support maintenance companies for field-level maintenance; field feeding companies; and hospital units for bed and minimal care support. Transportation support is coordinated through sustainment brigade headquarters or similar elements when DCAS exceeds its organic lift capabilities.

3-25. The unit provides command and control of subordinate dental elements and delivers emergency and essential dental care in support of area-based operations. It reinforces and reconstitutes brigade and cavalry regiment dental assets and can project forward operational dental care to small or isolated troop concentrations through three forward dental treatment sections, each composed of six semi-mobile teams. DCAS also supports medical operations during MASCAL incidents and maintains a three-day supply level for all organic elements.

3-26. Though focused on clinical support, DCAS personnel may assist in the coordinated defense of their area or installation when required. The unit performs limited maintenance on organic medical equipment and augments the maintenance capabilities of other units for vehicles and non-medical systems.

3-27. The DCAS consists of several functional elements, each with specific responsibilities. The company headquarters oversees command, administration, and logistics for the unit and its subordinate elements. The support section provides non-clinical services such as power generation, vehicle operation, and maintenance. The field dental clinic delivers general and specialty dental care, including comprehensive procedures such as endodontics, periodontics, and prosthodontics. The forward support platoon headquarters directs and coordinates the activities of the forward support treatment sections, which consist of mobile dental teams equipped to provide expeditionary care across the combat zone. Figure 3-1 on page 31 depicts the task organization of the DCAS.

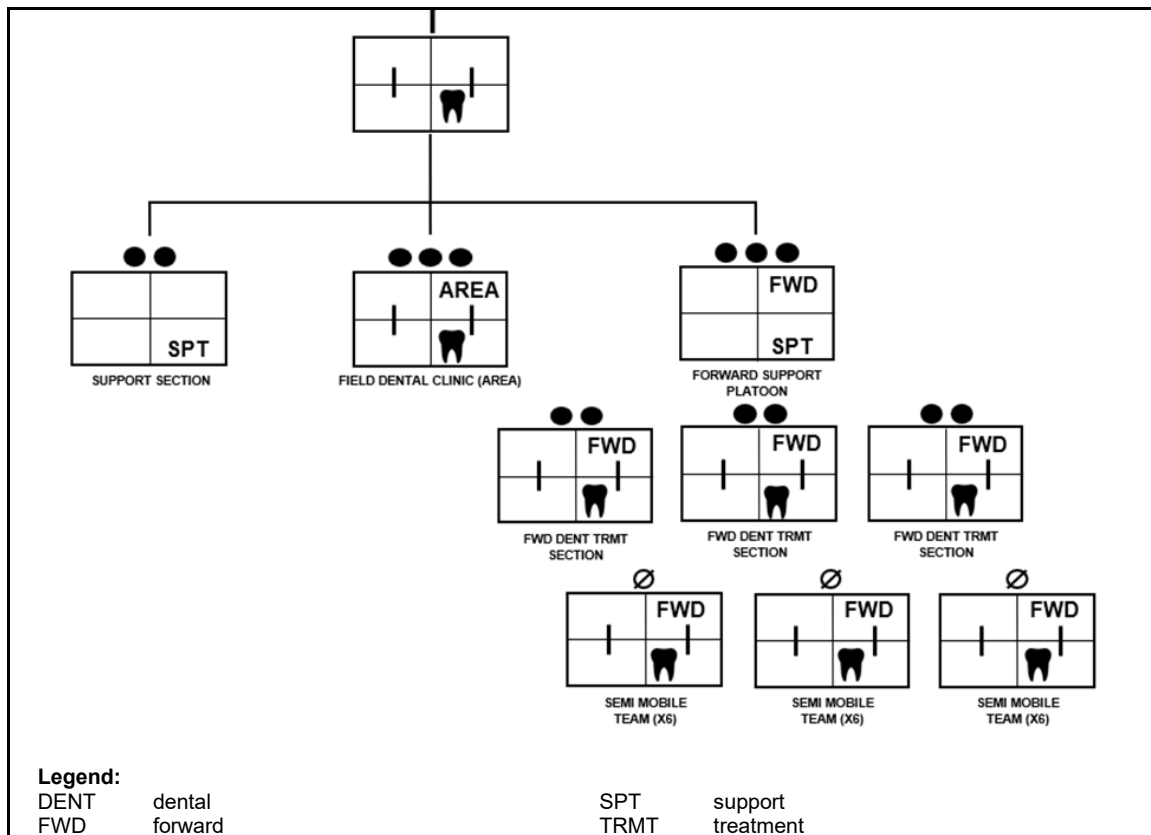


Figure 3-1. Task organization of the dental company (area support)

3-28. The DCAS is typically employed with the TMC or MEDBDE and may deploy its forward support treatment sections into the division or brigade areas to meet mission demands. One DCAS is allocated per 43,000 supported personnel, based on a planning ratio of one dentist per 1,175 Soldiers. This allocation may vary depending on the composition of Army forces, the inclusion of multinational partners, anticipated detainee populations, and the expected duration of operations.

3-29. The unit requires 50 percent of its table of organization and equipment (TOE) to be capable of being transported in a single lift using organic vehicles. This ensures its mobility in dynamic operational conditions.

MEDICAL COMPANY AREA SUPPORT

3-30. The MCAS provides Role 1 and Role 2 AHS support on an area basis. Among its many medical functions, it includes an embedded dental element capable of delivering Role 2 operational dental care. This includes emergency dental treatment, stabilization of maxillofacial injuries, essential dental care to reduce the risk of dental emergencies and limited preventive services. These capabilities ensure that Soldiers operating across the MCAS area of operations maintain oral health readiness and reduce dental-related evacuations from the theater.

3-31. The MCAS dental element operates as part of the area support squad and is structured similarly to the dental capability found in the BSMC. However, the MCAS functions on an area basis and may serve a larger or more diverse supported population, which can strain available dental resources. When patient volume exceeds the MCAS's ability to provide timely care, additional support may be requested from the DCAS. The DCAS forward dental treatment section can deploy to augment MCAS operations, bringing added capacity and expeditionary dental care capabilities.

3-32. Although the MCAS is capable of supporting dispersed and mobile forces, its dental teams is not designed for independent or prolonged operations in isolation. It relies on the company's mobility, logistics, and mission command for effectiveness. Figure 3-2 on page 32 depicts the task organization of the MCAS, including its integrated dental support.

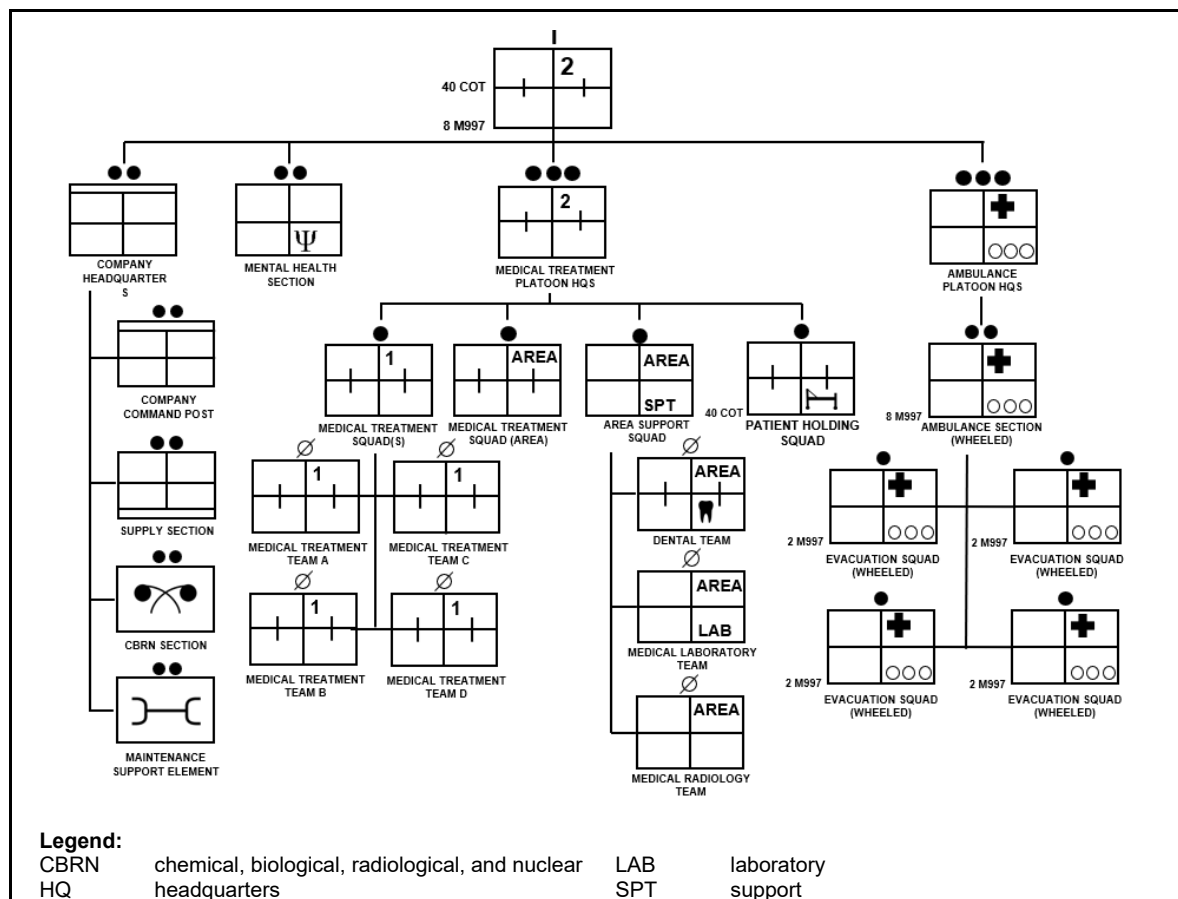


Figure 3-2. Task organization of the medical company (area support)

HOSPITAL AUGMENTATION DETACHMENT (SURGICAL 24-BED)

3-33. The Hospital Augmentation Detachment (24-bed), also referred to as the Surgical Augmentation Detachment (SAD), enhances the field hospital's capabilities with specialized surgical services, including oral and maxillofacial surgery. This capability is embedded within the operating room and centralized material services section and provides complex surgical interventions critical to managing combat-related facial trauma and severe dental injuries. These services are essential for sustaining Soldier survivability and function following maxillofacial trauma in large-scale combat operations.

3-34. The oral maxillofacial surgery capability in the SAD supports the field hospital with 36 additional operating table hours per day, significantly increasing the hospital's capacity to manage complex head, neck, and dental trauma. This integration allows SAD to deliver advanced dental surgical support alongside thoracic and urologic procedures, ensuring multidisciplinary surgical care for wounded personnel. Dental providers also assist with casualty care during MASCAL incidents and support surgical teams in stabilizing patients for evacuation or further treatment.

3-35. While the SAD's primary mission is to augment field hospital capabilities, its dental component plays a critical role in managing injuries not treatable at lower roles of care. The unit is assigned to the hospital center's headquarters and relies on external support for evacuation, logistics, and maintenance. Figure 33 on page 33 depicts the task organization of the SAD, including its surgical dental support embedded within the operating room and centralized material services section.

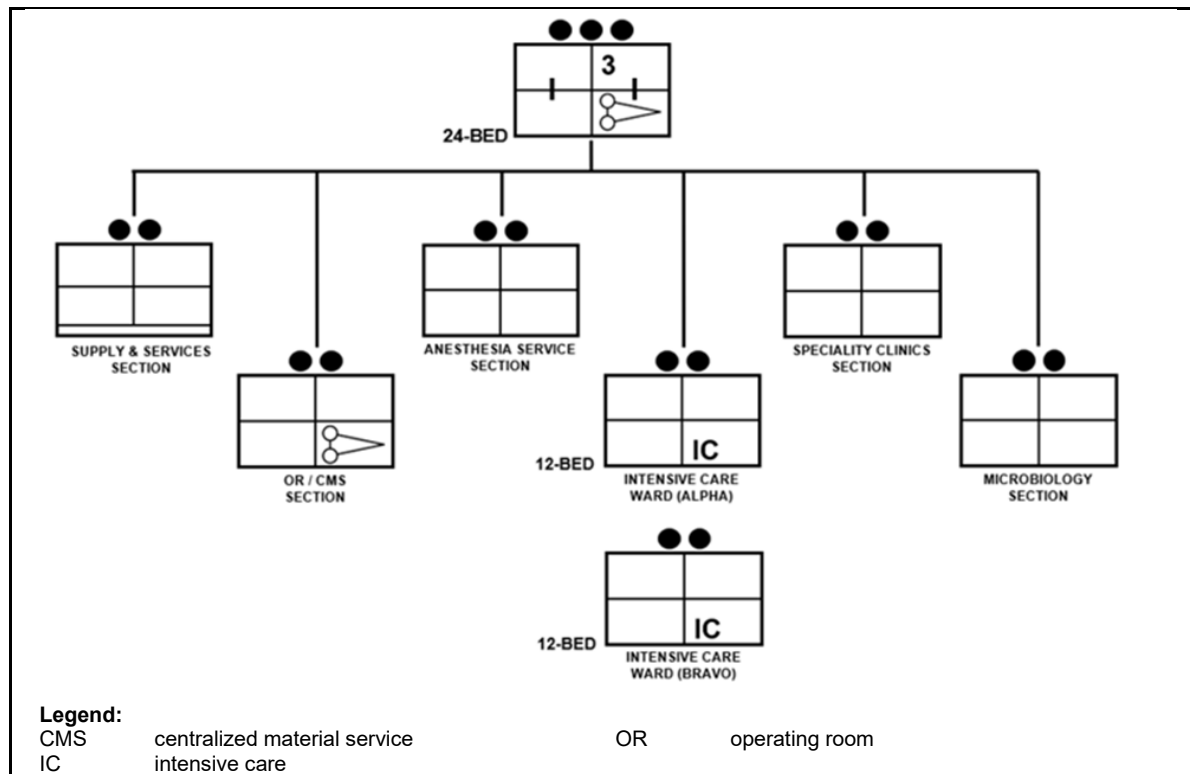


Figure 3-3. Task organization of the surgical augmentation detachment (24-bed)

HOSPITAL AUGMENTATION DETACHMENT (MEDICAL 32-BED)

3-36. The Hospital Augmentation Detachment (32-bed), also referred to as the Medical Augmentation Detachment (MAD), enhances the field hospital with expanded patient care services, including operational dental capabilities. This dental capability provides emergency and essential dental treatment aimed at reducing the risk of dental emergencies in the theater of operations. These services improve Soldier readiness and reduce the likelihood of evacuations for dental issues, ensuring operational continuity in prolonged or large-scale combat operations.

3-37. The dental section within the MAD functions as part of a broader specialty clinic capability and is staffed to manage both patient and staff dental needs. While collocated with the field hospital and integrated into its daily operations, the dental team can also support broader combat casualty care efforts during MASCAL situations. The MAD also includes a preventive dentistry sergeant, providing an enhanced focus on oral health protection not found in all lower-echelon dental capabilities. This added preventive component supports unit readiness by identifying and mitigating risks before they become operational liabilities.

3-38. The MAD is assigned to the headquarters and headquarters detachment of the hospital center and depends on various theater-level assets for logistical, medical, and operational support. In situations where dental workload exceeds internal capacity, the DCAS may be called upon to augment care. Figure 3-4 on page 34 depicts the task organization of the MAD, including its dedicated dental section.

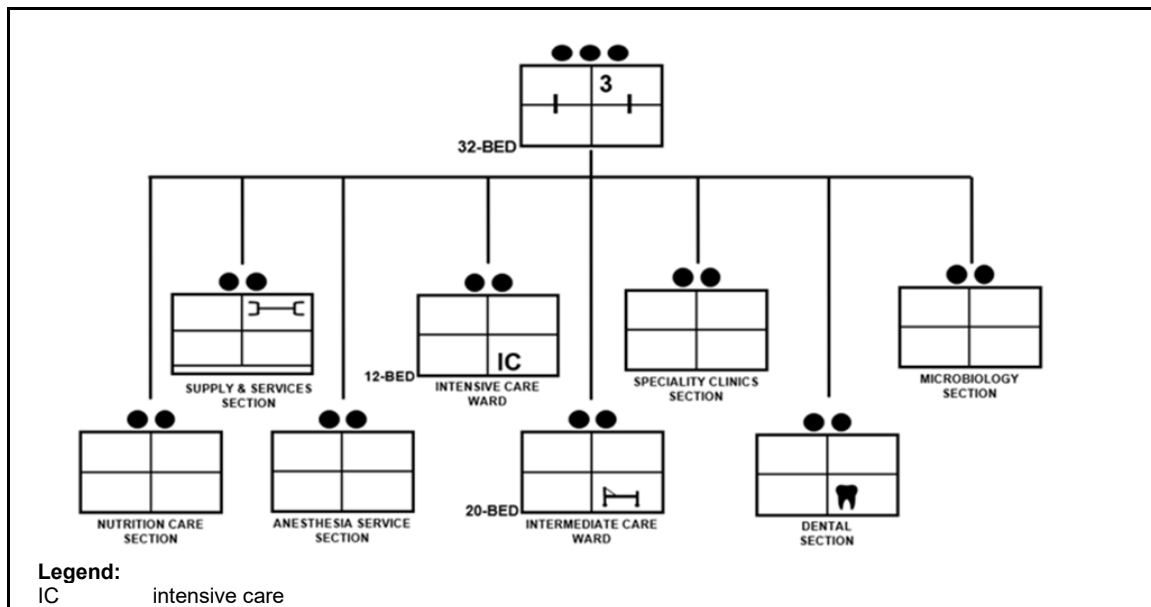


Figure 3-4. Task organization of the medical augmentation detachment (32-bed)

Chapter 4

Planning and Execution of Dental Services

This chapter details the comprehensive planning and execution required for Army dental services across the full spectrum of military operations. It emphasizes the importance of proactive planning, adaptability, and integration with broader medical and operational strategies to ensure Soldier dental readiness and mission success, regardless of the environment.

The chapter also outlines the roles and responsibilities of dental personnel at all levels – from strategic command to tactical units—and covers essential aspects of dental support, including site selection, shelter, security, logistical considerations, and administrative procedures. It also addresses specialized functions like support to reconstitution, veterinary services, forensic identification, and mass casualty events, while highlighting the need to adhere to legal and ethical standards, including the Geneva Conventions, in all operations.

SECTION I – PLANNING

4-1. *Planning* is the art and science of understanding a situation, envisioning a desired future, and determining effective ways to bring that future about (ADP 5-0). Planning helps leaders understand situations; identify and develop solutions to problems; direct, coordinate, and synchronize actions; prioritize efforts; and anticipate events. In its simplest form, planning helps leaders determine how to move from the current state to a more desirable future state and identify opportunities and threats that may arise along the way. Planning is a continuous activity of the operations process. For more information on Army planning refer to FM 5-0 and see Appendix F for the tab example for dental services.

4-2. There are several resources available to planners including planning factors by warfighting functions, friendly unit tables of organization, detailed sustainment planning factors, and threat models. For AHS support, refer to ATP 4-02.55 on the use of the joint medical planning tool and AHS planning.

4-3. Dental service support planning in Army operations is guided by the mission variable framework. Active involvement of dental unit leaders in the planning process ensures that their plans align with directives from higher headquarters and are seamlessly integrated into the broader operational strategy. This collaboration enhances the effectiveness and coordination of dental support within the overall mission framework. For detailed guidance on the military decision-making process, refer to FM 5-0, and for specific dental planning considerations related to AHS support, refer to ATP 4-02.55. This structured approach enables thorough preparation, rehearsal, and assessment of mission execution.

ENVIRONMENTAL CONSIDERATIONS

4-4. The Army is capable of operating in all environments. Characteristics of an OE can significantly influence the deployment and utilization of dental services and can impact the types and severity of dental casualties. When planning, dental leaders, staff, and planners must carefully assess the different factors as they relate to maritime, arctic, mountainous, jungle, desert, urban, and subterranean operations.

MARITIME OPERATIONS

4-5. The maritime domain spans the globe—from the Arctic to the Antarctic—encompassing strategic littoral regions and heavily trafficked coastal zones. For maneuver commanders, the decisive terrain in maritime operations is typically not the sea itself, but the land it borders. Army forces operating in this domain must adjust to supporting roles within joint and multinational formations, often under Navy or Marine Corps command structures. For an overview of maritime operational concepts, refer to FM 3-0.

4-6. Dental services in maritime operations support joint force readiness by preserving oral health in environments where evacuation and resupply options may be limited. The maritime setting introduces environmental and logistical constraints that require dental units to plan proactively and adapt their practices.

Dental leaders must ensure their capabilities are integrated with the joint planning process to maintain continuity of care in austere or shipboard environments.

4-7. Environmental conditions such as high humidity, saltwater exposure, and temperature shifts can degrade dental equipment and compromise sterilization standards. Dental units must account for these risks by inspecting equipment more frequently, using corrosion-resistant storage, and planning for short-notice resupply of key Class VIII items. In littoral or island-based operations, selecting a treatment site requires consideration of drainage, access, terrain elevation, and storm risk, alongside operational mobility.

4-8. MEDEVAC in the maritime environment is often waterborne or airlifted, requiring dental teams to locate near embarkation points and coordinate closely with Role 2 and Role 3 facilities afloat or ashore. Communication with higher headquarters and adjacent units may be degraded by geographic isolation or enemy interference. Dental units must develop procedures to maintain situational awareness, ensure medical reporting continuity, and anticipate delays in decision-making and guidance.

4-9. Dental operations in maritime environments demand interoperability with Navy, Marine Corps, and allied forces. Dental teams may need to operate in confined shipboard spaces or co-locate with other Services' medical teams in shared maritime support zones. This requires close coordination of treatment schedules, equipment compatibility, and infection control standards. Personnel may also assist with emergency procedures in joint environments, requiring familiarization with Navy afloat protocols and practices.

4-10. To sustain operations, dental leaders must implement robust scheduling, follow-up procedures, and contingency plans to support personnel rotations and casualty management. Training should emphasize expeditionary dental care, maritime survival, and emergency response techniques suited to remote or mobile operations. By preparing dental teams to meet these challenges, the AHS ensures its ability to preserve force readiness and contribute to successful joint operations in the maritime domain.

EXTREME COLD WEATHER OPERATIONS

4-11. Extreme cold weather operations present unique challenges across land, air, and maritime domains. Conditions such as sub-zero temperatures, persistent darkness or daylight, unpredictable weather shifts, and freeze-thaw terrain cycles significantly affect unit mobility, survivability, and support operations. These harsh environmental factors demand additional planning to sustain forces and mitigate medical risk. For a detailed discussion of military operations in these environments, refer to ATP 3-90.97.

4-12. Dental services play a critical role in supporting Army forces operating in Arctic and sub-Arctic environments. Oral health issues can be exacerbated by dehydration, nutritional shifts, cold-induced injuries, and logistical isolation. In these environments, dental readiness directly impacts the ability of commanders to sustain forward operations. Dental teams must prepare for degraded infrastructure, restricted access, and limited evacuation options, often operating with little external support for extended periods.

4-13. Site selection is crucial. Dental facilities should be established on flat, stable terrain close to supported units to reduce patient transport time and increase accessibility. Locations should offer natural protection from wind and blowing snow and avoid thaw-affected bogs or unstable ground. During the winter season, frozen terrain often improves ground mobility, while spring thaws can severely restrict access and increase risk. Facilities must be hardened with insulated liners, flooring, heaters, and wind barriers to ensure safe operations in sub-zero temperatures.

4-14. Cold weather degrades many medical materials and systems. Dental units must employ specialized tools and materials resistant to freezing, including insulated containers and temperature-tolerant medications. Supply lists should favor freeze-dried or solid-form dental products to reduce storage failures. Establishing dependable Class VIII resupply plans is essential, as Arctic resupply may be dependent on seasonal access to roads, ports, or airfields. Delays are common, requiring on-hand reserves and emergency contingency stocks.

4-15. Personnel readiness is equally important. Dental teams operating in these environments must complete cold-weather training to develop survival proficiency, acclimatization, and confidence working in extreme conditions. This includes understanding cold injury prevention, arctic hygiene practices, and operating equipment with reduced dexterity due to layered clothing. Teams must also be capable of operating semi-independently and responding to shifts in mission or mobility caused by weather.

4-16. Dental leaders must coordinate closely with operational planners, medical elements, and sustainment units to ensure integration into the broader AHS. MEDEVAC may be delayed or restricted, placing greater emphasis on return-to-duty capabilities and the ability to treat and retain Soldiers forward. Dental support in cold weather enables commanders to preserve combat strength, minimize evacuations, and sustain the momentum of operations in some of the Army's most demanding environments.

MOUNTAINOUS OPERATIONS

4-17. Mountainous environments exist on every continent and vary significantly in terrain, climate, and elevation. From the equatorial jungles of Central and South America to the glaciated highlands of Asia and the arid mountains of North Africa, these regions pose serious operational challenges. Forces operating in mountainous terrain may encounter sudden temperature shifts, persistent precipitation, rugged elevation changes, and poor mobility routes. At higher latitudes and altitudes additional threats include snowpack, avalanche risk, and restricted evacuation windows. For more information on mountain operations, refer to ATP 3-90.97.

4-18. Dental service support in mountainous operations must address challenges related to isolation, terrain, altitude, and climate. Rugged terrain may prevent regular resupply, requiring dental teams to deploy with sufficient Class VIII stockpiles to support sustained independent operations. Site selection must prioritize relatively flat and stable ground close to supported units to minimize patient movement over dangerous terrain. High-altitude conditions can also degrade sterilization effectiveness and affect personnel performance. Dental leaders should consult technical bulletin medical (TB MED) 505 and TC 3-97.61 for guidance on acclimatization and high-altitude health threats.

4-19. Weather in mountainous regions changes rapidly and may include snow, fog, sleet, and heavy rain, all of which can limit patient access and disrupt communications. Dental teams must prepare for winter operations by equipping shelters and treatment areas with heaters, insulation, and ruggedized power systems. Sterilization and dental materials must be protected against freezing or moisture exposure. Increased demand for supplies due to extended mission durations and high operational tempo should be anticipated in sustainment planning.

4-20. Mountainous terrain often prevents reliable radio or line-of-sight communication. Dental elements must coordinate alternative communication methods, including satellite systems or single-channel radios, to remain integrated with supported medical and maneuver units. Teams should anticipate signal disruption from weather phenomena such as fog or airborne snow and include redundant communication options in their planning.

4-21. The safety of mobility and evacuation routes is a key concern for dental support operations in mountainous areas. Rockslides, sudden thawing, and landslides may cut off access to or from dental facilities. Route recon, engineering support, and alternate site selection must be built into operational plans to ensure continued access to dental care.

4-22. Dental personnel assigned to mountainous operations should undergo targeted training in high-altitude medicine, field hygiene, and rugged terrain operations. This ensures they are physically and technically prepared to deliver care under extreme and variable conditions. In multinational environments, coordination with allied medical teams may also be required to ensure interoperability and mutual support.

4-23. Dental support in mountainous operations directly contributes to preserving combat power, minimizing evacuation, and supporting commanders' ability to maintain tempo and initiative in complex terrain. Well-prepared dental teams provide critical return-to-duty capability and reinforce the resilience of forward-deployed forces.

JUNGLE OPERATIONS

4-24. Jungle environments present complex challenges to Army operations, including thick vegetation, heavy rainfall, extreme humidity, and limited infrastructure. These regions occur primarily in tropical zones such as Southeast Asia, Africa, and Latin America. Terrain may include swamps, ravines, and cultivated areas, each affecting movement and sustainment. For more information on the tactical characteristics of jungle terrain, refer to ATP 3-90.98.

4-25. Dental support in jungle operations plays a key role in maintaining force readiness under harsh and degraded conditions. Dense terrain, isolation, and environmental hazards complicate evacuation and resupply, making forward-positioned dental care essential. Dental teams must be capable of operating independently and providing return-to-duty care to reduce reliance on external movement or MEDEVAC assets, which may be delayed or unavailable.

4-26. Site selection for dental facilities must prioritize flat, elevated terrain with minimal vegetation to avoid flooding and enable access. Proximity to maneuver units is essential to reduce the burden of patient movement. Natural water sources are often contaminated, so clean water access must be ensured for oral hygiene and sterilization. Shelters must be constructed or adapted to withstand humidity and protect dental equipment and medications from degradation.

4-27. Jungle humidity and temperature extremes accelerate the breakdown of medications, electronics, and sterilization materials. Dental units should use moisture-resistant packaging, secure dry storage, and insulated equipment containers. Transportation and storage plans must address rugged, limited routes that complicate Class VIII distribution. Dental leaders should plan for increased supply consumption due to prolonged operations, high operational tempo, and difficult working conditions.

4-28. Dental personnel must be trained in field-expedient care techniques adapted to remote, high-humidity conditions. This includes emergency dental stabilization, infection management, and managing facial trauma from falls or accidents. Preventive education is also vital, Soldiers operating in jungles face elevated risk of dental issues due to dehydration, restricted hygiene options, and environmental exposure. Educating troops on oral hygiene practices under austere conditions supports overall force health.

4-29. Communication in the jungle is often degraded due to dense foliage and rugged terrain. Very high and ultrahigh frequency radios may be ineffective, requiring the use of single-channel or satellite systems for coordination. Dental leaders must establish redundant communications plans to maintain contact with medical planners, supported units, and higher headquarters, ensuring synchronized support and situational awareness.

4-30. Successful dental support in jungle environments requires flexible planning, resilient equipment, and a clear understanding of how terrain, weather, and isolation affect HSS. By providing forward dental care, reducing evacuation requirements, and sustaining oral health, dental teams help commanders preserve combat power and sustain operations in one of the most demanding environments on Earth.

DESERT OPERATIONS

4-31. Deserts are among the harshest operational environments, marked by arid conditions, extreme temperature fluctuations, and minimal precipitation. These regions can include sandy dune fields, rocky plateaus, dry riverbeds, and wind-swept escarpments. Deserts exist on every continent and can range from blazing hot to freezing cold, depending on latitude and elevation. Operations in these areas require adjustments in tactics, logistics, and sustainment to account for environmental stressors. For more information on desert operations and terrain classifications, refer to ATP 3-90.99.

4-32. Dental service operations in desert environments must address the dual challenges of environmental degradation and wide-area sustainment. Dry air, heat, dust, and wind erosion degrade equipment, compromise sterilization, and accelerate the wear of dental materials. Dental teams must employ ruggedized, portable equipment and ensure shelters are insulated, ventilated, and protected from sand intrusion. Medical devices and supplies should be stored in sealed, temperature-resistant containers to prevent damage or contamination.

4-33. Logistics planning in the desert must account for extended lines of communication, limited water availability, and intermittent power sources. Dental leaders must coordinate with sustainment elements to secure reliable Class VIII resupply and to ensure access to potable water, power generation, and sanitation capabilities. Reliable water and electricity are critical for sterilization and infection control and may require organic or modular capabilities in more remote areas.

4-34. Personnel operating in deserts face increased risk of dehydration, which can lead to oral dryness, gum disease, and delayed wound healing. Dental teams must educate Soldiers on oral hygiene and hydration

practices and distribute necessary hygiene supplies during preventive care engagements. Emphasis on daily care helps reduce non-battle injuries and sustain unit effectiveness during prolonged operations.

4-35. Desert terrain also increases the risk of trauma from vehicle rollovers, falls, and combat-related injuries. Dental personnel must be trained to provide emergency interventions for maxillofacial trauma and dental emergencies, often under austere conditions and without rapid evacuation options. Establishing dental care close to Role 1 or Role 2 facilities allows rapid triage, pain management, and stabilization to support return-to-duty decisions.

4-36. The operational dispersion typical of desert environments requires dental leaders to maintain flexible support plans, ensure communication with maneuver elements, and monitor patient movement and MEDEVAC coordination. Satellite communications or high-frequency radios may be needed to overcome terrain and distance limitations. Dental services that are integrated early into operational planning can preserve combat power by reducing evacuations and enabling sustained operations in extreme desert conditions.

URBAN OPERATIONS

4-37. Urban environments are characterized by dense populations, complex infrastructure, and restricted maneuver space. Military operations in cities often occur under the simultaneous pressures of offensive, defensive, and stability tasks. The presence of civilian populations, essential services, and political structures creates an interdependent system where tactical actions can have strategic consequences. Urban terrain features, including multistory buildings, underground networks, narrow routes, further complicate command and sustainment operations. For more information on operating in urban environments, refer to ATP 3-06, ATP 3-06.11, and TC 90-1.

4-38. Dental services in urban operations play a critical role in maintaining force readiness and preserving combat strength during prolonged or high-intensity engagements. The proximity of friendly, enemy, and civilian elements can result in higher rates of trauma and DNBI. Dental teams must be positioned to support Role 1 and Role 2 facilities, while coordinating closely with Role 3 hospitals, which are likely to experience significant patient throughput during urban combat.

4-39. Site selection for dental treatment facilities should prioritize flat, accessible ground near supported units and existing medical nodes. Urban infrastructure may allow for repurposing existing buildings such as warehouses, malls, stadiums, or parking decks. Locations should offer concealment and some measure of protection, particularly in contested or high-crime areas. Mobility and security are critical concerns; movement of personnel, equipment, and patients may be disrupted by debris, damaged infrastructure, or civilian activity.

4-40. Urban combat generates high operational tempo and casualty rates. Dental units must increase stocks of critical Class VIII supplies to meet surging demand, particularly at Role 3 hospitals. In offensive operations, planners should anticipate a 20-30 percent increase in dental supply usage and aim to stock at least 120 percent of normal requirements. Maintaining on-site sterilization and diagnostic capacity is essential to avoid dependency on external resupply under uncertain or intermittent conditions.

4-41. Civil-military coordination becomes more complex in urban environments. Dental leaders must assess host-nation dental infrastructure to determine availability, functionality, and security. While support to civilians is not the primary mission, augmentation may be required in humanitarian scenarios or stabilization efforts. Coordination with the G-9, civil affairs units, local governments, and U.S. interagency partners ensure that any engagement with civilian systems is deliberate, authorized, and supports the broader operational objective.

4-42. Personnel protection and site security are constant concerns. Dental units must account for potential threats from both hostile actors and opportunistic crime. This may include escort requirements, physical site fortification, and coordination with adjacent security elements. Commanders must determine risk thresholds for static dental sites and authorize movement or repositioning as tactical conditions evolve.

4-43. Urban operations demand flexible, responsive, and well-integrated dental support. Dental leaders must anticipate high casualty loads, rapidly shifting terrain control, and operational constraints imposed by population density. By maintaining access to forward dental care, reducing evacuations, and contributing to

rapid return-to-duty decisions, dental services enhance the endurance, cohesion, and combat effectiveness of Army forces in complex urban terrain.

SUBTERRANEAN OPERATIONS

4-44. Subterranean environments, such as tunnels, bunkers, and underground military facilities, present complex challenges that affect maneuver operations, sustainment, and HSS. Several adversaries, including Russia, China, Iran, and the Democratic People's Republic of Korea, have invested heavily in underground infrastructure to conceal forces, protect key capabilities, and complicate targeting. In regions like the Korean Peninsula, subterranean operations are not only possible but expected. These environments can restrict access, delay evacuation, and degrade sustainment, which places unique demands on Army dental services.

4-45. Dental service operations in subterranean settings require compact, mobile equipment and specially trained personnel capable of delivering care under low-light, low-airflow, and confined-space conditions. Dental teams must establish treatment sites in structurally sound areas with reliable ventilation and adequate power. Portable lighting, night vision tools, and battery-backed sterilization systems are essential to maintaining patient safety and procedural hygiene. Dental elements may need to rely on local power or engineer support to establish workable facilities underground.

4-46. Movement within underground environments is restricted by narrow corridors, sharp elevation changes, and limited vehicle access. As a result, dental units must adapt to manual transport of supplies and personnel. Forward placement near Role 1 or Role 2 facilities ensure that care can be delivered promptly and that patients requiring urgent intervention are stabilized and evacuated efficiently. Contingency planning must address potential collapse zones, blocked exits, and the difficulty of executing casualty evacuation under fire or structural failure.

4-47. Communications within subterranean terrain are also degraded, requiring pre-coordinated use of signal repeaters, wired systems, or short-range hand-held radios. Dental teams must remain connected with command and medical elements to receive patient flow updates and synchronize RTD decisions. Coordination with military engineers is essential to verify the structural safety of proposed treatment areas and to establish power, lighting, and airflow solutions in cooperation with facility managers or host-nation partners.

4-48. The physical and psychological stress of working in confined, high-risk areas also affects dental personnel. Units should incorporate rest cycles, environmental monitoring, and behavioral health support into mission planning to protect provider performance and resilience. Dental leaders must also be ready to adjust treatment protocols to accommodate temperature extremes, equipment degradation, and evacuation delays.

4-49. Despite the inherent difficulties of subterranean operations, forward-positioned dental support helps preserve combat strength, limit evacuation requirements, and sustain Soldier readiness. By anticipating environmental constraints and coordinating with maneuver and sustainment planners, dental units can maintain continuity of care and contribute to mission success below ground.

CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR OPERATIONS

4-50. Dental services must be prepared to operate in CBRN environments where contamination risks can disrupt treatment and threaten personnel and equipment. While dental units are not primarily responsible for decontaminating patients, they must coordinate with medical and CBRN elements to ensure continuity of care and the safety of the force. Planning for dental operations in CBRN environments must address individual protection, equipment resilience, and flexible patient support options in contaminated or high-threat areas.

4-51. When notified of a CBRN hazard, dental leaders must immediately assess the operational impact. If the dental unit is inside a collectively protected facility, it may continue limited operations. If unprotected, the unit may need to cease treatment and shift to an appropriate mission-oriented protective posture (known as MOPP). Dental personnel must be trained to recognize CBRN threats and execute battle drills that protect themselves, their patients, and their equipment. Early recognition and quick response can prevent the loss of critical capabilities and reduce casualties.

4-52. Like all Army units, dental teams must apply the assess, protect, and mitigate framework. Assessment includes identifying likely contamination routes, understanding terrain, and monitoring threat alerts. Detection capabilities may be limited within dental units, so close coordination with adjacent CBRN and command elements is essential for situational awareness. Dental planners should ensure their TACSOPs include communication procedures and response checklists for operating under CBRN conditions.

4-53. Protection involves safeguarding personnel and equipment through proper mission-oriented protective posture, site hardening, and minimizing exposure. Dental tools, suction systems, and sterilizers must be protected from contamination, and where possible, stored in sealed containers or collective protection systems. Personnel should rehearse patient management while in mission-oriented protective posture gear to ensure they can provide limited but essential care under degraded conditions. Using disposable instruments or barrier techniques may reduce contamination risk and preserve operational tempo.

4-54. Mitigation includes contingency plans for decontamination and recovery of dental operations. Units should rehearse immediate and operational decontamination procedures in coordination with their parent medical company or brigade. Dental personnel must be able to safely transfer contaminated patients to higher roles of care or designated decontamination stations. If facilities or equipment become contaminated, units must determine whether they can continue limited operations, displace, or enter a recovery phase. Commanders and planners must consider the logistical implications of decontamination on Class VIII supplies and sterilization capabilities.

4-55. By integrating into protection planning and maintaining trained personnel and CBRN-compatible equipment, dental units help preserve the fighting strength of supported forces. Dental readiness is a key element of FHP. Providing preventive and emergency dental care—especially in austere and contaminated environments—reduces nonbattle injuries and keeps Soldiers in the fight. Dental leaders must stay engaged in operational planning and protection coordination to ensure their teams can adapt and respond effectively in CBRN-contested environments.

ELIGIBILITY OF CARE DETERMINATION FOR DENTAL SERVICES

4-56. During large-scale combat operations, it is essential to clearly define who is eligible to receive care at Army-established MTFs and what type of care is authorized. Eligibility determination applies to all medical capabilities within the AHS, including dental services. Dental care does not require a separate eligibility process but is provided under the same legal, policy, and doctrinal guidance that governs all HSS. For detailed guidance on determining eligibility for care, refer to FM 4-02.

4-57. Personnel in the area of operations may seek dental care when the local or host-nation infrastructure is insufficient. These requests are evaluated using the same eligibility standards that apply to all medical care. Determinations are made at the highest level possible, often with guidance from the supporting staff judge advocate. Additional input may come from agencies such as the Department of State or the Assistant Chief of Staff, Civil Affairs Operations, G-9 or S-9, depending on the mission context. Eligibility decisions are governed by U.S. and international law, Department of Defense directives and instructions, Army regulations, standing doctrine, and relevant standard operating procedures (SOPs). Command guidance, humanitarian considerations, and available AHS resources also influence decision-making.

4-58. To determine who is eligible for dental care under operational conditions, commanders and medical personnel should consult documents such as AR 40-400, FM 6-27, applicable sections of Title 10, U.S. Code, and relevant Department of Defense directives. Additional references include interagency agreements, acquisition and cross-servicing agreements, higher headquarters orders, and multinational operation guidance. Contractors authorized to accompany the force must meet specific medical and dental readiness requirements as outlined in DODI 3020.41 and JP 4-10. This includes undergoing a dental assessment within 12 months prior to deployment, along with other medical readiness tasks such as immunizations, health screenings, and deoxyribonucleic acid (known as DNA) sample collection.

4-59. The political and military conditions within the assigned area must be considered when determining eligibility for medical and dental care. Commanders at higher echelons, in coordination with surgeon and legal staffs, create an eligibility matrix that guides care decisions. This matrix applies to all AHS functions, including dental services. In some cases, determinations may be made by name or group category. If an

individual not listed in the eligibility matrix presents at an MTF, medical personnel are expected to stabilize the patient first. Eligibility for continued care is then confirmed through the designated command authority. Emergency stabilization is required for dental conditions that threaten life, limb, or eyesight, regardless of the patient's status. Once stabilized, patients who are not eligible for further care should be prepared for transfer to a host nation, coalition, or civilian facility, provided their condition allows for it.

GENEVA CONVENTIONS AND MEDICAL ETHICS

4-60. The United States is a signatory to international treaties that shape the legal and ethical framework for military operations, including the Geneva and Hague Conventions. These agreements form the legal foundation for medical neutrality, humane treatment of the wounded, and protection for medical personnel and facilities. The Geneva Conventions, signed in 1949, contain four core treaties that remain binding today. Together, they reinforce the legitimacy of AHS operations, especially in combat environments. A summary of medical-specific protections and obligations is provided here, with a full implementation guide in Appendix C.

4-61. The law of armed conflict (LOAC) governs how wars are conducted and emphasizes minimizing unnecessary suffering. It requires that commanders and medical leaders plan operations in a way that respects both military necessity and humanitarian considerations. For the dental services function, LOAC impacts not only how and where care is delivered, but also what protections are afforded to personnel and patients. Strategic compliance with LOAC enhances mission legitimacy and ensures alignment with U.S. and partner nation expectations. Leaders should consult Appendix C and FM 6-27 for operational guidance and training standards.

4-62. The Geneva and Hague Conventions safeguard medical units, personnel, and transport platforms. These protections apply regardless of the patient's status, friend, foe, or civilian. However, compliance is not guaranteed in all operating environments. Dental and medical commanders must weigh the risks of enemy noncompliance and consider appropriate protective measures when sitting in treatment areas or marking medical assets. Appendix C outlines the practical implementation of these protections and provides examples of violations that may jeopardize legal status or operational continuity.

4-63. Ethical medical practice is both a professional standard and a legal requirement in military operations. Dental personnel must provide care impartially and without discrimination, consistent with both medical ethics and international law. In detention settings and high-risk operations, medical ethics guides how care is prioritized, documented, and protected. Upholding these standards preserves trust, reinforces U.S. values, and protects the force. Appendix C includes additional ethical guidance for detainee care, consent, confidentiality, and medical documentation.

4-64. Strategic planning for detainee operations includes security considerations, patient screening protocols, emergency response, and detailed recordkeeping. Facilities must be designed with both clinical efficiency and force protection in mind. Care is documented, monitored, and coordinated through proper medical channels in accordance with U.S. and international standards.

4-65. Medical operations must be planned with legal and ethical compliance in mind. Violations can result in loss of protected status for medical units, legal consequences for personnel, and strategic risks to the legitimacy of the mission. Commanders and medical leaders should incorporate Appendix C into planning, training, and operational SOPs to ensure compliance with international law and to reinforce ethical standards in all environments.

SECTION II – OPERATIONAL ROLES AND SPECIALIZED DENTAL SUPPORT FUNCTIONS

4-66. Dental service capabilities extend beyond routine care to include a range of operational and contingency tasks that directly support joint and multinational health service operations. These roles include support to reconstitution, MASCAL response, forensic dental identification, and veterinary dental emergencies. Dental personnel may operate in joint environments or alongside allied and partner nations, requiring interoperability, adaptability, and integration into broader medical support systems. Commanders and planners must understand and incorporate these specialized capabilities during planning and execution of

operations to ensure readiness, mission success, and compliance with international standards. This section outlines key operational applications of dental services and highlights their contributions to joint and multinational health efforts across the range of military operations.

DENTAL SUPPORT TO RECONSTITUTION

4-67. *Reconstitution* is an operation that commanders plan and implement to restore units to a desired level of combat effectiveness commensurate with mission requirements and available resources (ATP 3-94.4). Unlike routine sustainment, reconstitution is a command directed process that spans all warfighting functions and requires coordination across echelons. It is typically initiated two levels above the affected unit and executed using existing systems and personnel. Reconstitution operations demand full integration of the AHS and dental capabilities to ensure readiness for follow-on missions.

4-68. Commanders conducting reconstitution must assess mission variables, future operational requirements, and available resources. They determine the level of combat power necessary, set training and recovery priorities, and allocate support to enable successful reemployment of the unit. Dental leaders support this process by advising on the operational status of dental elements, forecasting Class VIII requirements, and identifying personnel or equipment shortfalls that affect readiness. In joint or multinational environments, dental reconstitution may also involve coordination with partner forces or medical commands to synchronize recovery timelines, enable interoperability, and align sustainment expectations. For more information on reconstitution, refer to ATP 3-94.4 and ADP 3-90.

4-69. *Reorganization* is all measures taken by the commander to maintain unit combat effectiveness or return it to a specified level of combat capability (ATP 3-94.4). At the tactical level, dental leaders can execute reorganization by shifting personnel within a dental platoon or section, consolidating treatment functions, or reallocating mission roles. This may include modifying work schedules, reprioritizing patient care (such as emergency versus routine), or establishing mobile treatment teams to maintain support during degraded operations. In multinational settings, coordination with coalition partners may be required to standardize reorganization practices and ensure continuity of care.

4-70. *Regeneration* is the rebuilding of a unit through large-scale replacement of personnel, equipment, and supplies, including the reestablishment of essential command and control and the conduct of mission essential training for the unit (ATP 3-94.4). For dental units, regeneration includes restoring critical equipment (such as x-ray machines, sterilization systems, and suction units), replenishing Class VIII supplies, and reestablishing clinical operations and patient tracking systems. It also includes conducting refresher training to regain technical proficiency and operational integration with supported forces. Regeneration requires significant support from higher headquarters and is time-sensitive. When part of a joint or multinational task force, dental regeneration efforts must align with the command's overall medical regeneration plan to ensure timely restoration of dental services within the larger force structure.

DENTAL SUPPORT TO VETERINARY SERVICES

4-71. Military working dogs (MWDs) are critical force multipliers whose effectiveness depends on their overall health, including oral health. Dental personnel may be called upon to support veterinary operations by providing emergency or essential dental treatment to MWDs in deployed or garrison environments. While Veterinary Corps officers maintain full clinical oversight and responsibility, they may request the technical expertise of dental assets to enhance care delivery. This support is especially important in austere or time-sensitive settings where specialized procedures may be required. Planning dental support for MWDs should be coordinated in advance of deployment, integrated into veterinary support plans, and included in theater AHS planning.

4-72. Dental treatment for MWDs may include radiographic assessments, local anesthesia, extractions, and root canal therapy. These procedures are vital for maintaining the animals' mission readiness and reducing operational risks for units that rely on them. Dental personnel must not perform any procedures on MWDs without a Veterinary Corps officer present to ensure patient safety and regulatory compliance. Dental personnel involved in MWD care should be trained on handling procedures, anesthesia considerations, and proper documentation. In joint or multinational operations, coordination with allied veterinary teams may also be necessary to ensure consistent standards and interoperability. For more information on dental care procedures and requirements for MWDs, refer to TB MED 298.

This paragraph is in consensus with STANAG 2464

FORENSIC DENTAL IDENTIFICATION

4-73. Dental personnel serve as critical enablers in forensic identification missions, supporting the Armed Forces Medical Examiner System, the Army Mortuary Affairs Program, and theater-level personnel recovery operations. Their primary responsibility is to conduct dental postmortem examinations, compare ante- and postmortem records, and provide expert analysis to confirm the identity of deceased personnel. These activities may also include documenting and interpreting dental features for charting, radiographic comparisons, and photographic records. Dental officers may be required to train non-dental personnel in basic forensic dental recognition to increase identification capacity in MASCAL or austere operational environments.

4-74. Dental personnel contribute to expeditionary forensics, which supports forensic-enabled intelligence, criminal investigations, and battlefield exploitation. Their skills are vital to multinational and joint operations involving mortuary affairs, personnel recovery, or humanitarian response to mass fatality events. Dental officers should coordinate closely with forensic, mortuary, and legal personnel to ensure the integrity of identification procedures, especially when managing remains in multinational or host-nation contexts. Interoperability considerations, such as standardized documentation, evidence handling, and terminology, must align with applicable agreements, including STANAG 2464 or bilateral technical arrangements. Early integration into operational planning enhances the ability of dental teams to support civil military operations.

DENTAL SUPPORT TO MASS CASUALTY SITUATIONS

4-75. *Mass casualty* is defined as any number of human casualties produced across a period of time that exceeds available medical support capabilities (JP 4-02). Dental personnel may be tasked to augment medical personnel during MASCAL situations. In such scenarios, dental officers and enlisted personnel can provide critical support, particularly when medical resources are overwhelmed or specialized skills are in short supply.

4-76. Dental providers may assist in a variety of clinical and support roles based on their training, local scope of practice, and operational requirements. These tasks can include:

- Triage of combat casualties.
- Emergency wound care and bleeding control.
- Maxillofacial injury management.
- Soft tissue wound repair.
- Forensic dental identification.
- Basic surgical assistance.
- Initial burn care.
- CBRN casualty support.
- Infection, control, and sterile techniques.
- Intravenous infusion and fluid resuscitation.
- Airway management, including intubation under supervision.

4-77. While most of these roles are performed by individual dental officers or enlisted personnel, there may be operational situations where the collective capability of the dental unit or its subordinate elements is integrated into a consolidated medical response. Dental units should therefore be involved in MASCAL planning, coordination, and rehearsal activities.

4-78. The medical command and control element should not assume all dental personnel possess the training or confidence to perform expanded clinical functions described in paragraph 4-76. The role of the dental team during MASCAL events must be clearly defined in the unit's medical SOP and practiced through joint rehearsals. If a dental officer is designated for triage or surgical support, they must understand surgical team priorities and protocols. Coordination with the surgical team, as well as validation of training and credentials, is essential to ensure safe and effective care under pressure.

4-79. In joint and multinational operations, expectations for dental augmentation in MASCAL situations may differ based on host-nation policies, coalition doctrine, or allied medical practices. Dental leaders must be prepared to coordinate with higher headquarters and allied counterparts to clarify their roles, establish interoperability, and ensure the effective employment of dental capabilities during MASCAL events.

This paragraph is in consensus with STANAG 2598

SECTION III – DENTAL ROLES AND RESPONSIBILITIES

4-80. Dental service support is a coordinated effort across all echelons of command, from strategic headquarters to unit-level formations. Each level plays a vital role in planning, supervising, and delivering dental care as part of integrated AHS support. This section describes the roles and relationships of dental personnel in ensuring Soldiers receive effective, timely, and mission focused dental care.

4-81. From the TMC to the battalion and unit level, Army dental personnel form a coordinated network that ensures dental care is available across all phases of operations. Their contributions to planning, readiness, treatment, and coalition interoperability are essential to the health and combat power of the force. Whether supporting a BCT in combat, providing technical guidance at the theater level, or coordinating care with multinational partners, dental officers and noncommissioned officers (NCOs) remain vital to the success of joint and Army health service operations

COORDINATED DENTAL STAFF RESPONSIBILITIES

4-82. Dental staff personnel at all echelons are responsible for developing and executing dental policies, procedures, and operational plans that support the force across the roles of care. These personnel assess requirements, produce dental estimates, and contribute to the HSS annexes of OPLANs. Their technical expertise ensures that dental services remain aligned with mission priorities and are effectively integrated into joint and Army operations.

4-83. To maintain readiness, these staff members evaluate operational needs, oversee dental readiness rates, and provide guidance to subordinate dental teams. Their duties also include surveillance of dental resources and capabilities within the area of operations, addressing factors such as operational readiness, troop strength, detainee care, and the delivery of authorized services to other populations.

4-84. Planning references such as ATP 4-02.42, ATP 4-02-.55, and FM 5-0, help dental planners synchronize their contributions to HSS and overall operational effectiveness. Training resources such as STP 8-68E14-SM-TG (for 68E dental specialists), STP 8-68EN5-SM-TG (for dental laboratory specialists) and TC 8-20.1 support the development and sustainment of enlisted dental personnel.

STRATEGIC LEVEL INTEGRATION

4-85. At the strategic level, the TMC main command post (known as the MCP) includes a dental surgeon on its TOE. This officer serves as the senior dental authority in the theater and ensures dental operations align with theater-level medical objectives and FHP priorities.

4-86. The TMC dental surgeon leads dental planning and coordination across the theater. Their responsibilities include:

- Developing theaterwide dental service programs and guidance.
- Consolidating and forwarding dental treatment data to theater repositories.
- Advising the TMC commander on dental policy, support planning, and integration.
- Exercising technical oversight of dental units when the MEDBDE is not deployed.
- Supporting modular deployment by tailoring dental capabilities based on mission needs.
- Assisting the joint force commander in selecting augmentation packages to meet operational demands.

OPERATIONAL LEVEL SUPPORT

4-87. At the operational level, dental service integration ensures that oral health readiness is maintained across wide areas of responsibility. The MEDBDE and its subordinate Medical Battalion (Multifunctional) provide the command, control, and technical oversight needed to align dental capabilities with mission demands. Dental personnel within these formations coordinate preventive and emergency care, manage resources, and support deployment planning in both joint and multinational environments. Through the combined leadership of dental officers and NCOs, operational units synchronize dental services to support sustained combat operations and contribute to overall FHP.

MEDICAL BRIGADE

4-88. At the operational level, the MEDBDE provides command and control of assigned dental assets. The brigade staff includes a chief dental officer and a senior medical NCO who together lead the integration of dental services across subordinate units.

4-89. The chief dental officer, serving as the MEDBDE dental surgeon, advises the clinical operations chief and oversees all brigade dental support. Their duties include:

- Supervising dental operations in assigned hospitals and clinics.
- Monitoring readiness rates and preventive dentistry programs.
- Recommending policies and protocols for care delivery and oral surgery.
- Coordinating with Air Force evacuation channels for dental surgical patients.

4-90. This officer may also serve as division dental surgeon. The chief dental officer provides technical guidance to dental officers assigned to brigade combat teams, armored cavalry regiments, and SFGs.

4-91. The MEDBDE's senior medical NCO supports the dental mission by:

- Monitoring dental activities across subordinate units.
- Consolidating readiness and treatment data.
- Assisting with policy implementation and personnel assignment.
- Advising enlisted dental personnel and recommending force structure adjustments.

MEDICAL BATTALION (MULTIFUNCTIONAL)

4-92. The medical battalion (multifunctional) delivers flexible and modular medical command and support to deployed forces. Within its medical operations section, a dental NCO coordinates the execution of dental support, particularly for Role 1 and Role 2 care through the DCAS. The dental NCO assists with FHP planning, equipment coordination, and tracking readiness indicators.

TACTICAL LEVEL EXECUTION

4-93. At the tactical level, dental officers are assigned to medical companies that support brigade combat teams, SFGs, armored cavalry regiments, and the active component civil affairs brigade. These officers serve as dental surgeons for their parent units and advise commanders on unit dental readiness. Their duties include:

- Assessing readiness using dental classification reports.
- Developing running estimates and recommendations to sustain readiness.
- Advising on preventive and emergent dental care during operations.
- Supporting civil-military and multinational efforts when appropriate.

4-94. Tactical dental personnel contribute to operational planning through participation in mission analysis and by advising on casualty estimates. They also integrate with operational and HSS planning cells.

SECTION IV – ESTABLISHING AND OPERATING THE DENTAL TREATMENT FACILITY

4-95. Dental treatment facilities deployed in support of operational missions must deliver care in alignment with AHS principles and in compliance with international humanitarian law. Dental units must adapt to dynamic environments, support the FHP mission, and integrate with broader medical operations across the roles of care. This section provides tactical and operational guidance for establishing, protecting, and sustaining dental care capabilities in the field.

4-96. Operational-level planning ensures dental assets are positioned effectively and equipped appropriately to meet mission demands. Considerations include site selection, sheltering, security, and compliance with the Geneva Conventions, and STANAG 2931. Dental personnel must also ensure safety and quality through infection control measures, risk management, and adherence to established clinical standards. Operations such as dental care, MEDEVAC, and logistics support are essential to maintaining oral health and mission readiness. This section supports the tactical employment of dental services and complements strategic guidance provided in FM 4-02, and legal principles in FM 6-27.

SITE SELECTION CONSIDERATIONS

4-97. Choosing the right location for a dental treatment facility is one of the most important steps in field setup. A well-selected site improves access, supports smooth vehicle movement, and provides natural concealment and defensibility. Good drainage is essential to avoid flooding during adverse weather. Using current imagery and terrain data during planning helps identify sites that meet operational needs.

4-98. Several mission-driven factors influence site location. These include the mission itself, the commander's intent, and the details of the operation plan. Additional considerations include terrain that allows for vehicle access, troop support, and operational space.

4-99. Sites should be free of hazards such as unexploded ordnance or contamination and should allow for communication setup. Natural concealment, good visibility, and physical security are important. The site should also be away from pest-breeding areas, garbage dumps, and potential enemy targets. Planners should ensure that enough space is available for ambulance movement, evacuation, and basic defensive measures.

4-100. If the unit is expected to move often, it may not be practical to set up a complete treatment facility. In these situations, dental teams may use an expedient shelter and provide only essential services with the minimum necessary equipment. If the unit expects to remain in place longer, existing shelters or permanent buildings should be used when available.

SHELTERING THE DENTAL TREATMENT FACILITY

4-101. In a deployed environment, dental care must be provided under shelter to protect both patients and staff from weather and environmental hazards. Even basic environmental control, such as shade or wind protection, can improve treatment quality and safety. Sheltering of the treatment facility can be accomplished through the use of expedient shelters, tents, semi-permanent buildings, and buildings of opportunity.

EXPEDIENT SHELTERS

4-102. Expedient shelters are useful when dental teams need to operate quickly or during unit movement. They may include a tarp, vehicle tailgate setup, or shaded space along a route. These shelters allow for limited dental care during short-term operations or emergency support.

TENTS

4-103. Field dental units do not have organic tents listed in their TOE. However, they may use tents issued under common tables of allowance or modified tables of organization. These tents should meet heating, cooling, and electrical requirements for dental operations.

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.

4-104. Tents are lightweight, portable, and easy to set up or conceal. These features make them valuable for forward-deployed dental teams. Tents provide flexibility in site selection and help protect equipment and personnel.

SEMI-PERMANENT BUILDINGS

4-105. In long-term operations or during extended stays in base camps, semi-permanent buildings offer ideal conditions for dental care. These buildings can be constructed to meet specific needs, providing space, power, and climate control for efficient treatment.

BUILDINGS OF OPPORTUNITY

4-106. When available, existing buildings provide many benefits, including lighting, running water, toilets, and temperature control. However, before use, engineers must inspect the building and approve it for occupancy. The building layout may limit how dental teams organize their treatment areas, so careful planning is still required.

SECURITY AND PROTECTION

4-107. Field dental units help support base security by managing protective measures around the dental facility. While they may contribute to local defense efforts, their primary responsibility is the care of patients. Under the Geneva Conventions, dental personnel can only take defensive action to protect themselves and their patients. These protections ensure compliance with international law and reinforce the noncombatant status of medical providers.

4-108. Secure and effective dental care increasingly depends on the Department of Defense Information Network-Army (known as DODIN-A). This network faces threats from many sources, including hackers, insider threats, and human error. A single vulnerability could compromise the unit's mission. All personnel are responsible for protecting network systems. For more information on cyberspace operations, see FM 3-12; for cybersecurity standards, refer to AR 25-2.

4-109. Protective positions or hardening of existing structures strengthens facilities and reduces risk to personnel and equipment. This may include passive and active hardening measures such as barriers, reinforced walls, overhead cover, and bunkers. These measures protect against attacks and environmental hazards. For more details, on base security and survivability refer to ATP 3-37.10 and ATP 3-37.34.

This paragraph implements STANAG 2931

CAMOUFLAGE OF DENTAL UNITS

4-110. The U.S. Army implements STANAG 2931 as the guiding authority for the camouflage of medical personnel and facilities during armed conflict. This standard allows for the concealment of medical services when their visibility could compromise military operations. It provides a balanced approach to protecting operational security while maintaining the internationally recognized protection of medical units under the LOAC.

4-111. STANAG 2931 aligns with the Geneva Conventions of 12 August 1949 for the *Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*. This convention, along with Protocols I and II, governs the use of protective emblems on medical personnel, facilities, and transport. Although the United States has not ratified Protocols I and II, U.S. doctrine applies the foundational principles of the Geneva Conventions in conjunction with STANAG 2931.

4-112. The Geneva Conventions require parties to a conflict to respect and protect medical personnel, units, and transports. These protections aim to ensure that medical personnel can perform their duties without

interference and are not made the object of attack. STANAG 2931 supports these protections by regulating when and how camouflage may be applied to reduce exposure without forfeiting legal protections.

4-113. Under STANAG 2931, competent military authorities are responsible for ensuring medical units are sited away from likely military targets whenever possible. These authorities also ensure that medical emblems are displayed properly unless there is a valid tactical reason to obscure them. This helps protect medical facilities from becoming collateral damage in attacks against nearby military objectives.

4-114. Although medical emblems should be clearly visible under normal circumstances, there may be times when such visibility endangers the unit. STANAG 2931 authorizes camouflage of emblems when it is necessary for operational reasons. This includes covering, obscuring, or removing the emblem temporarily. However, this action increases the risk that the facility may not be recognized as protected and could be mistakenly targeted. National regulations govern when and how this camouflage is applied.

4-115. The decision to camouflage medical personnel or facilities rests with a qualified military authority, typically a brigade-level commander or higher. That authority must weigh the operational risks against the protections provided by visible emblems. Even when camouflaged, medical personnel must continue to conduct themselves according to humanitarian principles and noncombatant roles, in accordance with both the Geneva Conventions and STANAG 2931.

4-116. STANAG 2931 also calls for dispersion of tents and medical equipment to reduce vulnerability. Units are expected to establish controlled access points and avoid clustering equipment in ways that draw attention. The standard specifically includes the camouflage of medical units, vehicles, and aircraft on the ground. In practice, this means obscuring the Red Cross, Red Crescent, or other protective emblems if required for tactical purposes. It is important to note that a black cross on an olive background is not a recognized protective emblem under the Geneva Conventions.

4-117. Fixed or large medical facilities are typically not camouflaged, as their function and permanence make concealment impractical. These facilities usually maintain visible emblems unless otherwise directed. For more detailed information on implementing the Geneva Conventions, ATP 3-37.34, FM 4-02, FM 6-27, and STANAG 2931.

TREATMENT FACILITY OPERATIONS

4-118. Patient care during clinical operations relies on adherence to established SOPs, which are fundamental to ensuring efficiency and effectiveness. These guidelines provide a structured approach to delivering high-quality care while minimizing risks.

4-119. 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, the management process is vital to impact current and future operations.

4-120. 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.

4-121. 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 safety program.

4-122. 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.

4-123. 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 D. Refer to TB MED 510 on safety precautions related to waste anesthetic gas exposure.

INFECTION AND EXPOSURE CONTROL

4-124. United States Army dental treatment facilities and medical providers operate under strict infection control policies and regulatory guidelines. These policies are established and monitored by several key authorities, including the Assistant Secretary of Defense for Health Affairs, the Office of The Surgeon General, the DHA, the Occupational Safety and Health Administration (known as OSHA), and the Centers for Disease Control and Prevention (known as CDC). Each organization contributes expertise to ensure comprehensive infection control standards that align with both military and civilian health care practices.

4-125. Army dental units follow infection control and exposure programs tailored to their specific operational environments. These programs provide detailed, site-specific guidance to address all aspects of infection prevention and exposure management. By adhering to these regulatory frameworks, dental units maintain a safe environment for both patients and providers, ensuring high-quality care while mitigating risks associated with infectious diseases and cross-contamination.

QUALITY ASSURANCE PLAN

4-126. The quality assurance plan (QA) 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 dental treatment facility. The plan allows the dental commander to make a standardized assessment of the Soldier's 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 E.

WASTE MANAGEMENT

4-127. Dental units produce three primary types of waste: general waste, hazardous waste, and medical waste, which includes regulated medical waste. Each category requires careful management to ensure safety and environmental compliance during operations. Proper handling and disposal processes are essential to safeguard personnel, protect the environment, and maintain operational effectiveness.

4-128. Guidance on the collection, handling, and disposal of these waste materials is outlined in Technical Manual (TM) 3-34.56. This resource provides detailed procedures for safely managing waste to minimize risks associated with contamination or improper disposal. Support for waste removal and disposal is often coordinated through engineer units, preventive medicine teams, or host nation disposal contracts, ensuring that these processes are carried out effectively and in compliance with established standards.

RADIOLOGY OPERATIONS

4-129. 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. However, this equipment cannot perform extraoral x-rays, which reinforces the necessity of obtaining Panorex images prior to deployment. 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. Refer to TB MED 521 for additional information on x-ray system safety.

4-130. Dental radiology equipment is found in the DCAS, hospital augmentation detachment (medical 32-bed), BSMC, and MCAS. The handheld digital x-ray equipment can produce a full range of intraoral x-rays and, when necessary, may be used for other medical procedures. Operation of handheld digital x-ray equipment is an additional responsibility of the dental specialists assigned to the unit.

4-131. 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 standard operating procedure (CSOP).

PROSTHODONTIC CARE OPERATIONS

4-132. Soldiers who have fixed crowns and bridges, have implant crowns, or wear fixed or removable 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 utilizing specialized equipment.

4-133. The dental company has an array of assemblages that contain the tools and materials necessary to provide temporary fixed and removable prosthodontic coverage and cementation. Additionally, each treatment section of the DCAS is equipped with emergency denture repair kits to effect prosthodontic repairs.

4-134. 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.

4-135. When patient needs surpass the capabilities of dental company DES, dental units can utilize intratheater in Department of Defense dental laboratories, and the Army post office system between the dentist and Continental U.S. area dental laboratories for fabrication. This process eliminates the need for units to maintain additional personnel and equipment in the field, significantly enhancing mobility by reducing logistical burdens such as weight and storage requirements.

4-136. Advancements in digital workflows, including 3D scanning and 3D printing, offer an even more efficient alternative to traditional methods. These technologies streamline the fabrication process and further enhance the mobility of dental units by minimizing the need for physical impressions and extensive equipment. As digital dentistry continues to evolve, it is anticipated that these methods will become the standard for prosthodontic support. For more detailed information on prosthodontic services and digital solutions.

MEDICAL EVACUATION OF DENTAL PATIENTS

4-137. When dental patients require care that exceeds the capability of their supporting dental assets, they may require MEDEVAC. MEDEVAC of these patients is no different than that which is provided for combat casualties or severe illnesses. The MEDEVAC 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. For additional information on MEDEVAC refer to ATP 4-02.2.

MEDICAL LOGISTICS

4-138. Medical products and services play a vital role in mission success and are governed by stringent regulatory standards, including those established by the United States Food and Drug Administration (known as FDA) and the Drug Enforcement Administration (known as DEA). Medical logistics (MEDLOG) is designed to meet the specialized needs of the Military Health System, focusing on reducing morbidity and mortality among Soldiers through the effective management of medical supplies and equipment.

4-139. Class VIII material has unique characteristics that require careful attention during storage, handling, and transportation. These include items with short shelf lives, susceptibility to temperature extremes, and specific preservation needs such as refrigeration or freezing. Additionally, flammable, corrosive, or radioactive items, controlled substances, and fragile equipment necessitate specialized storage and handling procedures. Medical gases, another component of Class VIII, require precise management to ensure safety and usability.

4-140. The disposal of Class VIII items and associated medical waste is a critical process that MEDLOG personnel oversee to mitigate risks to health and the environment. Proper coordination is essential to address the sensitivity of these materials and ensure compliance with safety standards. For detailed guidance on MEDLOG operations and procedures, refer to ATP 4-02.1.

SECTION V – ADMINISTRATIVE TOOLS AND REQUIREMENTS

4-141. Administrative tools and requirements play a critical role in ensuring the effective operation of any treatment facility, including dental units. These tools are essential for accurately documenting patient care and maintaining the operational efficiency of the facility. Proper use of these administrative elements ensures

that all aspects of dental treatment, from patient records to procedural compliance, are handled systematically and align with regulatory guidelines. By adhering to these administrative protocols, dental units can deliver high-quality care while supporting mission objectives.

STANDARD OPERATING PROCEDURE

4-142. An SOP provides a detailed set of instructions or steps designed to guide Soldiers in completing tasks efficiently and safely. These procedures help minimize environmental impact, align with regulatory guidance, and ensure operational goals are met effectively. By following an SOP, units can achieve consistency in their operations while maintaining compliance with established standards. Chapter 1 Appendix G provides information on how to write an SOP.

4-143. In the medical community, SOPs can take one of two primary forms: the TACSOP and the CSOP see Chapter 1 Appendix G. The TACSOP focuses on tactical operations, such as responses to CBRN threats, perimeter defense, and road marches. In contrast, the CSOP addresses the organization and functioning of clinical areas within dental treatment facilities, covering aspects like patient flow, equipment operation, maintenance, and safety protocols. For example, the CSOP might outline how a dental facility manages patient intake, provides care, and ensures the safety and functionality of its tools and equipment.

4-144. Dental units play a vital role in developing, publishing, and updating their SOPs to maintain high operational standards. It is equally important for personnel to be trained in these procedures to ensure they understand and can implement them effectively. Regular updates and training sessions help adapt SOPs to evolving mission requirements and operational environments, ensuring ongoing readiness and compliance.

DENTAL RECORDS

4-145. The purpose of a dental record is to provide a complete dental history for patient care, medicolegal support (for example, reimbursement and tort claims), research, and education. A dental record also provides a means of communication, where necessary, to fulfill other Army functions (for example, identification of remains). Maintenance and disposition of dental treatment records are governed by AR 40-66 and DHA procedures manuals. Refer to TB MED 250 for additional information on paper dental records.

4-146. The Electronic Health Record will be used whenever possible and during times of competition. Times of conflict might necessitate the use of paper records. Paper records should be maintained according to TB MED 250 and be uploaded into the Electronic Health Record when possible.

OUTPATIENT TREATMENT RECORDS

4-147. Outpatient treatment records are prepared for each patient treated by a United States Army dental treatment facility. An outpatient treatment record will be prepared by the first dental treatment facility to which a person reports for outpatient treatment. Outpatient treatment records will be kept as an electronic health record whenever possible. Paper health records will be maintained at the dental treatment facility and care will be uploaded to the electronic health record whenever possible.

DENTAL TREATMENT FACILITY LOGBOOKS

4-148. The dental treatment facility's daily dental treatment logs are maintained by the dental officer at each dental treatment facility. to record the names, rank, and unit of the patients treated at that dental treatment facility, 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 clinic's record, and the information provides a valuable source of data for statistical reporting.

DENTAL REPORTS

4-149. The following are possible reports that the dental treatment facility may have to complete during combat operations. For a complete list of what reports are required in the assigned area of operation, further guidance must be sought by the command surgeon.

DAILY DENTAL UNIT STATUS REPORT

4-150. The daily dental unit status report provides a summary of supported units' current dental condition. The frequency with which the report is submitted is situationally dependent. The report is submitted to the dental company's higher headquarters.

MONTHLY DENTAL ACTIVITY REPORT

4-151. The monthly dental activity report summarizes a facility's treatment activities for the previous month. The unit's TACSOP establishes the specific report format and submission deadlines based on mission requirements. The dental activity report includes:

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

4-152. Personnel and equipment information includes—

- Name, rank, and area of concentration for officers and the name, rank, and military occupational specialty and additional skill identifier for all enlisted personnel.
- Identity of the officer in charge, executive officer, and NCO in charge.
- Date of arrival and departure of all personnel.
- Personnel awards, honors, and achievements.
- Units supported, to include date support began and date support terminated.
- Dental and organizational equipment to include deficiencies, excesses, problems, and recommendations.
- Supply and maintenance, to include deficiencies, excesses, problems, and recommendations.
- Activities and programs (for example, foreign humanitarian assistance, preventive programs, professional and unit training, and distinguished visitors).
- Suggestions for improvement.

4-153. 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.

4-154. 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.

4-155. Daily dental unit status reports and quarterly dental activity reports are submitted through command channels to the TMC dental surgeon. The dental treatment facility 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 dental treatment facility's daily dental activities report is the only numerical manipulation required at the dental treatment facility level. Dental surgeons and dental commanders may extract additional information required to prepare their quarterly dental activities report.

ANNUAL HISTORICAL REPORT

4-156. AR 870-5, *Military History: Responsibilities, Policies, and Procedures*, prescribes procedures for providing the Department of the Army with annual reports of administrative, professional, and operational activities of Army Medicine. They are essential as reference and source material for the historical programs and missions of Army Medicine. They are frequently referred to when data are required by or requested of Army Medicine in its current operations. The reports are also used as teaching reference material.

4-157. Reports will be written in narrative form and prepared on one side of an 8 1/2 x 11-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. A margin of 1 1/2 inches will be left at the top and left of each page. Each report will be stapled by not more than two staples along the left margin. No other form of fastener will be used.

4-158. 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, and operational impact.
- **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 the development of personnel staffing guides.
- **Training.** Significant and unusual training activities, objectives, and programs.
- **Material.** 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.
- **Dental service.** Significant factors relating to operation of dental services, progress, and accomplishments in preventive dentistry and continuing educational programs.
- **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 Public Health Nursing programs and activities and where indicated, medical and health problems of the civilian or multinational military population in the area.

DENTAL READINESS AND COMMUNITY ORAL HEALTH PROTECTION REPORT

4-159. 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. AR 40-35 provides guidance for the development and conduct of dental readiness and the community oral health protection programs for all authorized beneficiaries of the dental care system. It describes the dental readiness program for active-duty Soldiers and other programs that benefit all members of the Army community. See Appendix A for more information on dental readiness.

4-160. 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.

Appendix A

Dental Readiness Program

Maintaining dental readiness is a critical aspect of ensuring overall force health and operational effectiveness. This appendix outlines the procedures, responsibilities, and organizational requirements for achieving and sustaining optimal dental readiness across Army units. By addressing noncombat-related dental issues, the dental readiness program reduces the risk of dental emergencies during deployments and other critical operations. The program integrates annual dental examinations, prioritization of treatment for high-risk personnel, and regular reporting to commanders to ensure transparency and accountability.

This section also details the responsibilities of unit commanders, dental activities, and clinic personnel in supporting and managing dental readiness efforts. The collaborative efforts outlined here emphasize timely identification and treatment of dental concerns, proactive recordkeeping, and adherence to established dental readiness standards. Through these comprehensive measures, the dental readiness program ensures Soldiers are prepared to meet the demands of their missions while minimizing risks associated with oral health issues.

PROCEDURES

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

- Regular Army Soldiers in-processing at their permanent duty stations whose dental records indicate that no examination has been performed within the previous six months or who are dental class 3 or dental class 4 must have a dental examination at the local dental treatment facility prior to completing their in-processing procedures. Every effort will be made to achieve dental class 1 or dental class 2 for all in-processing 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 panoramic x-ray is present and that it is of adequate quality for diagnostic/identification purposes. If no panoramic x-ray is present, one will be taken and placed in the dental record. There is no time requirement on updating panoramic x-rays; however, the existing images must accurately represent the current oral condition of the Soldier.

A-2. 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 15th month from the date of their last examination or dental readiness update are automatically classified as dental class 4. This Soldier is then in a partially medical ready but deployable status in accordance with Army Directive 2019-07 and DODI 1332.45.

A-3. 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.

- Soldiers in class 4 will have their annual or other required dental examinations scheduled. The Soldier's dental readiness category is updated, and an appointment is scheduled as above.

ORGANIZATIONAL RESPONSIBILITIES

A-4. 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 supported unit's dental clinic is the sole custodian of all unit personnel dental records.
- When out-processing, Soldiers whose records indicate no examination in the previous six months or who are a dental class 3 or dental class 4 will have dental examinations prior to completing their out-processing procedures.
- If a Soldier out-processes 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 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 dental treatment facility 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 the Medical Protection System 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 United States Army Reserve, 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 the early deployment forces are maintained in a dental class 1 or dental class 2 status.

A-5. Commanders of dental treatment facilities, and separate Regular Army dental units are responsible for assisting supported units in maintaining the readiness of Soldiers.

A-6. Dental treatment facility 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 90 percent total force medical readiness DODI 6025.19 (dental class 1 dental class 2 and dental class 4 combined).
- Screen dental records of newly arrived Soldiers to establish their dental readiness classification.
- Support the unit commander's dental readiness program by providing timely access to care to help eliminate Class 3 and Class 4 ratings. While unit commanders are responsible for tracking their Soldiers' readiness status using provided tools, a close and proactive partnership between the unit and the dental facility creates an effective way to coordinate dental examinations and ensure a medically ready force.
- 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.

Appendix B

Dental Support within the Army Strategic Contexts

This appendix outlines how Army Dental Corps capabilities support operations across the three Army strategic contexts: competition, crisis, and armed conflict. It provides planners and commanders with operational detail on how dental units operate at the tactical, operational, and strategic levels to preserve fighting strength, maintain readiness, and enhance HSS across the continuum of military operations.

Appendix B builds upon the overview provided in Chapter 2 and serves as a doctrinal bridge between FM 4-02 guidance and practical execution. Planners should tailor the application of this guidance to mission variables, available resources, and theater-specific conditions. Throughout Appendix B, see table B-1 for all acronyms used in figures B-1 through B-3.

Table B-1. List of acronyms for figures B-1 through B-3

Acronym	Definition	Acronym	Definition
AH	Army hospital	HHD	headquarters and headquarters detachment
AO	area of operations	km	kilometer
APOD	aerial port of debarkation	MCAS	medical company (area support)
ALP	ambulance loading point	MED	medical
ASCC	Army Service component command	MEDBDE	medical brigade
BAS	battalion aid station	METT-TC (I)	mission, enemy, terrain and weather, troops and support available, time available, civil considerations, and (informational considerations)
BCT	brigade combat team	POI	point of injury
BSB	brigade support battalion	SAD	surgical augmentation detachment (24-bed)
BSMC	brigade support medical company	SEC	section
CCP	casualty collection point	SPO	support operations
CONUS	continental United States	SPOD	sea port of debarkation
DCAS	dental company (area support)	SPT	support
DIV	division	SRGN	surgeon
EAB	echelons above brigade	TAC	tactical command post
FWD	forward	TM	team
HC	headquarters company	TMC	theater medical command

DENTAL SERVICES DURING COMPETITION

B-1. During periods of competition, dental services play a critical role in preserving the health and readiness of the force. The emphasis is on operational dental care, focused on preventing and managing dental conditions that could reduce combat power. Dental teams must be prepared to operate with limited assets, deliver responsive care to dispersed formations, and support broader security cooperation and engagement activities. Support occurs across all echelons, tactical, operational, and strategic, with each level contributing to FHP and readiness. Medical planners must ensure dental services are integrated into theater support plans and positioned to transition rapidly to crisis or conflict.

B-2. At the tactical echelon, the BSMC provides the only organic dental capability to a BCT. This team, composed of a general dentist and a dental specialist, supports a population at risk of up to 5,000 Soldiers. Their responsibilities include routine examinations, emergency care, and minor restorative procedures. By maintaining dental readiness and addressing urgent conditions, the team helps reduce noncombat dental casualties and ensures Soldiers remain mission capable.

B-3. At the operational echelon, which includes division, corps, and theater-level formations, the DCAS typically remains at its home station during competition. However, the DCAS may deploy forward as directed through the orders process based on mission demands. A fully staffed DCAS can support up to 43,000 Soldiers and falls under the command of a MEDBDE when deployed. Within the DCAS, forward dental platoons are modular and can be task-organized to meet operational needs. These platoons include mobile treatment teams capable of semi-independent operations or augmenting BSMC dental assets in dispersed or austere environments.

B-4. At the strategic echelon, the Army Service component command supports dental readiness through engagement activities, including multinational exercises, security cooperation, and humanitarian operations. Dental teams may conduct bilateral or multilateral events to build allied and partner capacity while improving their own readiness. These efforts support “set-the-theater” tasks and contribute to contingency planning, ensuring dental services can transition effectively to crisis or armed conflict if required.

B-5. Several key considerations shape dental planning during competition. Units are primarily responsible for ensuring dental readiness before deployment, as delays caused by dental emergencies during mobilization can result in the loss of three to five duty days per Soldier. Mobilization also places a heavy burden on existing dental resources, which may already be reduced due to operational deployments. Although the DCAS typically remains in garrison, its deployment is authorized through formal orders based on theater requirements and FHP assessments. Figure B-1 on page 59 illustrates the alignment of dental services with operational requirements during competition below the threshold of armed conflict.

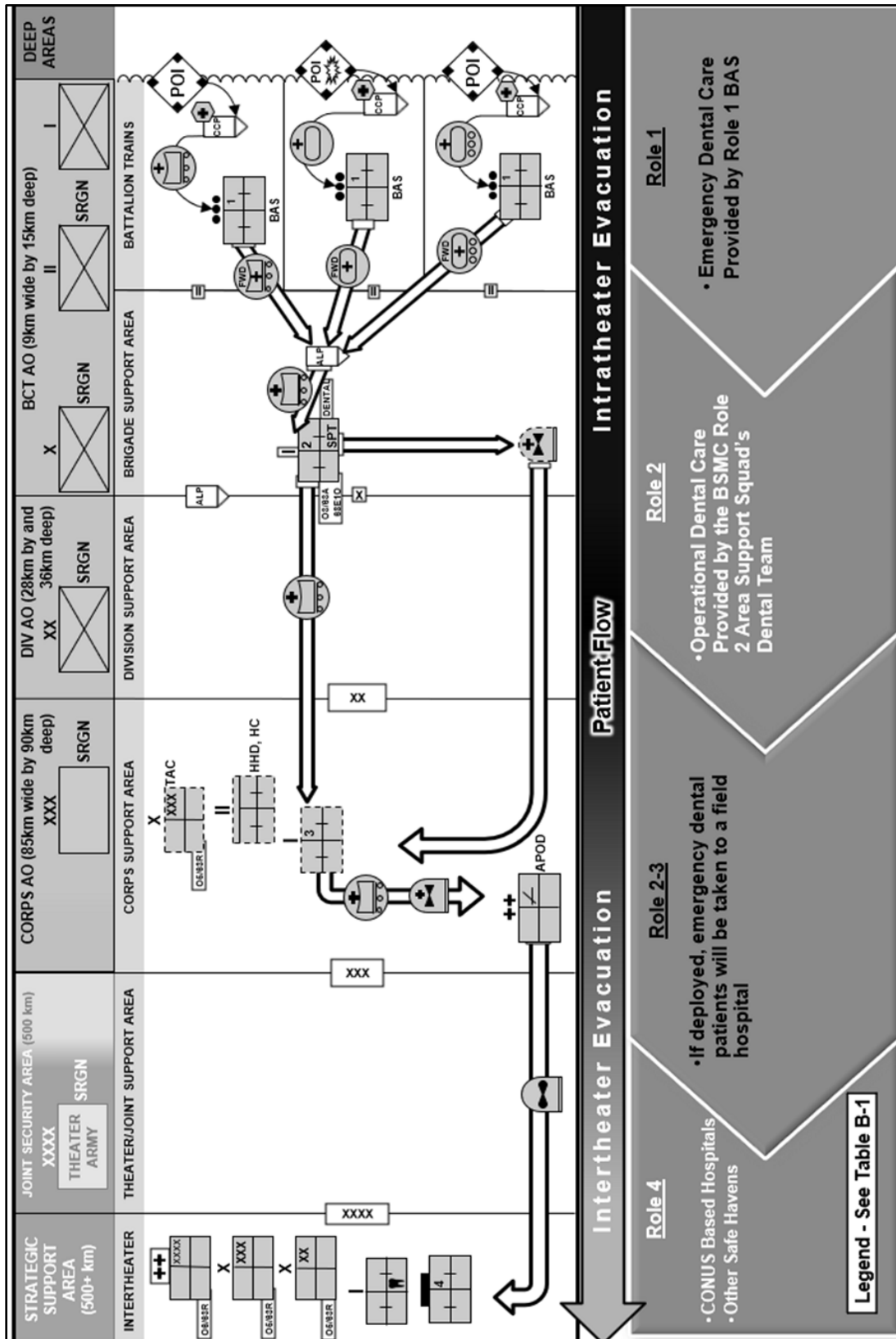


Figure B-1. Dental services during competition

DENTAL SERVICES DURING CRISIS

B-6. During crisis, Army dental services shift to a more responsive and mobile posture to address unpredictable operational demands and the potential for escalation to armed conflict. Dental support continues to emphasize operational dental care, emergency and essential services aimed at preserving the force. The flexibility and mobility of dental teams enable expeditionary care delivery across multiple dispersed locations, including support to joint and multinational efforts. As the operational environment becomes more volatile, dental planners must adapt support plans in near real-time, adjusting personnel and equipment packages to meet evolving requirements.

B-7. At the tactical echelon, the BSMC dental team continues to serve its assigned BCT. This team provides emergency dental treatment and essential care to maintain readiness and minimize dental-related evacuations. As crises intensify or the brigade's mission expands, the BSMC may be augmented by mobile dental teams from the forward dental platoon of the DCAS. Each forward dental support section within the DCAS includes six mobile treatment teams equipped with portable dental units, power generation, and trained personnel to deliver care in austere or rapidly changing conditions.

B-8. At the operational echelon, the DCAS is assigned to a MEDBDE or the TMC, and may deploy in part or in full based on mission needs and the PAR. The DCAS provides care across division, corps, and theater levels, significantly expanding the range of dental capabilities beyond what is available at the BCT level. These capabilities include restorative dentistry, prosthodontics, and more sustained preventive and emergency care, allowing the force to remain effective and combat-ready for extended periods.

B-9. At the strategic echelon, dental assets must be integrated into broader contingency and joint operational plans. Crisis response operations often involve coordination with other Services, governmental agencies, and multinational partners. Dental teams may be tasked to support host-nation forces, humanitarian assistance missions, or displaced populations, depending on the scenario. Strategic planners play a key role in aligning DCAS deployments with reception, staging, onward movement, and integration (known as RSOI) operations. They must also ensure interoperability with allied medical forces and synchronization with the Department of Defense health services.

B-10. Several key considerations influence the planning and employment of dental services during crisis. First, the DCAS may deploy incrementally, with forward elements sent ahead of the main body based on PAR estimates and mission variables factors. Second, forward dental treatment teams may be used to fill coverage gaps for small or geographically isolated units before full DCAS capabilities arrive. Third, medical planners must continuously reassess and update dental OPLANs to accommodate rapid changes in the operational context. These updates are essential to support transitions either back to competition or forward into armed conflict. Figure B-2 on page 61 depicts dental services in crisis.

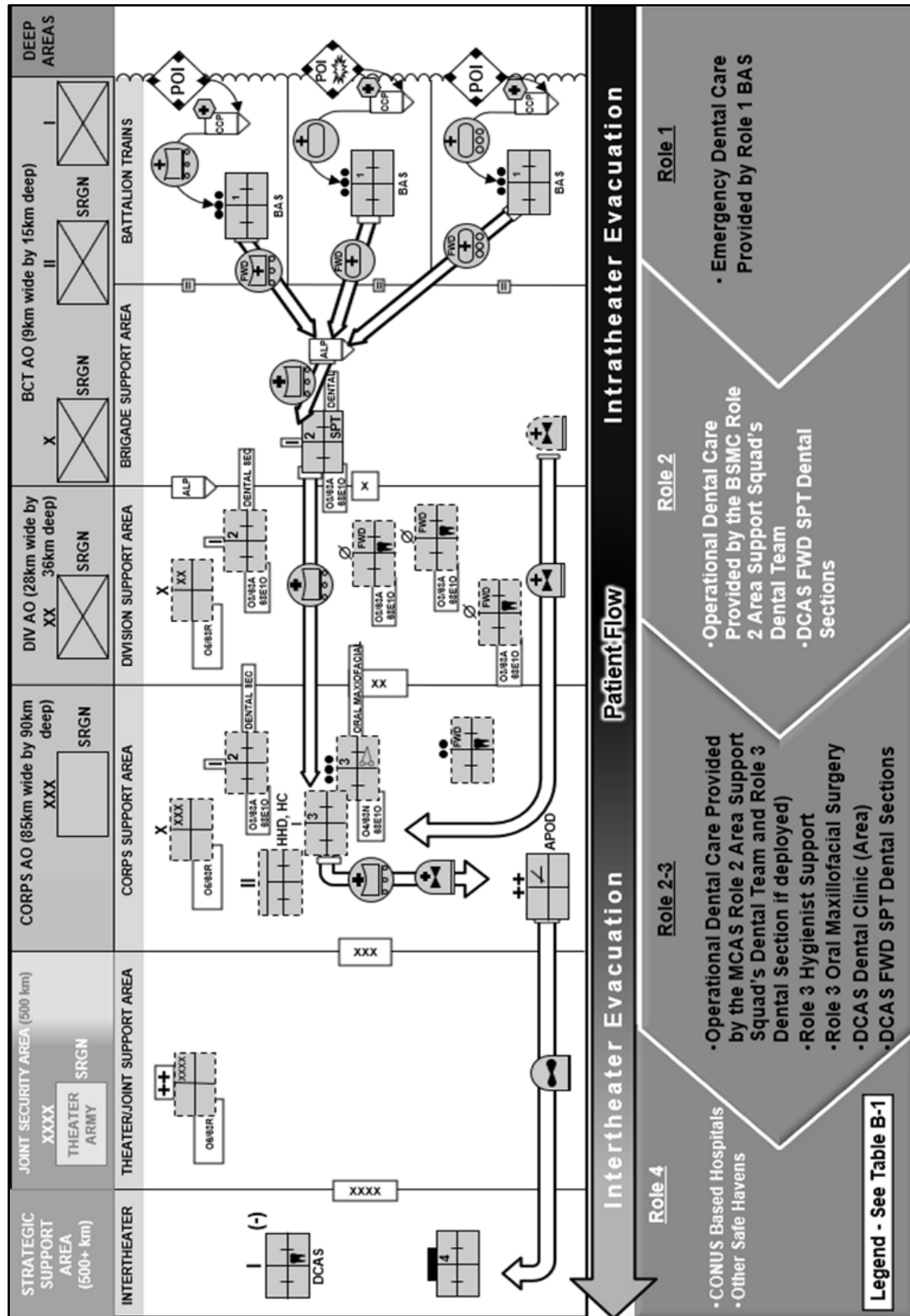


Figure B-2. Dental services during crisis

DENTAL SERVICES DURING ARMED CONFLICT

B-11. During armed conflict, dental services play a critical role in supporting the continuity of operations and force preservation under the most austere and hazardous conditions. The scope of dental responsibilities expands significantly, with teams expected to provide emergency, essential, and specialized care while also contributing to MASCAL response and casualty regulation. Forward-positioned dental teams are essential enablers of combat power, helping sustain troop strength by managing dental trauma, preventing infection, and augmenting surgical teams during surge events. Dental service planning must account for degraded environments, rapid shifts in tactical situations, and the need for interoperability across joint and multinational medical networks.

B-12. At the tactical echelon, the BSMC continues to provide Role 1 and Role 2 emergency dental care in proximity to the point of injury. Dental personnel contribute to triage and casualty stabilization during MASCAL situations and may assist with emergency procedures such as hemorrhage control or establishing intravenous/intraosseous access. In addition to their primary mission, dental teams may also participate in forensic dental identification, especially in high-casualty or sensitive recovery operations. Tactical dental care ensures rapid RTD when possible and contributes directly to sustaining combat effectiveness.

B-13. At the operational echelon, the DCAS is fully deployed and functions as the primary provider of Role 2 and Role 3 dental services. The DCAS delivers a full range of dental capabilities, including emergency treatment, essential dental services, and specialty procedures such as endodontics, periodontics, prosthodontics, and limited oral surgery. These clinics may augment hospital centers or SADs to expand capacity. The employment of DCAS elements is determined by PAR, mission priorities, and logistical feasibility. Their ability to operate semi-independently across wide areas makes them highly adaptable to fluid combat environments.

B-14. At the strategic echelon, the TMC and MEDBDE coordinate the strategic integration, deployment, and sustainment of dental capabilities in support of theater-level operations. Dental support is woven into the broader medical architecture for casualty regulation and evacuation, ensuring patients receive timely, appropriate care. During consolidation of gains, dental assets may be tasked with stabilization care for coalition partners, detainees, or local populations, particularly when host-nation dental infrastructure is insufficient. These missions require planners to balance humanitarian obligations with combat support priorities and - prepare dental elements for flexible mission profiles.

B-15. Several key considerations influence dental support in armed conflict. Dental teams must be equipped, trained, and mentally prepared to operate in degraded, high-threat environments. Forward-positioned dental teams are essential to force regeneration, helping reduce the evacuation burden and preserve fighting strength. Finally, transition and sustainment planning must account for the reconstitution or redeployment of dental assets as combat operations evolve or subside. Figure B-3 on page 63 depicts illustrates the structure and distribution of dental assets in armed conflict.

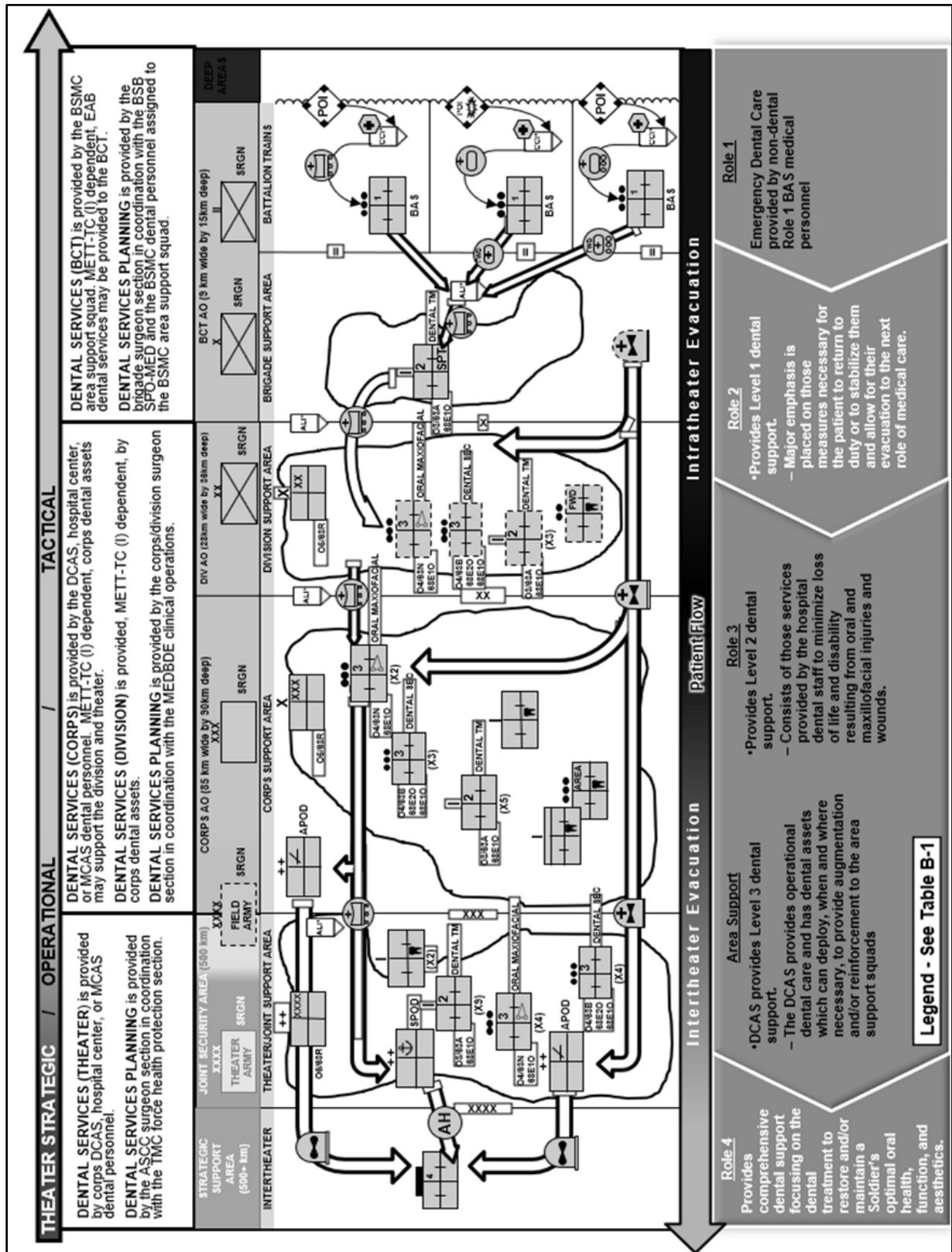


Figure B-3. Dental services during armed conflict

DENTAL SERVICES SUPPORT TO CONSOLIDATION OF GAINS AND TRANSITIONS

B-16. Consolidation of gains and transitions mark a critical phase in operations where dental services contribute to both FHP and broader stabilization efforts. As combat operations diminish or shift toward security and civil-military operations, dental assets support not only U.S. forces but may also extend care to displaced civilians, coalition personnel, or detainees. These missions require adaptable, scalable, and legally compliant dental capabilities that can operate within a dynamic and often resource-limited environment. Dental support during transitions also plays a role in restoring basic services, preventing public health crises, and maintaining medical readiness for follow-on forces.

B-17. At the tactical echelon, brigade dental teams remain focused on supporting the BCT and its subordinate units during security and stabilization tasks. These teams monitor unit dental readiness, respond to emergent dental issues, and support medical screening activities that accompany changes in troop disposition, demobilization, or rotation.

B-18. At the operational echelon, the DCAS continues to provide area dental support within the division, corps, or theater. Based on orders and operational needs, DCAS elements may reallocate or reposition in support of reconstitution efforts, post-combat assessments, or humanitarian dental missions. Forward dental platoons can augment units operating in recently secured areas where local infrastructure is damaged or nonexistent, delivering preventive and emergency dental care to U.S. personnel and, when directed, eligible non-U.S. populations.

B-19. At the strategic echelon, the TMC and MEDBDE coordinate dental service participation in joint, interagency, and multinational stabilization efforts. These may include multinational medical engagements, detainee care under the Geneva Conventions, and support to host-nation dental capacity building. Strategic planners must also consider redeployment timelines, reconstitution of dental forces, and the potential need for long-duration sustainment or transition to civilian-led health services.

B-20. Key considerations include the following:

- A dental assessment may be required in areas with minimal or no host-nation capability, but this does not obligate U.S. forces to provide full-spectrum care.
- MTFs and DCAS elements are responsible for stabilization of life-, limb-, and eyesight-threatening conditions prior to patient evacuation or referral.
- Dental assets may be employed in ways that support public health, detainee operations, and civil-military engagement, reinforcing security, and legitimacy during transitions.
- Medical planners must ensure that dental support to consolidation of gains is nested within broader sustainment and reconstitution plans.

B-21. This phase requires an agile approach to dental service employment, ensuring that as forces transition out of combat operations, dental capabilities remain aligned with operational priorities, and legal responsibilities.

Appendix C

Geneva Conventions, Medical Ethics, and Detainee Dental Operations

The United States is committed to upholding the LOAC, the Geneva Conventions, and medical ethics in all military operations, regardless of an adversary's actions. These principles are not contingent on reciprocity; rather, they reflect the enduring values of the U.S. Armed Forces. Adhering to international humanitarian law is both a legal obligation and a moral imperative. Medical and dental personnel must uphold the highest professional and ethical standards in protecting and treating the wounded, sick, and detained with dignity and impartiality.

The Geneva Conventions and their Additional Protocols codify the standards for humane treatment during armed conflict. These treaties define the protected status of medical units, personnel, and transport, and require the impartial care of all individuals, friends or foe, who are wounded or ill. Medical and dental teams must understand their responsibilities under these agreements to ensure lawful and ethical operations in all environments.

This appendix provides operational and tactical guidance for dental units operating under the protection of the Geneva Conventions. It explains how international law applies to patient care, the ethical conduct required of health professionals, and the treatment of detainees in field and fixed facilities. Dental services are expected to meet the same standards as all other medical functions. Compliance with these legal and ethical frameworks preserves the protected status of U.S. medical personnel and ensures our actions align with the principles outlined in FM 4-02 and FM 6-27.

SECTION I – GENEVA CONVENTIONS

C-1. The Geneva Conventions and their associated protocols serve as the legal foundation for protecting wounded and sick personnel, detainees, and civilians during armed conflict. At the operational and tactical levels, these treaties guide how AHS personnel, including dental teams, treat patients and safeguard facilities. Understanding and applying these protections enables units to deliver care while maintaining compliance with international law and preserving their protected status.

OVERVIEW OF THE GENEVA CONVENTIONS

C-2. The Geneva Conventions consist of four primary treaties signed in 1949. These treaties establish protections for specific groups during war:

- Convention (I): *Wounded and Sick in Armed Forces in the Field*.
- Convention (II): *Wounded, Sick, and Shipwrecked at Sea*.
- Convention (III): *Prisoners of War*.
- Convention (IV): *Civilians in Times of War*.

C-3. These Conventions apply equally to all individuals, regardless of nationality or affiliation. For medical and dental units, these treaties mandate humane treatment, protection from attack, and respect for the neutral role of healthcare personnel.

APPLICATION TO DENTAL SERVICES

C-4. Dental units operate close to combat elements and often provide care in austere environments. Under the Geneva Conventions, they are protected from direct attack when marked with the appropriate medical emblem and used solely for medical functions. Dental leaders must understand that these protections are not guaranteed, compliance depends on enemy behavior and adherence to the Conventions. Tactical dental units must be prepared to relocate, camouflage, or implement protective measures while maintaining documentation that proves adherence to the laws of war.

MARKING AND PROTECTION OF FACILITIES

C-5. Medical and dental treatment facilities should prominently display the Red Cross, Red Crescent, or Red Crystal emblems. However, in situations where visibility increases risk, STANAG 2931 allows for temporary removal or camouflage of these markings with proper authorization from a NATO brigade-level commander or higher. Such decisions must be documented and reversed as soon as tactical conditions permit.

SECTION II – MEDICAL ETHICS

C-6. Medical ethics are inseparable from legal compliance in the operational environment. Dental teams face situations where ethical obligations must be upheld under duress. These situations include the impartial treatment of enemy wounded, managing detainee care, and maintaining the integrity of clinical decisions in complex security conditions.

CORE ETHICAL PRINCIPLES

C-7. Dental professionals are required to treat all patients, whether friendly, enemy, or detainee, with dignity, impartiality, and professionalism. The ethical duty to “do no harm” extends to every patient, regardless of affiliation. Decisions must be based solely on clinical need, medical urgency, and the best interest of the patient, without influence from intelligence, command pressure, or logistical challenges.

C-8. When treating detainees, dental personnel may not participate in interrogations, forceful procedures, or any activities that violate ethical norms. Ethical treatment also includes safeguarding patient privacy, minimizing unnecessary pain, and obtaining informed consent when possible.

USE OF FORCE AND DEFENSE

C-9. Medical and dental personnel may carry personal weapons for self-defense and the defense of patients. However, they may not resist lawful capture or participate in offensive operations. Medical facilities may have a guard force, but such guards must act strictly in defense. Any involvement in combat activities—such as manning perimeter weapons or using treatment areas for tactical operations, jeopardizes protected status under international law.

RISKS OF ETHICAL VIOLATIONS

C-10. Violations of ethical standards or misuse of medical resources, such as using marked vehicles for transporting weapons or placing medical personnel in offensive roles, can result in prosecution, loss of protected status, or retaliatory attacks. Dental leaders must continuously assess compliance, brief their teams on limitations, and coordinate with legal advisors and the unit ministry team when unclear situations arise.

SECTION III – DENTAL SUPPORT TO DETAINEES

C-11. Detainee dental care presents unique operational and tactical challenges. These include facility design for security, handling of treatment refusals, documentation standards, and adherence to both medical ethics and international law. Dental leaders must balance humane treatment with safety protocols and resource limitations.

FACILITY DESIGN AND SECURITY CONSIDERATIONS

C-12. Detainee treatment areas must be configured to minimize risk. Chairs should face away from exits and be positioned for maximum visibility by guards. Dental instruments must remain out of detainee reach, and staff weapons must be secured before care begins. If care is provided in detention facilities without organic dental support, coordination with supporting dental units and military police is essential.

C-13. Detainees must never have unsupervised access to treatment areas. At no time should clinic space be used for nonmedical purposes, nor should detainees be treated alongside general population Soldiers or civilians. All appointments should be pre-coordinated, with written notice provided to guards for scheduling and transport.

TREATMENT SCOPE AND REFERRAL

C-14. Dental care for detainees typically includes emergency and essential procedures. Comprehensive care is rarely provided in theater and is subject to operational policy. All detainee treatment must be documented on SF 603. (Medical Record-Dental) and SF 603A (Medical Record-Dental-Continuation) Records should include pain assessments, examination findings, radiographs, and treatment recommendations. Consent to treatment, or a detainee's refusal, must be clearly noted and witnessed when possible.

C-15. Detainees have the right to refuse treatment. If they do, dental staff must inform them of potential complications and ensure follow-up plans are documented. Care should never be delayed or withheld due to a detainee's legal status. Radiographs and medical histories must be collected with support from translators as needed to ensure clear communication.

EMERGENCY CARE AND INPATIENT COORDINATION

C-16. Dental emergencies, such as uncontrolled bleeding, rapidly spreading infection, or trauma, require prompt evaluation and treatment. These cases may be triaged in coordination with the emergency department and may require hospital admission under dental consult. Inpatients must be escorted by guards when moved, and bedside care should be arranged when necessary.

C-17. Nutritional support, such as oral rehydration or protein drinks, should be offered to detainees undergoing oral surgery or those requiring pre-medication without having eaten.

PHOTOGRAPHS, TRANSLATORS, AND DOCUMENTATION

C-18. Medical photographs may only be taken to document clinical necessity (such as traumatic injuries or pre-existing conditions). These images must become part of the official medical record. Translators are required when language barriers exist and should facilitate both clinical questions and consent discussions.

C-19. Patient privacy must be respected within operational limitations. Dental personnel must also understand what medical information may be disclosed to the detention chain of command, such as infectious disease status or behavioral concerns that affect facility security.

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Appendix D

Dental Equipment Sets

Dental equipment sets are essential tools that enable the delivery of dental services in a variety of operational environments. These sets are designed to meet the unique challenges of field operations, providing flexibility, portability, and durability to support mission success. This appendix outlines the key dental equipment sets authorized for use by Army dental units, their intended purposes, and their configurations to support comprehensive dental care in austere and dynamic conditions.

From emergency care kits to specialized sets for prosthodontics and oral surgery, these equipment sets ensure that dental teams are equipped to address a wide range of oral health needs. Additionally, the management of Class VIII supplies, including medical and dental material, is critical for maintaining readiness and operational effectiveness. By understanding the capabilities and applications of these equipment sets, dental leaders and personnel can better plan and execute dental service support in alignment with mission requirements and environmental constraints.

This appendix is in consensus with STANAG 2128

FIELD DENTAL SETS

D-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.

D-2. All medical material, where specific conditions for storage or transportation such as humidity or temperature limitations apply, must be clearly marked with all relevant information.

D-3. All pharmaceuticals must be clearly marked with specific information on contents with the addition of generic name and the number of contents in metric. All requirements for storage and conditions for transportation must be clearly indicated, if the requirements go beyond the “normal” conditions for storage and transportation of pharmaceuticals (for example drugs which are to be transported free from frost or preparations which must be protected from excessive heat, such as ointments or suppositories).

D-4. Ideally date of production, lot number, and date of expiration should appear. As a minimum date and time (if applicable) expiration must be stated.

D-5. Each general and comprehensive dental officer in a field clinical position has the following equipment available:

- Dental equipment set - operational care, emergency.
- Dental equipment set - operational care, essential.
- Dental Material set - operational care, specialty.
- Dental equipment set - denture repair, limited.
- Dental equipment set - dental x-ray field.

D-6. The descriptions provided below are intended only to provide a brief description of the set and its intended purpose.

DENTAL EQUIPMENT SET – OPERATIONAL CARE, EMERGENCY

D-7. The DES is a small dental emergency kit that is contained in a hand carried medical aid bag to support mobile emergency dental treatment. 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.

D-8. The DES operational care, emergency is intended for use when the situation does not permit the setup of the dental officer's standard equipment.

DENTAL EQUIPMENT SET – OPERATIONAL CARE, ESSENTIAL

D-9. The DES operational care, essential is considered the primary dental equipment set for providing operational care. The field dental equipment contained in the DES is compact, lightweight, mobile and requires a limited power demand. This set provides the dental armamentarium used in the procedures to diagnosis and treat:

- Dental Caries.
- Defective restorations.
- Occlusal trauma.
- Tooth luxation/evulsion.
- Gingivitis and early/moderate periodontitis.
- Periodontal abscess.
- Traumatic or inflammatory oral lesions.
- Routine endodontics.
- Postmortem dental examination.
- Tooth Extractions.

D-10. Major items include one each, portable, field-type: dental chair and stool unit; dental operating and treatment unit; dental light set; and compressor.

DENTAL MATERIAL SET – OPERATIONAL CARE, SPECIALTY

D-11. The Dental Material Set (commonly known as DMS) operational care, specialty contains dental support equipment and durable and consumable supplies to support the capability to perform operational dental care and to sustain operations for 72 hours. This assemblage contains the necessary dental support equipment and material needed to support operational care given for the relief of oral pain, elimination of acute infection, control of life-threatening oral conditions and treatment of trauma to teeth, jaws, associated facial structures and includes support items that include a curing light, composite resin, electric pulp tester, sterilizer, sink, and laboratory table.

DENTAL EQUIPMENT SET – DENTURE REPAIR, LIMITED

D-12. The DES denture repair limited is a compact, lightweight, and mobile dental prosthetic repair kit for emergency use in the field when a prosthetic facility is not reasonably accessible or when one is impractical to set up. This set contains dental equipment and supplies to support the dentist's capability to perform routine and emergency repair on damaged dentures or to fabricate replacement dentures in support of operational care.

DENTAL EQUIPMENT SET – DENTAL X-RAY, FIELD

D-13. The DES dental x-ray field provides dental x-ray equipment, durable and consumable supplies to support the dentist's capability to perform Operational Dental Care and to sustain operations for 72 hours. This assemblage contains the necessary dental x-ray equipment and material needed to support operational care given for the relief of oral pain, elimination of acute infection, control of life-threatening oral conditions, and the treatment of trauma to teeth, jaws, and associated facial structures. It provides imaging capabilities to assist the dentist in diagnosis and treatment of dental conditions resulting from trauma, caries, and other oral pathology.

SPECIALTY DENTAL SETS

D-14. 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 - prosthodontics – increment 2.
- Dental material set - oral and maxillofacial surgery.
- Dental material set -dental hygienist, field.

DENTAL EQUIPMENT SET -PROSTHODONTICS – INCREMENT 2

D-15. This set provides clinical and laboratory items necessary to support fixed and removable prosthodontic procedures. The prosthodontics DES must be used in conjunction with the DES, operational care specialty.

DENTAL MATERIAL SET – ORAL AND MAXILLOFACIAL SURGERY

D-16. This set is designed for performing surgeries on the mouth, jaw and facial structures. It includes specialized instruments such as surgical drills, bone saws and bone grafting materials for complex and invasive procedures

DENTAL MATERIAL SET – DENTAL HYGIENIST FIELD

D-17. This set is lightweight and mobile and includes those instruments and materials necessary for providing preventive dentistry services to Soldiers in an operational environment, where access to advanced dental facilities is limited.

MANAGEMENT OF CLASS VIII SUPPLIES

D-18. Effective management of Class VIII supplies is critical for maintaining operational readiness and supporting dental service delivery in medical units. These supply functions primarily involve overseeing the assigned medical and dental equipment sets and ensuring timely replenishment through standardized ordering procedures. Proper management helps sustain dental operations by ensuring that essential materials, medications, and equipment are available when needed.

D-19. For a detailed understanding of MEDLOG processes, including the acquisition, distribution, and maintenance of Class VIII supplies, refer to ATP 4-02.1. This resource provides detailed guidance on optimizing supply chain management to support medical and dental units in both routine and operational settings.

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Appendix E

Quality Assurance Plans

This appendix outlines the framework and essential components of quality assurance (QA) plans for dental service operations in military settings. QA plans are critical for ensuring the delivery of high-quality, efficient dental care to Soldiers, aligning with the capabilities of the dental treatment facility, and maintaining the highest standards of patient safety and satisfaction. Through a system of checks and balances, dental commanders and their staff can assess the quality of care, evaluate practitioner performance, and optimize resource utilization. Key objectives of QA plans include providing dental care that matches staff qualifications and facility capabilities, minimizing risks to patients, enhancing communication between providers and patients, and systematically improving patient satisfaction. The appendix addresses the application of QA principles for operational dental care, highlighting areas such as patient care evaluation, utilization management, risk management, and dental radiology procedures. These efforts collectively aim to ensure that Soldiers receive consistent, high -quality dental care, even in operational environments.

QUALITY ASSURANCE IN THE THEATER

E-1. 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. While QA policy in AR 40-68 is designed for peacetime care, it must be adjusted to fit the realities of tactical and operational environments.

E-2. Regardless of location, the principles of QA remain essential. The goal is to provide Soldiers in theater with the highest possible quality of dental care, consistent with the tactical situation, comparable to the care available in a garrison dental facility. By establishing a sound QA plan, dental commanders and staff dental surgeons at all levels help ensure that Soldiers have access to necessary care when and where they need it.

PATIENT CARE EVALUATION

E-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.

E-4. 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

E-5. Access to and the effective utilization of dental services in theater is mission variable driven. The goal of utilization management is to provide the highest quality dental care possible in the most efficient manner.

E-6. Utilization management is part of performance improvement data collected for the purpose of organizational improvement. For more information on this subject, refer to 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.

E-7. Emergency and preventive care should be provided as close to supported troop populations as possible. The result is faster RTD 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

E-8. The risk management program in dental operations focuses on identifying and reducing the likelihood of accidents and injuries within dental support operations. In a theater setting, this program addresses potential risks to patients, visitors, and unit personnel, ensuring a safer environment for everyone involved. By taking proactive measures and applying risk reduction strategies, commanders can minimize hazards and improve the overall safety of dental care operations. For additional details on implementing risk management principles, refer to ATP 5-19.

DENTAL RADIOLOGY

E-9. 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 radiographic information is entered into the patients' records.

Appendix F

Format for Tab C (Dental Services) of Appendix 9 (Force Health Protection), to Annex E (Protection) of an Operation Plan or Order

This appendix provides commanders and staffs guidance on developing Tab C (Dental Services) of Appendix 9 (Force Health Protection), to Annex E (Protection) of an operation plan or order. For further information on developing annexes and supporting appendices, tabs, and exhibits for plans and orders, refer to FM 5-0 and ATP 4-02.55.

TAB FORMAT

F-1. Attachments (annexes, appendixes, tabs, and exhibits) are information management tools that expand on the base plan or order. Staffs refer to attachments by letter or number and title. They use the following naming conventions:

- Annexes - staffs designate annexes with capital letters, for example, Annex E (Protection) to OPORD 25-07-3 Infantry Division (ID).
- Appendixes - staffs designate appendixes with Arabic numbers, for example, Appendix 9 (Force Health Protection) to Annex E (Protection) to OPORD 25-07-1 Armored Division (AD).
- Tabs - staffs designate tabs with capital letters, for example, Tab C (Medical Evacuation) to Appendix 9 (Force Health Protection) to Annex E (Protection) to OPORD 25-07-101 Airborne Division (air assault) (AAD).
- Exhibits - staffs designate exhibits with Arabic numbers, for example, exhibit 1 (Medical Eligibility of Care Determination) to Tab C (Dental Services) to Appendix 9 (Force Health Protection) to Annex E (Protection) to OPORD 25-07-82 Airborne Division (ABD).

F-2. Figure F-1. Example of dental services tab to Annex E to operations order on page 2 provides a format and basic instructions for developing Tab C (Dental Services) of Appendix 9 (Force Health Protection), to Annex E (Protection) of an Operation Plan or Order. This provides an example of the level of detail that goes into creating a Tab. Units should tailor their content to reflect their mission, task organization, and operational environment. This example is not all-inclusive and must be refined through the military decision-making process, unit tactical standard operating procedures, command and staff input, and coordination with higher headquarters. Units are highly encouraged to develop base attachments for each medical function and maintain them in their unit tactical standard operating procedures to facilitate rapid planning in support of large-scale combat operations.

[CLASSIFICATION] (Change from verbal orders, if any)	Copy ## of ## copies Issuing headquarters Place of issue Date-time group of signature Message reference number
Include the full heading if the tab is distributed separately from the base order or higher-level attachment. [TAB C (DENTAL SERVICES) TO APPENDIX 9 (FORCE HEALTH PROTECTION) ANNEX E (PROTECTION) TO OPERATION PLAN/ORDER (number) (code name)— (issuing headquarters) (classification of title)] (U) References: <i>Refer to higher headquarters' operation plan or operation order and identify map sheets for operation (optional). If applicable, list references concerning only the attachment (optional).</i> a. <i>List maps, overlays, charts, or other documents required to understand the dental services plan first.</i> b. <i>List other references in subparagraphs labels as shown.</i> c. <i>List documents essential to the understanding of Tab _ to Appendix _ to Annex _ . List references concerning dental support in the appropriate attachments.</i> d. <i>List doctrinal references for (medical function). Include FM 4-02 and applicable joint publications, army regulations, pamphlets, technical manuals, Army techniques publications, and training circulars.</i> (U) Time Zone Used Throughout the Operation Plan (OPLAN): <i>State the time zone used in the assigned area during execution. When the plan or order applies to units in different time zones, use Greenwich mean time (ZULU).</i> (U) Task Organization. <i>Describe the organization of dental services forces (including attachments and detachments to and from the issuing headquarters) and their command and support relationships. State when each attachment or detachment is effective (for example, on order, by phase, by assigned area). Refer to Annex A (Task Organization).</i> 1. (U) Situation. <i>Include information affecting dental services that paragraph 1 of the plan, Intelligence Estimate, or order does not cover or that needs expansion. This paragraph provides an overview of the operational environment as it pertains to dental services support. It identifies factors such as mission type, operational phase, civil-military conditions, and dental health threats (including infection risks, contaminated water and food supplies, and untreated cavities, periodontal disease). This framing sets the stage for describing how dental support will be organized and prioritized. Include only information that directly influences the planning and execution of dental tasks—such as proactive measures, including preventative care, rapid trauma response, and access to dental care.</i> a. (U) Area of Interest. <i>Describe the area of interest as it relates to the AHS and dental services (EXAMPLE) Identify regions outside the assigned area that may affect dental services. This includes monitoring potential threat areas, border regions for disease transmission, and strategic infrastructure crucial for supply lines. Refer to Annex B (Intelligence) as required.</i> b. (U) Assigned Area. <i>Refer to Appendix 2 (Operation Overlay) to Annex C (Operations). Focus on key dental services concerns within the assigned area, (EXAMPLE) such as traumatic dental injuries, acute dental pain and infections, limited access to definitive care, assessment and triage and FHP. Highlight any areas of significant dental risk or where dental services will be concentrated. Refer to Appendix 2 (Operation Overlay) to Annex C (Operations) as required.</i>	
[page number] [CLASSIFICATION]	

Figure F-1. Example of dental services tab to Annex E to operations order

[CLASSIFICATION] [TAB C (DENTAL SERVICES) TO APPENDIX 9 (FORCE HEALTH PROTECTION) ANNEX E (PROTECTION) TO OPERATION PLAN/ORDER (number) (code name)—(issuing headquarters) (classification of title)] (1) (U) <u>Terrain</u>. Describe the aspects of terrain that impact dental services (EXAMPLE) Identify terrain features that complicate maneuver and logistics, equipment performance and corrosion, evacuation, and site selection. Jungle environments areas may limit access to facilities or due to dense vegetation. Natural terrain (e.g., swamps, mountains, deserts) may restrict the mobility of dental teams and cause corrosion and or flooding issues and may require special planning. Refer to Annex B (Intelligence) as required. (2) (U) <u>Weather</u>. Describe the aspects of weather that impact dental services (EXAMPLE) Weather affects facility integrity, equipment function, and the ability to provide dental care. Inclement weather may restrict movement of mobile dental teams, impact evacuations and timely treatment of dental casualties. Temperature fluctuations can decrease dexterity for dental materials and increase the risk of infection. Refer to Annex B (Intelligence) as required. c. (U) <u>Enemy Forces</u>. List known and templated locations and activities of enemy dental services units for one echelon up and two echelons down. List enemy maneuver and other area capabilities that will impact friendly operations. State expected enemy courses of action and employment of enemy dental services assets. Refer to Annex B (Intelligence) as required. (EXAMPLE) Identify enemy capabilities that could impact dental services operations. This includes direct and indirect attacks and sabotage, electronic warfare, cyberthreats, misinformation warfare, and CBRN attacks. Assess the enemy's ability to disrupt dental logistics or introduce hazards and drones/UAVs into the AO. The subparagraphs below are examples of possible topics. (1) (U) <u>Enemy Capabilities</u>. Describe the enemy capabilities that could degrade or disrupt dental support. This includes direct kinetic attacks like artillery and IEDs, infrastructure sabotage, or utilization of CBRN weapons to contaminate dental facilities and patients. (2) (U) <u>Weapons</u>. Note any dental-relevant threats from enemy weapon systems—particularly those that could harm dental casualties (such as, chemical, biological, radiological, and nuclear (CBRN) threats or evacuation route attacks). d. (U) <u>Friendly Forces</u>. Outline the higher headquarters' plan as it pertains to the dental services. List designation, location, and outline of plan of higher, adjacent, and other dental services assets that support or impact the issuing headquarters or require coordination and additional support. (EXAMPLE) Include locations of DCAS, and other MTFs with dental capabilities. Identify supporting units without organic dental assets and outline coordination requirements. The subparagraphs below are examples of possible topics. (1) (U) <u>Attachments and Detachments</u>. List dental units attached to or detached from the issuing command. Include dental service detachments, teams, or medical elements with dental capability. Clarify command relationships and the effective dates or conditions for attachments (e.g., "on order," "upon initiation of Phase II"). Only include those affecting dental support. Refer to Annex A (Task Organization) as required. e. (U) <u>Interagency, Intergovernmental, and Nongovernmental Organizations (NGO)</u>. Identify and describe other organizations in the assigned area that may impact the conduct of dental services or implementation of dental services-specific equipment and tactics. (EXAMPLE) host nation ministries of health, U.S. Department of State, International Committee of the Red Cross, Public Health Departments, or NGOs conducting dental services. Highlight opportunities or conflicts in dental roles, especially in stability operations or humanitarian settings. Refer to Annex V (Interorganization-Interagency Coordination) as required. [page number] [CLASSIFICATION]

Figure F-1. Example of dental services tab to Annex E to operations order (continued)

[CLASSIFICATION] [TAB C (DENTAL SERVICES) TO APPENDIX 9 (FORCE HEALTH PROTECTION) ANNEX E (PROTECTION) TO OPERATION PLAN/ORDER (number) (code name)—(issuing headquarters) (classification of title)] f. (U) <u>Civil Considerations</u>. Describe the aspects of the civil situation that impact dental services. Refer to Annex B (Intelligence) and Annex K (Civil Affairs Operations) as required. (EXAMPLE) This includes displaced civilians. Note how these may impact oral health, public health infrastructure, or supply chains. Identify any constraints imposed by cultural norms, public perception, or civil-military dental cooperation. g. (U) <u>Assumptions</u>. List any dental specific assumptions that support the development of this attachment. (EXAMPLE) These may include increased trauma rates, limited oral surgery capabilities, untreated dental disease, or anticipated support requirements from host nation dental assets. Use assumptions to guide planning and identify critical unknowns that may affect mission success. (1) (U) <u>Special Factors</u>. List dental services conditions or planning factors that may impact the mission. Examples include environmental dental issues, dental material degradation, sterilization challenges, or ongoing dental hygiene situations that affect operations. (2) (U) <u>Definitions</u>. List any dental services definitions required to support the appendix development. (3) (U) <u>Dental Services Estimate Considerations</u>. Summarize key dental services factors that influence mission planning. (EXAMPLE) This includes conditions affecting dental treatment, patient safety, health risks, and the presence or absence of local dental services. These considerations help assess mission feasibility and determine support requirements. h. (U) <u>Civilian population</u>. Note how the civilian population impacts dental operations— such as increased in demand for dental services, increased the demand for pediatric-dental services, resource strains, nutritional deficiencies, or public health risk from unique or local disease transmission. (1) (U) <u>Disease Transmission</u>. List diseases in the AO that pose a risk to U.S. personnel, animals, or local public health. Include those affecting mission readiness and stability (2) (U) <u>Trauma and Injury</u>. Implement plans for civilians that require immediate dental intervention since civilians are often caught in the crossfire of conflict, resulting in a surge in maxillofacial trauma cases (fractures, soft tissue injuries). (3) (U) <u>Untreated Dental Disease</u>. Civilians may have pre-existing, untreated dental disease, particularly in areas with limited access to healthcare. This leads to increased demand for restorative and emergency dental care. (4) (U) <u>Indigenous Dental Services</u>. Assess local dental capabilities—personnel, infrastructure, quality of care, and reliability. Note gaps or opportunities for coordination or civil affairs engagement. (5) (U) <u>Nutritional Deficiencies</u>. Malnutrition can exacerbate dental problems and impair healing. (6) (U) <u>Transportation and movement restriction</u>. Identify transportation restrictions, poor infrastructure areas, security risks, specific resupply needs, including cold chain, Class VIII items, or mission-specific dental materials. (7) (U) <u>Other</u>. Use this space to capture any unique dental planning factors not otherwise addressed. 2. (U) Mission. State the mission of dental services in support of the base plan or order. (EXAMPLE) This should clearly describe who (dental assets), what (dental functions), when (timing tied to operational phases), where (assigned area), and why (purpose in support of protection and sustainment). 3. (U) Execution. Explains how dental services are carried out. It describes the scheme of support, priorities, specific tasks, and coordination needed to execute dental services with the overall concept of operations. [page number] [CLASSIFICATION]
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Figure F-1. Example of dental services tab to Annex E to operations order (continued)

[CLASSIFICATION] [TAB C (DENTAL SERVICES) TO APPENDIX 9 (FORCE HEALTH PROTECTION) ANNEX E (PROTECTION) TO OPERATION PLAN/ORDER (number) (code name)— (issuing headquarters) (classification of title)] a. (U) <u>Commander's Intent</u>. <i>Use this paragraph to summarize the commander's overarching guidance for dental support. It should explain the purpose of dental services in the operation, outline key tasks that must be achieved regardless of changes to the situation, and describe what success looks like (end state). Keep the language clear and focused on outcomes, such as:</i> <u>Purpose</u>: <i>Why dental services is essential to mission success (such as, identify emerging dental disease, maintain force health protection readiness, provide accurate and timely dental care).</i> <u>Key Tasks</u>: <i>Non-negotiable actions like preventive dentistry, restorative dentistry, oral and maxillofacial surgery, force health protection and dental surveillance.</i> <u>End State</u>: <i>What dental services success looks like— optimized soldier readiness, robust and responsive dental support system, and proactive force health protection.</i> <i>The commander's intent should provide dental services planners and subordinate units with the flexibility to adapt while still aligning with the overall mission goals. Avoid restating the mission or duplicating detailed task lists from later in the order.</i> b. (U) <u>Scheme of Support</u>. <i>Describe how dental services support the commander's intent and concept of operations. Establish the priorities of support to units for each phase of the operation. If required information for a specific protection task or system is brief, include it in this paragraph and eliminate the associated appendix. Refer to the base order and Annex C (Operations) as required.</i> (1) (U) <u>Dental Services</u>. <i>(EXAMPLE) Provide dental information, priorities, instructions, and guidelines. Identify and list area units without organic dental resources requiring support and describe how to support these units. Describe the procedures maximizing Soldier readiness and contributing to overall force health protection. Identify and determine the eligibility and extent of dental services authorized within an operational environment or across the range of military operations. Identify and reference the current dental evacuation plan. Identify and list the location(s) of the dental detachments and teams, and dental services personnel conducting dental services (to include unified action partners, host nation, and joint services operating in the AO). Describe how the Dental services and systems support the commander's intent and concept of operations for dental services through the different phases of the operation. Explain how dental services contribute critical FHP, inform situational awareness regarding dental health threats, and synchronize medical support with maneuver elements. Describe how dental units influence evacuation decisions and contribute directly to maintaining the overall readiness and fighting strength of the deployed force, allowing the commander to achieve the desired end state. Establish the priorities of support to units for each phase of the operation.</i> c. (U) <u>Tasks to Subordinate Units</u>. <i>List only dental services tasks assigned to specific units not contained in the base order.</i> d. (U) <u>Coordination Instructions</u>. <i>This section includes dental-specific instructions that require synchronization between two or more subordinate or supporting units. These instructions establish patient management coordination and reporting coordination and enable effective force health protection that support the operational objectives. They are not found elsewhere in the base plan or order.</i> [page number] [CLASSIFICATION]

Figure F-1. Example of dental services tab to Annex E to operations order (continued)

[CLASSIFICATION] [TAB C (DENTAL SERVICES) TO APPENDIX 9 (FORCE HEALTH PROTECTION) ANNEX E (PROTECTION) TO OPERATION PLAN/ORDER (number) (code name)—(issuing headquarters) (classification of title)] (1) (U) <u>Establish Logistics and Supply Coordination</u>. <i>Coordinate ground and air routes used for dental Class VIII transport and for dental equipment maintenance not available at a Role 1 or Role 2. Include primary and alternate routes, reconnaissance status, and integration with evacuation overlays. Dental assets supporting maneuver units may require airspace or ground movement priority in contested environments.</i> (2) (U) <u>Forensic Odontology Support</u>. <i>Dental units will provide forensic odontology support for potential mass casualty events or identification of remains. This includes dental charting, radiographic comparison, and expert testimony. They will secure and rapid transfer of dental records and ensure strict adherence to the chain of custody protocols for all dental evidence</i> (3) (U) <u>Advanced Maxillofacial Trauma Management</u>. <i>Coordinate the transfer of patients requiring advanced maxillofacial trauma management (complex fractures, soft tissue reconstruction) to Role 3 and Role 4 Hospitals. Establish a clear surgical pathway for maxillofacial trauma patients, outlining expected timelines, and required resources.</i> (4) (U) <u>Medical Treatment Facility and Dental Locations</u>. <i>List existing and proposed locations of all available MTFs and dental capabilities</i> (5) (U) <u>Vulnerability Assessment</u>. <i>The vulnerability assessment identifies physical characteristics or procedures that render critical assets, areas, infrastructures, or special events vulnerable to known or potential threats and hazards. The staff addresses “who” or “what” is vulnerable and “how” it is vulnerable.</i> (6) (U) <u>Capability Assessment</u>. <i>Capability assessment of an organization determines its current capacity to perform protection tasks based on the integrated material and nonmaterial readiness of the assets. A capability assessment considers the mitigating effects of existing manpower, procedures, and equipment. It is especially important in identifying capability gaps, which may be addressed to reduce the consequences of a specific threat or hazard.</i> (7) (U) <u>Essential Elements of Friendly Information</u>. <i>dental services-specific essential elements of friendly information. Identify sensitive operational details that, if compromised, could degrade dental services or expose medical vulnerabilities. Units will apply operational security measures to protect this information:</i> (a) (U) <i>Date-time group, location, movement, and capability of evacuation transportation.</i> (b) (U) <i>Deployment, mobility, and mission readiness of assigned dental detachments and teams.</i> (c) (U) <i>Coordination timelines and delivery routes for dental Class VIII resupply.</i> (d) (U) <i>Details of the teledentistry network, including bandwidth allocation and security protocols.</i> (e) (U) <i>Known weaknesses in the security posture of dental facilities.</i> (f) (U) <i>Trends in dental disease prevalence within the force.</i> (g) (U) <i>Any relationships, agreements, or operational dependencies with host nation or NGO dental partners that could affect mission credibility or support continuity if exposed.</i> (8) (U) <i>Coordination timelines and delivery routes for dental Class VIII resupply, cold chain-sensitive items, or high-value dental materials.</i> [page number] [CLASSIFICATION]

Figure F-1. Example of dental services tab to Annex E to operations order (continued)

[CLASSIFICATION] [TAB C (DENTAL SERVICES) TO APPENDIX 9 (FORCE HEALTH PROTECTION) ANNEX E (PROTECTION) TO OPERATION PLAN/ORDER (number) (code name)—(issuing headquarters) (classification of title)] (a) (U) <i>Any relationships, agreements, or operational dependencies with HN or NGO dental partners that could affect mission credibility or support continuity if exposed.</i> (9) (U) <u>Risk Reduction Control Measures.</u> <i>These measures mitigate operational threats to physical and personnel security, dental facility safety and personnel welfare, and public health. Dental units will implement the following:</i> (a) (U) <i>Apply infection control procedures by ensuring strict adherence to standard precautions (hand hygiene, PPE) for all patient interactions and monitoring and validation of sterilization/disinfection equipment.</i> (b) (U) <i>Establish trigger-based escalation procedures for dental protective posture adjustments in line with supported unit's MOPP guidance in a CBRN environment.</i> (c) (U) <i>Apply operational exposure guidelines to personnel and equipment, especially during operations in contaminated or degraded environments.</i> (d) (U) <i>Implement principles of time, distance, and shielding to minimize exposure.</i> (e) (U) <i>Enforce OPSEC protocols during dental missions, including evacuation schedules, movement orders, and maintain constant situational awareness of the surrounding environment.</i> (10) (U) <u>Dental Estimate Mission Analysis Requirements.</u> <i>Accurate dental patient evacuation planning requires dental personnel to integrate staffing estimates with assessments of necessary support and available resources. Describe how the analysis ensures sufficient logistical capacity for safe evacuation during contingencies.</i> (11) (U) <u>Dental Services Personnel Estimate.</u> <i>Provide the required information listed below.</i> (a) (U) <i>Describe the distribution of Class I installations.</i> (b) (U) <i>Describe the distribution of subsistence (perishable and nonperishable).</i> (c) (U) <i>Describe the extent of local procurement.</i> (d) (U) <i>Describe the extent of inspection load of indigenous foods for indigenous personnel, if applicable.</i> (e) (U) <i>Describe the estimate of wounded, ill, and injured, if applicable.</i> (f) <i>Describe the evacuation of wounded, ill, and injured, if applicable</i> (g) (U) <i>Describe the modes of transportation of subsistence (air [fixed wing and rotary wing aircraft] or surface [sea, highways, and rail]).</i> (h) (U) <i>Describe the routes.</i> (i) (U) <i>Describe the schedules.</i> (12) (U) <u>Dental Services Requirements.</u> <i>Provide the required information listed below.</i> (a) (U) <i>Support Requirements.</i> (b) (U) <i>DCAS and dental public health</i> page number] [CLASSIFICATION]
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Figure F-1. Example of dental services tab to Annex E to operations order (continued)

[CLASSIFICATION] [TAB C (DENTAL SERVICES) TO APPENDIX 9 (FORCE HEALTH PROTECTION) ANNEX E (PROTECTION) TO OPERATION PLAN/ORDER (number) (code name)—(issuing headquarters) (classification of title)]	page number] [CLASSIFICATION]
(c) (U) <i>Dental supply or Class VIII.</i> (d) (U) <i>Dental treatment facilities.</i> (e) (U) <i>Evacuation policy.</i> (f) (U) <i>Other dental services support to stability operations and global health engagements.</i> (13) (U) <u>Dental Resources Available</u>. <i>Provide the required information listed below.</i> (a) (U) <i>Organic dental personnel.</i> (b) (U) <i>Attached dental units.</i> (c) (U) <i>Supporting dental units.</i> (14) (U) <u>Dental personnel in Civil Affairs units and special forces groups</u>. <i>HN and dental personnel and supplies reported by Civil Affairs as available from civil public health agencies must also be listed. Cultural differences can impact dental support. Civil Affairs personnel assist in planning in order to maximize HN support. They also assist in carrying out HN agreements.</i> (a) (U) <i>Staff dental officer in theater medical command, corps, division and medical brigade,</i> (b) (U) <i>Dental company area support.</i> (c) (U) <i>Dental troop ceiling.</i> (d) (U) <i>Status of dental supply or resupply.</i> (e) (U) <i>Allied, Coalition, HN, unified action partner, and dental assets in the assigned area.</i> 4. (U) <u>Sustainment</u>. <i>Identify priorities of sustainment for key protection tasks and specify additional instructions as required. Refer to Annex F (Sustainment) as required.</i> a. (U) <u>Logistics</u>. <i>Use subparagraphs to identify priorities and specific instructions for protection logistic support. Refer to Annex F (Sustainment) and Annex P (Host-Nation Support) as required. Provide the required information listed below.</i> (1) (U) <u>Types of rations</u>. <i>Describe the type of rations to be used will include meals, ready-to-eat and unitized group rations. The unitized group rations require medical diet supplements at Role 3.</i> (2) (U) <u>Class I Status</u>. <i>Describe the status of Class I supplies.</i> (3) (U) <u>Class VIII status</u>. <i>Describe the status of Class VIII and other dental supplies.</i> (4) (U) <u>Global Health Engagement Activities</u>. <i>Describe the number and extent of GHEs. The CA staff provide liaison with indigenous health professionals and organizations for conducting civil-military operations.</i> (5) (U) <u>Dental personnel</u>. <i>Describe the status of dental services personnel. Dental services personnel are responsible for providing operational and emergency dental care. Dental personnel perform a wide range of dental tasks and are integral to maintaining the health and readiness of the fighting force. Their ability to provide timely and effective dental care is essential to mission success at all echelons.</i> (6) (U) <u>Personnel</u>. <i>Use subparagraphs to identify priorities and specific instructions for human resources support, financial management, legal support, and religious support. Refer to Annex F (Sustainment) as required</i>	

Figure F-1. Example of dental services tab to Annex E to operations order (continued)

[CLASSIFICATION] [TAB C (DENTAL SERVICES) TO APPENDIX 9 (FORCE HEALTH PROTECTION) ANNEX E (PROTECTION) TO OPERATION PLAN/ORDER (number) (code name)—(issuing headquarters) (classification of title)] b. (U) <u>Health Service Support</u>. Refer to Appendix 3 (Health Service Support) to Annex F (Sustainment) as required. (1) (U) <u>Medical Logistics</u>. Provide special procedures applicable to the operations for Class VIII resupply and medical maintenance requests and procedures if different from Tab D to Appendix 3 (Health Service Support) to Annex F (Sustainment). d. (U) <u>Financial Management</u>. Refer to Annex F (Sustainment) as required. 2. (U) <u>Command and Signal</u>. a. (U) <u>Command</u>. (1) (U) <u>Location of Commander</u>. State the location of key dental services commanders. (2) (U) <u>Succession of Command</u>. Identify the chain of command if not addressed in unit tactical standard operating procedures. b. (U) <u>Command Posts</u>. Describe the employment of command posts, including their locations and when operational and non-operational. State the primary controlling command post for specific tasks or phases of the operation (for example, “The division tactical command post will control dental services though phase Ranger.”). c. (U) <u>Signal</u>. Refer to Annex H (Signal) as required. Address any dental services specific communications requirements. State the primary, alternate, contingency, and emergency communications plan. Refer to Annex H (Signal) as required. ACKNOWLEDGE: Include only if attachment is distributed separately from base order. (Commander’s last name) (Commander’s rank) [CLASSIFICATION] OFFICIAL: (Authenticator’s name) (Authenticator’s position) <i>Either the commander or principal staff officer responsible for (medical function) will sign attachments.</i> ATTACHMENTS: List lower-level attachments as required. DISTRIBUTION: Show only if distributed separately from the base order or higher-level attachments. [page number] [CLASSIFICATION]

Figure F-1. Example of dental services tab to Annex E to operations order (continued)

EXHIBITS TO TABS EXAMPLE

F-3. While current doctrine does not provide standard examples of exhibits, units may include them to expand or clarify information presented in the medical function tab. Exhibits serve to organize supporting details such as matrices, flow charts, maps, or lists that inform execution. They support the tasks outlined in the body of the tab and help staff visualize or track key activities. When used, exhibits are listed at the end of the tab under the heading “Exhibits” and labeled alphabetically (for example, Exhibit A—Evacuation Flow, Exhibit B—Dental Task Organization). Units should develop exhibits based on their mission, the supported medical function, and coordination with higher headquarters. Commanders and planners may refine exhibit content through rehearsals, SOPs, and feedback during operations.

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Appendix G

Standard Operating Procedures

An SOP is a collection of clear, written instructions or guidelines that define the standard processes, procedures, and practices. Soldiers and units must follow during various operations and activities. SOPs are designed to promote consistency, efficiency, safety, and effectiveness across all aspects of military operations. They encompass everything from everyday routines and administrative tasks to combat operations and emergency responses.

The CSOP is a written set of instructions or guidelines that outline processes and protocols that address only those issues relating to policies, procedures, and operations in a clinical setting. The CSOP ensures consistency, quality and safety in patient care and standardizes procedures. The procedures selected for inclusion in the CSOP are those which meet the unit's clinical mission.

DEVELOPING THE STANDARD OPERATING PROCEDURE

G-1. After writing SOPs, they should be tested before being implemented. 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 the performance of a job, or the environment in which it is performed.

G-2. 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 incomplete, insufficient, or 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.

G-3. The SOPs are used for a variety of reasons and audiences; they 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, they 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.

G-4. Unit SOPs should always reflect the guidance contained in the parent organization's SOPs and support doctrinal standards.

REFERENCES

G-5. List all publications that guide or govern the reader in this subject area (for example, ARs, FMs, other SOPs, and policy memorandums). 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 gives 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

G-6. Write a precise purpose statement that indicates what specific goal the publication serves. For example: To specify the procedures required to perform operator maintenance on the field dental chair.

SUMMARY

G-7. In a paragraph less than one inch deep, recap the main points of your document. Write it after the Responsibilities and Procedures paragraphs have been written. Summarize (do not introduce) the key points but be precise. Write complete sentences in the present tense.

SCOPE

G-8. The scope outlines the extent and restrictions of the document, states to whom the SOP applies, specifies the areas, functions, specific conditions, or operations it pertains to.

DEFINITIONS

G-9. The definition paragraph provides clear explanations of key terms and concepts used within the document. It ensures that all personnel involved have a shared understanding of the terminology and specific language used in the SOP. If not needed, omit this paragraph.

RESPONSIBILITIES

- G-10. Focus here on WHO does WHAT. List precise duties for key people or groups.
- Specify WHOM is being addressed. 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.

PROCEDURES

G-11. 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.

G-12. 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. They also issue individual field rations and collect money from Soldiers on separate rations.

G-13. Create new paragraphs or use enclosures to discuss miscellaneous administrative and logistical topics.

FILES

- G-14. If applicable state what files or records must be kept, otherwise omit this paragraph.
- Maintain parallelism in your lists. If there is subparagraph "a" or an "a (1)", have a subparagraph "b" or a "b (1)".

**CLINICAL STANDARD OPERATING PROCEDURES PUBLICATION
FORMAT**

G-15. 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

G-16. 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.
- Records of changes and corrections.
- Annexes, appendixes, and tabs.

DIRECTIVE

G-17. The commander's directive should be the first page of the CSOP. This directive is a letter order, signed by the commander that directs the implementation of the CSOP. The directive should be on unit letterhead and in memorandum format.

TABLE OF CONTENTS

G-18. The information contained in CSOP is variable and will depend on the type of unit and, of course, guidance and policy from the unit commander and their higher headquarters. The table of contents should have an outline of annexes, appendixes, and tabs.

RECORD OF CHANGES AND CORRECTIONS

G-19. 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 dental treatment facility officer in charge to easily audit that particular copy of the CSOP. A single page formatted as shown in figure G-1 below will serve this purpose.

RECORD OF CHANGES AND CORRECTIONS <i>Dental treatment facilities designation or unit designation CSOP</i>				
NUMBER	DESCRIPTION	AUTHORITY	DATE	ENTERED BY
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Legend:
 CSOP clinical standard operating procedure

Figure G-1. Sample of record of changes and corrections

ANNEXES

G-20. 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.

G-21. There should be sufficient details to ensure proper performance of the task addressed or compliance with the policy prescribed. As with the TACSOP annexes to the CSOP are directive and address who, what, where, when, and how.

G-22. 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 TACSOP. 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.

G-23. 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 their higher headquarters. The following is an outline of annexes, appendixes, and tabs recommended for inclusion in a generic CSOP.

G-24. Annex A—Organization. A general statement of the mission and organization of the unit.

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

G-25. Annex B—Equipment. Listing of equipment assigned to the dental treatment facility.

- Appendix 1—Operation and maintenance. Statement of dental treatment facility policy for equipment operation and operator maintenance.
 - Tab A—Major End Items. Manufacturer's operator manual or service technical manual, if available, for each major item of equipment, to include vehicles and generators.
 - Tab B—Subcomponent Items. Manufacturer's operator manual or service technical manual, if available, for each component item of equipment, to include medical devices.
- Appendix 2—Maintenance support procedures. Prescribe procedure for obtaining maintenance support.

G-26. 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 procedures for maintaining accountability of the dental treatment facility's TOE and common tables of allowance property.
- Appendix 3—Precious metals control. Procedures for control of precious metals and finished fixed prosthodontic cases, if appropriate.
- Appendix 4—Medication control measures. Procedures for prescribing, issuing, storing, and disposing of schedule substances.

G-27. 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.
 - Tab C—Patient flow. Prescribe patient flow.
 - Tab D—Detainee dental operations. Provide information on security procedures.
- Appendix 2—Patient records. Prescribe the procedure for preparation and maintenance of patient records.
- Appendix 3—Workload reporting. Prescribe procedures for workload data accountability and reporting.
- Appendix 4—Preventive dentistry. Describe and define responsibilities for the dental treatment facility's preventive dentistry program.
- Appendix 5—Referrals. Prescribe procedure for referral and evacuation of patients for treatment available at other dental treatment facilities.
- Appendix 6—Nutritional supplements. Provide guidance on providing patients undergoing lengthy treatment nutritional supplements prior to undergoing a dental procedure.

G-28. Annex E—Immediate response situations.

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

G-29. Annex F—Infection control. Statement of required infection control procedures.

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

G-30. Annex G—Relocation. Procedures for the emplacement and displacement of the dental treatment facility.

- 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.

G-31. 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.

G-32. Annex I—Physical security. Statement of physical security plan for the dental treatment facility.

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Glossary

This glossary lists acronyms and terms with Army or joint definitions. Where Army and joint definitions differ, (Army) precedes the definition. Terms for which ATP 4-02.19 is the proponent are marked with an asterisk (*). The proponent publication for other terms is listed in parentheses after the definition.

SECTION I – ACRONYMS AND ABBREVIATIONS

Acronym	Definition
ABCANZ	American, British, Canadian, Australian and New Zealand
ADP	Army Doctrine Publication
AHS	Army Health System
AR	Army regulation
ATP	Army techniques publication
BAS	battalion aid station
BCT	brigade combat team
BSMC	brigade support medical company
CBRN	chemical, biological, radiological, and nuclear
CSOP	clinical standard operating procedure
DA	Department of the Army
DA PAM	Department of the Army Pamphlet
DCAS	dental company (area support)
DHA	Defense Health Agency
DNBI	disease and nonbattle injury
DODD	Department of Defense directives
DODI	Department of Defense instruction
DSCA	Defense Support of Civil Authorities
FHP	force health protection
FM	field manual
HSS	health service support
JP	joint publication
LOAC	law of armed conflict
MAD	medical augmentation detachment (32-bed)
MASCAL	mass casualty
MCAS	medical company (area support)
MEDBDE	medical brigade
MEDEVAC	medical evacuation
MEDLOG	medical logistics
MTF	medical treatment facility
MWD	military working dog

NATO	North Atlantic Treaty Organization
NCO	noncommissioned officer
OE	operational environment
OPLAN	operation plan
PAR	population at risk
PiX	Protected Internet eXchange
QA	quality assurance
RTD	return to duty
SAD	surgical augmentation detachment (24-bed)
SFG	special forces group
SOP	standard operating procedure
STANAG	standardization agreement
TACSOP	tactical standard operating procedures
TB MED	technical bulletin medical
TC	training circular
TM	technical manual
TMC	theater medical command
TOE	table of organization and equipment
U.S.	United States

SECTION II – TERMS

agility

The ability to move forces and adjust their dispositions and activities more rapidly than the enemy. (ADP 3-0)

Army Health System

A component of the Military Health system that is responsible for operational management of the health service support and force health protection missions for training, predeployment, deployment, and postdeployment operations. The Army Health System includes all mission support services performed, provided, or arranged by the Army Medicine to support health service support and force health protection mission requirements for the Army and as directed, for joint, intergovernmental agencies, coalition, and multinational forces. (FM 4-02)

***comprehensive dental care**

The dental treatment to restore or maintain a Soldier's optimal oral health, function, and aesthetics.

continuity of care

Attempt to maintain the role of care during movement at least equal to the care provided at the preceding facility. (FM 4-02)

contamination mitigation

The planning and actions taken to prepare for, respond to, and recover from contamination associated with all chemical, biological, radiological, and nuclear threats and hazards in order to continue military operations. (JP 3-11)

convergence

An outcome created by the concerted employment of capabilities against combinations of decisive points in any domain to create effects against a system, formation, or decision maker, or in a specific geographic area. (ADP 3-0)

defensive operation

An operation to defeat an enemy attack, gain time, and develop conditions favorable for offensive or stability operations. (ADP 3-0)

defense support of civil authorities

Support provided by U.S. Federal military forces, Department of Defense civilians, Department of Defense contract personnel, Department of Defense component assets, and National Guard forces (when the Secretary of Defense, in coordination with the governors of the affected states, elects and requests to use those forces in Title 32, United States Code, status) in response to requests for assistance from civil authorities for domestic emergencies, law enforcement support, and other domestic activities, or from qualifying entities for special events. Also called DCSA. Also known as civil support. (DODD 3025.18).

***dental care**

The preventive, restorative, and surgical treatment of the orofacial hard and soft tissues, which is comprised of comprehensive dental care and operational dental care.

depth

The extension of operations in time, space, or purpose to achieve definitive results. (ADP 3-0)

***emergency dental care**

The care given to relieve oral pain; diagnosis and treat infections; control of life-threatening oral conditions; and manage injuries to the teeth, jaws (maxilla/mandible), and associated facial structures.

endurance

The ability to persevere over time throughout the depth of an operational environment. (ADP 3-0)

***essential dental care**

The treatment provided to prevent potential dental emergencies that could affect a Soldier's health or ability to perform duties.

***expeditionary dentistry**

The provision of immediate and responsive dental care in a dynamic or developing operational environment.

force health protection

(Joint) Measures to promote, improve, or conserve the behavioral and physical well-being of Service members to enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards. Also called FHP. (JP 4-02)

(Army) Force health protection are measures that promote, improve, or conserve the behavioral and physical well-being of Soldiers comprised of preventive and treatment aspects of medical functions that include: combat and operational stress control, dental services, operational public health, and laboratory services. Enabling a healthy and fit force, prevent injury and illness, and protect the force from health hazards.. (FM 4-02)

health service support

(Joint) All services performed, provided, or arranged to promote, improve, conserve, or restore the mental or physical well-being of personnel. Also called HSS. (JP 4-02)

(Army) Health service support is support and services performed, provided, and arranged by the Army Medicine to promote, improve, conserve, or restore the behavioral and physical well-being of personnel by providing direct patient care that include medical treatment (organic and area support) and hospitalization, medical evacuation to include medical regulating, and medical logistics to include blood management. (FM 4-02)

mass casualty

Any number of human casualties produced across a period of time that exceeds available medical support capabilities. (JP 4-02)

multidomain operations

The combined arms employment of joint and Army capabilities to create and exploit relative advantages to achieve objectives, defeat enemy forces, and consolidate gains on behalf of joint force commanders. (ADP 3-0)

offensive operation

An operation to defeat or destroy enemy forces and gain control of terrain, resources, and population centers. (ADP 3-0)

***operational dental care**

The dental care provided for deployed Soldiers consisting of expeditionary dentistry, emergency dental care and essential dental care.

patient movement

The act or process of moving a sick, injured, wounded, or other person to obtain medical or dental care or treatment, which includes medical regulating, patient evacuation, and en route medical care. (JP 4-02)

planning

The art and science of understanding a situation, envisioning a desired future, and determining effective ways to bring that future about. (ADP 5-0)

protection

Preservation of the effectiveness and survivability of mission-related military and nonmilitary personnel, equipment, facilities, information, and infrastructure deployed or located within or outside the boundaries of a given operational area. (JP 3-0)

reconstitution

An operation that commanders plan and implement to restore units to a desired level of combat effectiveness commensurate with mission requirements and available resources. (ATP 3-94.4)

regeneration

The rebuilding of a unit through large-scale replacement of personnel, equipment, and supplies, including the reestablishment of essential command and control and the conduct of mission-essential training for the unit. (ATP 3-94.4)

reorganization

All measures taken by the commander to maintain unit combat effectiveness or return it to a specified level of combat capability. (ATP 3-94.4)

stability operation

An operation conducted outside the United States in coordination with other instruments of national power, to establish or maintain a secure environment and provide essential governmental services, emergency infrastructure reconstruction, and humanitarian relief. (ADP 3-0)

threat

Any combination of actors, entities, or forces that have the capability and intent to harm United States forces, United States national interests, or the homeland. (ADP 3-0)

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ATP 4-02.19

31 July 2026

By Order of the Secretary of the Army:

CHRISTOPHER C. LANEVE

*General, United States Army
Vice Chief of Staff*

Official:

A handwritten signature in black ink, appearing to read 'M. Sannito', with a stylized flourish at the end.

MATTHEW L. SANNITO

*Administrative Assistant
to the Secretary of the Army
2621108*

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