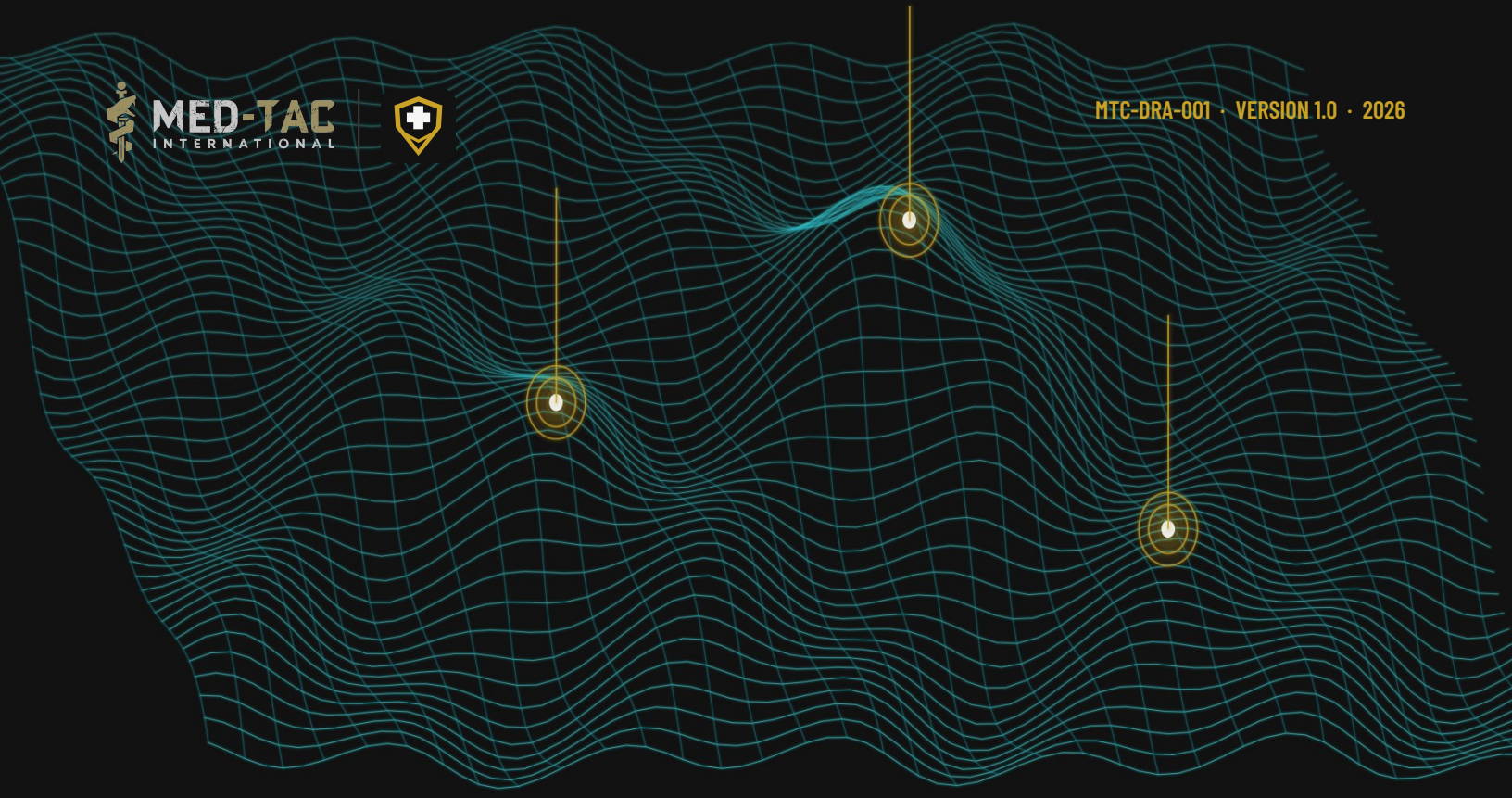
MED-TAC INTERNATIONAL

MTC-DRA-001 · VERSION 1.0 · 2026



MILITARY & SPECIAL OPERATIONS · PRE-DEPLOYMENT SELF-ASSESSMENT

UNIT DEPLOYMENT MEDICAL READINESS AUDIT

A Field-Tested Self-Assessment for Teams Preparing to Deploy

10	70	100	3
DOMAINS (A–J)	AUDIT ITEMS	POINT READINESS INDEX	READINESS TIERS

For unit medical readiness officers, medics, team leaders, and logistics/procurement NCOs.
Evidence-based. TCCC- and PCC-aligned. MARCH as the backbone. Interactive score fields with an auto-calculated index.

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HOW TO USE THIS AUDIT

Score what exists today, from evidence

This audit measures whether your team can deliver evidence-based, TCCC- and PCC-aligned casualty care on the mission you are about to execute. It has ten domains (A–J) and 70 items. MARCH is the backbone: Sections B–E walk Massive hemorrhage, Airway/Respiration, Circulation, and Hypothermia/Head injury; the rest cover the doctrine, sustainment, load, training, resupply, and documentation that make MARCH work in the field.

Who completes it and when

Team: the senior medic, the team leader, and the logistics/procurement NCO, with the unit medical readiness officer or medical director reviewing the result.

When: first at 90 days out, again at 30 days out, and a final validation in the last week. The change in score is the readiness trend command wants to see.

How: score from evidence — inventories, rotation logs, training records, SOPs, and what you can physically lay out. If you cannot show it, score it 1 or 0.

Scoring model

SCORE	MEANING	EVIDENCE THAT SUPPORTS IT
0 — Absent	The capability, item, or practice does not exist in the unit.	Nothing to show.
1 — Partial	Exists but incomplete, expired, untrained, not rehearsed, or not true for every operator.	Some records, some kit, gaps you can name.
2 — Standard	Meets the stated standard for every operator and every mission.	Current records, in-date kit, rehearsal on file.

Readiness index and tiers

Section subtotals add to a raw score out of **140** (70 items × 2). The readiness index converts that to a 100-point scale: **Index = (raw score ÷ 140) × 100**, rounded to the nearest whole number.

TIER	INDEX	RAW SCORE	WHAT IT MEANS
TIER 1 — DEPLOYABLE	85–100	119–140	Sustain. Close item-level gaps and re-validate before departure.
TIER 2 — GAP	60–84	84–118	Remediate before deployment. Assign owners and dates to every 0 and 1.
TIER 3 — CRITICAL	Below 60	0–83	Stop and resource. Command decision required on kit, training, and timeline.

Critical-item gate. Five items are marked CRITICAL ITEM: B1 (two tourniquets per operator), B4 (hemostatic gauze at the point of injury), C4 (vented chest seals), H1 (every member MARCH-competent), and J1 (TCCC Casualty Cards staged). A score of 0 on any of them caps the unit at Tier 2, whatever the index says.

Digital or print. Each item has a verification checkbox and a 0/1/2 score field. In Adobe Acrobat or another reader that runs form calculations, section subtotals, the raw score, the index, and the tier fill in automatically on pages 24–25. On paper, add the subtotals by hand.

THE DEPLOYMENT READINESS GAP

Most preventable deaths happen before the hospital

87.3%
of combat deaths in 2001–2011 occurred before reaching a treatment facility.

24.3%
of those prehospital deaths were judged potentially survivable.

90.9%
of the potentially survivable deaths involved hemorrhage.

90 → 43
minutes: median casualty transport time before and after the 2009 one-hour policy.

Sources: Eastridge 2012 (4,596 deaths reviewed); Kotwal 2016. Full references on page 27.

Where the preventable deaths are

In the largest review of U.S. combat deaths from 2001–2011, most potentially survivable deaths were from bleeding, and the bleeding site matters: **67.3% truncal**, **19.2% junctional**, and **13.5% extremity**. Tourniquets solve the extremity share. Junctional packing, resuscitation, and rapid movement to surgery decide the rest — which is why this audit scores Sections B, D, and F separately.

What a trained unit can do

A special operations unit that ran a command-directed casualty response system and trained **all** personnel in TCCC reported 32 fatalities among 419 casualties. Only one was judged potentially survivable, and none were potentially survivable through additional prehospital care. None died from extremity hemorrhage, tension pneumothorax, or airway obstruction (Kotwal 2011). The difference was not a product. It was doctrine, training for every member, and command ownership — Sections A, H, and J of this audit.

Why prolonged casualty care is now part of readiness

After the 2009 policy to move casualties to care within one hour, median transport time fell from 90 to 43 minutes, and the killed-in-action rate fell from 16.0% to 9.9% (Kotwal 2016). Teams should not plan on that timeline everywhere. The Joint Trauma System defines prolonged casualty care as *"the need to provide patient care for extended periods of time when evacuation or mission requirements surpass available capabilities"* (JTS CPG 91, 2021). Section F audits whether your team can hold a casualty for hours.

How to read your result. A low score is information, not failure — the point is to find the gap while there is time to close it. Section-level results matter more than the index: a strong total can hide a zero in Section B.

EVIDENCE	WHAT IT MEANS FOR YOUR TEAM	AUDITED IN
Hemorrhage drives most potentially survivable deaths	Tourniquets, hemostatic gauze, junctional packing, and drills for every operator	Sections B, H
Most survivable bleeding is truncal or junctional	Resuscitation capability, TXA criteria, and fast, planned evacuation	Sections D, A
A fully TCCC-trained unit nearly eliminated preventable death	Doctrine, training for all members, documentation, and debriefs	Sections A, H, J
Evacuation will not always be fast	Prolonged casualty care sustainment, load plan, and resupply	Sections F, G, I

SECTION A

A DOCTRINE & TCCC/PCC ALIGNMENT

A unit treats casualties the way it has rehearsed. Casualty care starts as a written, practiced SOP — not as a kit issue.

8 AUDIT ITEMS · MAXIMUM 16 POINTS · SCORING ON PAGE 5

Why it matters

The unit with the best published battlefield survival record treated casualty care as a command-directed system: written, trained for every member, and debriefed (Kotwal 2011). The TCCC Guidelines organize care into three phases — Care Under Fire, Tactical Field Care, and Tactical Evacuation Care — and the Joint Trauma System adds prolonged casualty care when evacuation is delayed. Your SOP should say what the team does in each.

Casualty response roles — fill in before every mission

ROLE	PRIMARY	ALTERNATE	BRIEFED (DATE)
Casualty treatment (medic / first responder)			
Documentation (TCCC Card, MIST)			
Tactical lead / command decisions			
Communications / MEDEVAC request			
Casualty collection point / evacuation lead			
Litter / movement team			

NOTES / FINDINGS

SECTION A · SCORING

Doctrine & TCCC/PCC Alignment

#	SECTION A — AUDIT ITEM	SCORE 0/1/2
A1	A written casualty response SOP exists and has been rehearsed, not just issued.	
A2	Team SOPs reflect the TCCC phases of care: Care Under Fire, Tactical Field Care, and Tactical Evacuation Care.	
A3	MARCH is the shared casualty-care language across all ranks.	
A4	Casualty collection points and evacuation triggers are pre-briefed for every mission.	
A5	The MIST handoff format is standardized across all documentation.	
A6	A prolonged casualty care (PCC) contingency is defined for delayed-evacuation scenarios.	
A7	Roles are delineated: who treats, who documents, who commands, and who communicates.	
A8	An after-action medical debrief occurs after every mission with casualty care or a near miss.	
	SECTION A SUBTOTAL — MAXIMUM 16 POINTS	

Gaps to close

ITEM	GAP TO CLOSE	OWNER	DUE

NOTES / FINDINGS

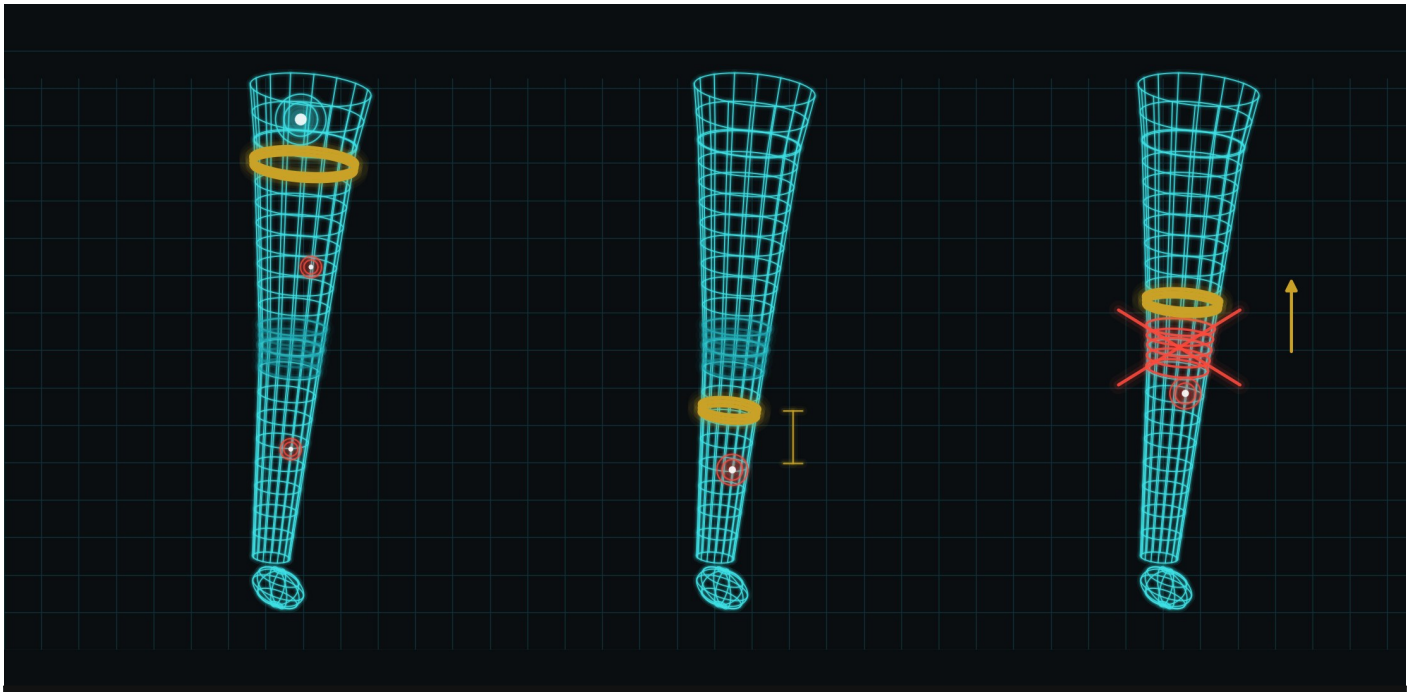
SECTION B · MARCH: M

B

MASSIVE HEMORRHAGE READINESS

Hemorrhage is the leading cause of potentially survivable death on the battlefield. It is controlled first, at the point of injury, by whoever is closest.

10 AUDIT ITEMS · MAXIMUM 20 POINTS · SCORING ON PAGE 7



A — HASTY	B — DELIBERATE	C — JOINT RULE
Care Under Fire, or the bleeding site is not apparent: tourniquet high and tight (as proximal as possible) over the uniform. Cyan marks the femoral pressure point.	Tactical Field Care, source identified: tourniquet directly on skin 2–3 in above the wound. Reassess, and convert in under 2 hours when bleeding can be controlled by other means.	Never over a joint. If 2–3 in above the wound lands on the knee or elbow, move the tourniquet proximal to the joint.

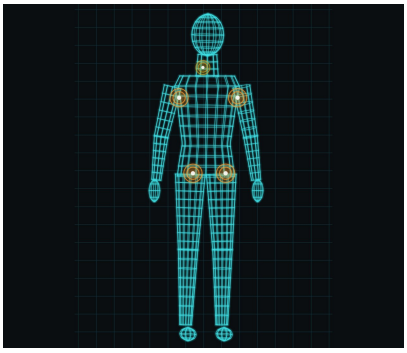
Gold band = tourniquet · red = wound · cyan = femoral pressure point · red X = joint. Placement per TCCC Guidelines (01 May 2026). Vector diagram — not a device illustration.

NOTES / FINDINGS

SECTION B · SCORING

Massive Hemorrhage Readiness

#	SECTION B — AUDIT ITEM	SCORE 0/1/2
B1	Tourniquets: a minimum of two CoTCCC-recommended tourniquets per operator, reachable with either hand. CRITICAL ITEM	
B2	Tourniquet models on hand are CoTCCC-recommended windlass or ratcheting designs, and every operator trains on the model they actually carry.	
B3	Junctional capability is staged at team level: an FDA-cleared junctional device, or hemostatic packing with sustained pressure, as trained under unit medical direction.	
B4	Hemostatic gauze (kaolin- or chitosan-based, CoTCCC-recommended) is in date and carried at the point of injury. CRITICAL ITEM	
B5	Pressure dressings are staged for both immediate application and later reassessment and re-dressing.	
B6	Operator self-application drills (tourniquet on each arm and leg) have been completed within the last 90 days.	
B7	Both tourniquet placements are rehearsed — high and tight over the uniform when the bleeding site is not apparent or under fire; on skin 2–3 in above the wound in Tactical Field Care; never over a joint — and groin/axillary wound packing is rehearsed.	
B8	Counterfeit-device screening: a known-counterfeit feature checklist is on file, and devices are procured from authorized sources.	
B9	Tourniquet reassessment and conversion criteria are understood: convert in under 2 hours when bleeding can be controlled by other means.	
B10	Hemostatic and tourniquet stock is tracked on a consumable rotation log with expiration dates.	
	SECTION B SUBTOTAL — MAXIMUM 20 POINTS	



Junctional sites

The groin, armpit, and base of the neck cannot take a limb tourniquet. Pack the wound tightly with hemostatic gauze (Combat Gauze is the CoTCCC hemostatic dressing of choice; Celox Gauze and ChitoGauze are listed alternatives) and hold pressure, or apply an FDA-cleared junctional device. Items B3 and B7 score this.

Amber = inguinal (groin) and axillary sites · gold = base of neck. Vector diagram.

SECTION C · MARCH: A · R

C AIRWAY & RESPIRATION READINESS

Airway and breathing problems are less common than bleeding but move fast. Every operator recognizes them; medics carry the tools to fix them.

8 AUDIT ITEMS · MAXIMUM 16 POINTS · SCORING ON PAGE 9

Why it matters

Airway obstruction and tension pneumothorax are the other preventable causes of death named alongside extremity hemorrhage in battlefield reviews (Kotwal 2011). TCCC treats every open or sucking chest wound with a vented chest seal, uses a nasopharyngeal airway and a 1,000 ml bag-valve-mask for ventilation, and reserves needle decompression or finger thoracostomy for trained providers.

Airway and respiration capability by level

CAPABILITY	EVERY OPERATOR	MEDIC	TEAM / VEHICLE
Recognize obstruction and tension pneumothorax	Yes	Yes	—
Recovery position / sit up and lean forward	Yes	Yes	—
Nasopharyngeal airway (sized)	Carry	Carry + insert	Spares
Vented chest seal	2 per IFAK	2+ in aid bag	Spares
Burp or remove a chest seal	Yes	Yes	—
Needle decompression / finger thoracostomy	—	Per scope and medical direction	—
Suction (manual)	—	Access	Named carrier
Bag-valve-mask (1,000 ml) and oxygen	—	Access	Staged per mission profile

NOTES / FINDINGS

SECTION C · SCORING

Airway & Respiration Readiness

	#	SECTION C — AUDIT ITEM	SCORE 0/1/2
	C1	A nasopharyngeal airway (NPA) is sized for every operator, and insertion has been verified in training.	
	C2	Suction capability is staged at team level (manual preferred for weight and field use).	
	C3	A bag-valve-mask resuscitator with airway adjuncts is staged at team or vehicle level.	
	C4	Vented chest seals: two per IFAK, to cover entry and exit wounds. CRITICAL ITEM	
	C5	Tension pneumothorax: every member recognizes it and can burp or remove a chest seal; medics perform needle decompression or finger thoracostomy within scope and current TCCC guidance.	
	C6	Airway positioning (recovery position; sit up and lean forward for a conscious casualty) is taught to non-medic team members.	
	C7	Oxygen availability is assessed against the mission profile, or deliberately waived and documented.	
	C8	Respiratory rate and quality are recorded in casualty tracking.	
		SECTION C SUBTOTAL — MAXIMUM 16 POINTS	

Gaps to close

ITEM	GAP TO CLOSE	OWNER	DUE

NOTES / FINDINGS

SECTION D · MARCH: C

D CIRCULATION & IV/IO ACCESS

Once bleeding is controlled, resuscitation decides whether the casualty reaches the next level of care.

6 AUDIT ITEMS · MAXIMUM 12 POINTS · SCORING ON PAGE 11

Why it matters

Most potentially survivable hemorrhage in combat is truncal (67.3%) and cannot be controlled with a tourniquet (Eastridge 2012). For those casualties, time to surgery and blood-based resuscitation carry the outcome. TCCC lists the preferred resuscitation fluids in order:

ORDER	TCCC PREFERRED RESUSCITATION FLUID (01 MAY 2026)
1	Cold stored low titer O whole blood
2	Pre-screened low titer O fresh whole blood
3	Plasma, red blood cells (RBCs), and platelets in a 1:1:1 ratio
4	Plasma and RBCs in a 1:1 ratio
5	Plasma or RBCs alone

Tranexamic acid: "Administer 2 gm of tranexamic acid via slow IV or IO push as soon as possible but NOT later than 3 hours after injury" (TCCC Guidelines). Blood programs, walking blood bank protocols, and medication scope are set by your medical director — this audit checks that the decision is made and briefed, not what it is.

NOTES / FINDINGS

SECTION D · SCORING

Circulation & IV/IO Access

	#	SECTION D — AUDIT ITEM	SCORE 0/1/2
	D1	IV start capability for every medic; IO capability staged at team level.	
	D2	Resuscitation doctrine follows the current TCCC blood-product hierarchy (low-titer O whole blood first), with blood capability — stored or walking blood bank — defined or deliberately waived under medical direction.	
	D3	Resuscitation endpoints and TXA criteria are briefed: 2 g IV/IO as soon as possible and not later than 3 hours after injury, per TCCC.	
	D4	Shock recognition is trained: mental status, radial pulse quality, capillary refill, and skin.	
	D5	Storage viability for fluids and blood products is confirmed for the climate and platform.	
	D6	Circulation interventions (time, product, volume) flow into the MIST handoff.	
		SECTION D SUBTOTAL — MAXIMUM 12 POINTS	

Gaps to close

ITEM	GAP TO CLOSE	OWNER	DUE

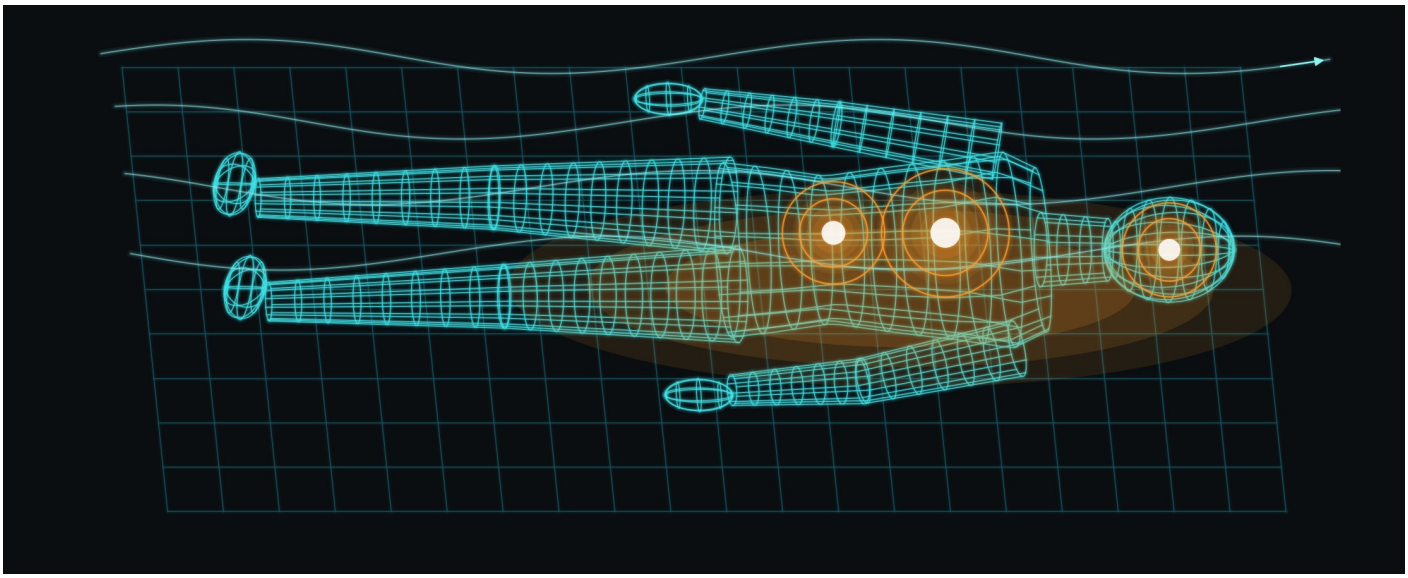
NOTES / FINDINGS

SECTION E · MARCH: H

E HYPOTHERMIA & HEAD INJURY

Hypothermia and head injury worsen quietly. Prevention and trending start with the first casualty, in every climate.

6 AUDIT ITEMS · MAXIMUM 12 POINTS · SCORING ON PAGE 13



Amber = radiant and conductive heat loss (head, torso, ground contact) · cyan streamlines = convective loss to wind. Wet clothing adds evaporative loss. Vector diagram.

Why it matters

Cold impairs clotting, so a casualty whose bleeding you controlled can start bleeding again as they cool — even in warm climates, after blood loss, on a helicopter, or lying on cold ground. TCCC directs teams to *"take early and aggressive steps to prevent further body heat loss and add external heat, when possible."* Insulate from the ground, replace wet clothing, wrap with a vapor barrier, and use active heating on the chest and under the arms.

Head injury: trend it

Record pupils and mental status (GCS or AVPU) at a set interval in the SOP, and hand the trend — not one reading — to the next level of care.

NOTES / FINDINGS

SECTION E · SCORING

Hypothermia & Head Injury

	#	SECTION E — AUDIT ITEM	SCORE 0/1/2
	E1	A hypothermia prevention kit (HPMK or equivalent active-heating system) is staged at the point of injury.	
	E2	Heat-reflective / vapor-barrier wrap capability is available at team level.	
	E3	The team understands why H matters: hypothermia worsens bleeding, so prevention starts with every hemorrhage casualty — in every climate.	
	E4	Head-injury monitoring intervals are defined in the SOP (pupils, mental status/GCS trend).	
	E5	Casualty insulation from the ground (foam pad or equivalent) is carried.	
	E6	Environmental exposure mitigation (cold, heat, wet, altitude) is briefed for the area of operations.	

SECTION E SUBTOTAL — MAXIMUM 12 POINTS

Gaps to close

ITEM	GAP TO CLOSE	OWNER	DUE

NOTES / FINDINGS

SECTION F

F PROLONGED CASUALTY CARE SUSTAINMENT

When evacuation is delayed, the team becomes the treatment facility. Plan for hours, not minutes.

8 AUDIT ITEMS · MAXIMUM 16 POINTS · SCORING ON PAGE 15

Why it matters

The Joint Trauma System defines prolonged casualty care as *"the need to provide patient care for extended periods of time when evacuation or mission requirements surpass available capabilities"* (CPG 91, 2021). The guideline organizes care around monitoring, resuscitation, airway and ventilation, pain, antibiotics, wounds, splinting, nursing care, and logistics. Sustainment is a quantity problem: plan per casualty, per 24 hours.

24-hour sustainment worksheet

CONSUMABLE CLASS	PER CASUALTY / 24 H	× CASUALTY ESTIMATE	= QTY STAGED	LOCATION
Hemostatic gauze and pressure dressings				
Wound packing / dressing changes				
Resuscitation capability (per medical direction)				
Analgesia (per medical direction)				
Antibiotics (per medical direction)				
Airway / respiration consumables				
Hypothermia prevention (active heat cells)				
Splints and pelvic binder				
Burn dressings and eye shields				
Casualty cards / documentation				

NOTES / FINDINGS

SECTION F · SCORING

Prolonged Casualty Care Sustainment

#	SECTION F — AUDIT ITEM	SCORE 0/1/2
F1	24-hour sustainment consumables are staged against a documented casualty estimate.	
F2	Analgesia options are defined and carried under medical direction.	
F3	Antibiotic capability is defined under medical direction and the mission profile.	
F4	A wound repacking and reassessment cadence is defined.	
F5	Burn capability is staged: coverage, TBSA estimation, and fluid calculation.	
F6	Eye protection and rigid eye-shield capability for penetrating eye injury are carried.	
F7	Splinting capability covers long-bone and pelvic injury (including a pelvic binder).	
F8	Litter carries and improvised casualty movement are rehearsed with full combat load.	

SECTION F SUBTOTAL — MAXIMUM 16 POINTS

Gaps to close

ITEM	GAP TO CLOSE	OWNER	DUE

NOTES / FINDINGS

SECTION G

G LOAD DISTRIBUTION & CARRY PLAN

The right item in the wrong pouch is a missing item. Every capability has a carrier, a location, and a backup.

6 AUDIT ITEMS · MAXIMUM 12 POINTS · SCORING ON PAGE 17

Why it matters

A standardized IFAK means any operator can treat any other operator with their kit, in the dark, without searching. Team adjuncts only exist if someone is assigned to carry them. The carry plan below is the evidence for items G1–G5.

Carry plan matrix

CAPABILITY	PER-OPERATOR IFAK	NAMED TEAM CARRIER	VEHICLE / PLATFORM	BACKUP PATH
Tourniquets (2+)				
Hemostatic gauze				
Vented chest seals (2)				
Nasopharyngeal airway				
Junctional device				
Suction				
Bag-valve-mask				
IV / IO				
Hypothermia kit				
Litter				
TCCC Casualty Cards				

NOTES / FINDINGS

SECTION G · SCORING

Load Distribution & Carry Plan

	#	SECTION G — AUDIT ITEM	SCORE 0/1/2
☐	G1	Per-operator IFAK contents are standardized across the element: same items, same locations.	
☐	G2	Team-level adjuncts (junctional, suction, BVM) are assigned to a named carrier.	
☐	G3	Vehicle / platform kits are mounted, inventoried, and labeled.	
☐	G4	Weight audit: no operator's medical burden exceeds the mission-carry standard.	
☐	G5	Redundancy: there are two ways to reach every critical capability.	
☐	G6	A temperature storage plan exists for vehicle-staged consumables.	
		SECTION G SUBTOTAL — MAXIMUM 12 POINTS	

Gaps to close

ITEM	GAP TO CLOSE	OWNER	DUE

NOTES / FINDINGS

SECTION H

H

TRAINING & SUSTAINMENT CADENCE

Skills decay. Cadence keeps every member — not just the medic — at deployment standard.

6 AUDIT ITEMS · MAXIMUM 12 POINTS · SCORING ON PAGE 19

Why it matters

The published record for eliminating preventable death came from training every member in TCCC, not only medics (Kotwal 2011). Hands-on skills fade without practice, so this audit scores cadence as well as completion.

Training cadence standard

CADENCE	WHO	STANDARD
Weekly / pre-mission	All members	Tourniquet self- and buddy-application: effective in under 60 seconds, either hand, any limb.
Monthly	Each team	MARCH lane: one casualty, full assessment, TCCC Card, MIST handoff.
Quarterly	Whole element	Full-scale multiple-casualty simulation, including casualty movement in full kit and a documented debrief.
Before first mission	New members	Medical integration checklist: kit layout, SOP roles, drills to standard.
Pre-deployment	Command + medic	Records validated and filed with this audit.

NOTES / FINDINGS

SECTION H · SCORING

Training & Sustainment Cadence

	#	SECTION H — AUDIT ITEM	SCORE 0/1/2
	H1	All team members are MARCH-competent, not just medics. CRITICAL ITEM	
	H2	Tourniquet drill standard: effective application in under 60 seconds, either hand, any limb.	
	H3	A full-scale multiple-casualty simulation is run quarterly.	
	H4	A new-member medical integration checklist is completed before the first mission.	
	H5	Casualty movement is rehearsed in full kit.	
	H6	Training records are retained for deployment readiness validation.	

SECTION H SUBTOTAL — MAXIMUM 12 POINTS

Gaps to close

ITEM	GAP TO CLOSE	OWNER	DUE

NOTES / FINDINGS

SECTION I

RESUPPLY & EXPENDABLE ROTATION

Consumables expire, get used, and get lost. Rotation and restock rules keep the kit real.

6 AUDIT ITEMS · MAXIMUM 12 POINTS · SCORING ON PAGE 21

Why it matters

Hemostatic gauze, chest seals, fluids, and medications all carry expiration dates and storage limits. A rotation log with restock triggers turns "we think we have it" into a number. This log is the evidence for items I1 and I5.

Expendable rotation log

ITEM	LOT	EXP.	QTY	LOCATION	REPLACE BY	CHECKED

NOTES / FINDINGS

SECTION I · SCORING

Resupply & Expendable Rotation

	#	SECTION I — AUDIT ITEM	SCORE 0/1/2
	I1	The expendable rotation log (hemostatics, chest seals, fluids, analgesics) is current.	
	I2	A replenishment plan for consumables exists through the supporting supply chain (air or port).	
	I3	Sealed backup kits are staged.	
	I4	A temperature-integrity plan covers climate extremes.	
	I5	Restock triggers are defined (percentage-used thresholds).	
	I6	Vendor lead times are documented for pre-deployment bulk purchases.	
		SECTION I SUBTOTAL — MAXIMUM 12 POINTS	

Gaps to close

ITEM	GAP TO CLOSE	OWNER	DUE

NOTES / FINDINGS

SECTION J

ACCOUNTABILITY & DOCUMENTATION

What is not written down does not hand off. Documentation carries the casualty's story to the next level of care.

6 AUDIT ITEMS · MAXIMUM 12 POINTS · SCORING ON PAGE 23

Why it matters

The TCCC Guidelines direct teams to "document clinical assessments, treatments rendered, and changes in the casualty's status on a TCCC Card (DD Form 1380)." The card and the MIST report are how tourniquet time, TXA time, and the trend reach the surgeon. After-action data is how the unit improves.

MIST HANDOFF

M	**MECHANISM** Mechanism of injury and time of injury.
I	**INJURIES** Injuries found, head to toe, including tourniquet locations.
S	**SIGNS** Vital signs and their trend: pulse, respiration, mental status.
T	**TREATMENT** Treatments given and times, including tourniquet time and TXA.

Casualty tracking worksheet

CASUALTY	TIME	INJURIES	INTERVENTIONS / TIMES	STATUS	EVAC

NOTES / FINDINGS

SECTION J · SCORING

Accountability & Documentation

	#	SECTION J — AUDIT ITEM	SCORE 0/1/2
	J1	TCCC Casualty Cards (DD Form 1380) are staged with every kit. CRITICAL ITEM	
	J2	The MIST format is printed on cards or referenced.	
	J3	Tamper seals on sealed kits carry inspection dates.	
	J4	Serial and lot numbers are tracked for medical consumables.	
	J5	A casualty tracking worksheet (who, what, when, status) template is available.	
	J6	After-action medical data is captured for trend review.	

SECTION J SUBTOTAL — MAXIMUM 12 POINTS

Gaps to close

ITEM	GAP TO CLOSE	OWNER	DUE

NOTES / FINDINGS

SCORING MATRIX & READINESS TIERS

Your readiness index

Section subtotals carry over automatically in form-capable readers. On paper, copy each subtotal from its scoring page, add the raw score, and convert to the index.

SEC.	DOMAIN	ITEMS	MAX	YOUR SCORE	% OF MAX
A	Doctrine & TCCC/PCC Alignment	8	16		
B	Massive Hemorrhage Readiness (MARCH M)	10	20		
C	Airway & Respiration Readiness (MARCH A · R)	8	16		
D	Circulation & IV/IO Access (MARCH C)	6	12		
E	Hypothermia & Head Injury (MARCH H)	6	12		
F	Prolonged Casualty Care Sustainment	8	16		
G	Load Distribution & Carry Plan	6	12		
H	Training & Sustainment Cadence	6	12		
I	Resupply & Expendable Rotation	6	12		
J	Accountability & Documentation	6	12		
	TOTAL	**70**	140		

READINESS INDEX _____ **READINESS TIER** _____

Index = (raw score ÷ 140) × 100. The tier field applies the critical-item gate automatically.

Readiness tiers

TIER	INDEX	RAW	COMMAND ACTION
TIER 1 — DEPLOYABLE	85–100	119–140	Sustain. Close remaining 1s, re-validate at T-7, and file this audit with deployment records.
TIER 2 — GAP	60–84	84–118	Remediate before deployment. Every 0 and 1 gets an owner and a due date. Re-score at T-30.
TIER 3 — CRITICAL	Below 60	0–83	Command decision required on kit, training, and timeline. Start with Sections B, C, and H.

CRITICAL-ITEM GATE & SIGN-OFF

Gate check and validation

A score of 0 on any critical item caps the unit at Tier 2, regardless of the index. Tick each item once it is confirmed at a score of 1 or higher.

	ITEM	CRITICAL CAPABILITY
☐	**B1**	Two CoTCCC-recommended tourniquets per operator, reachable with either hand
☐	**B4**	Hemostatic gauze, in date, carried at the point of injury
☐	**C4**	Two vented chest seals per IFAK
☐	**H1**	Every member MARCH-competent, not only medics
☐	**J1**	TCCC Casualty Cards (DD Form 1380) staged with every kit

Section heat map

Shade or mark each section by its percentage of maximum. Any section below 50% is a priority for the remediation plan on page 26, even when the overall index is in Tier 1.

A DOCTRINE	B HEMORRHAGE	C AIRWAY / RESP	D CIRCULATION	E HYPO / HEAD	F PCC	G LOAD	H TRAINING	I RESUPPLY	J DOCUMENTS

Validation and sign-off

ROLE	NAME	DATE
Audit completed by (name, role)		
Senior medic		
Team leader / commander		
Medical director / readiness officer review		
Audit round (T-90 / T-30 / T-7)		

COMMAND NOTES

RECOMMENDED NEXT STEPS

Phase-based remediation

Work the gaps in the order that saves lives first: hemorrhage and the critical items, then airway and respiration, then sustainment and logistics. Re-score after each phase so command sees the trend.

PHASE	FOCUS	ACTIONS
T-90	Baseline	Complete the full audit. Clear every critical-item 0. Order long-lead items (Section I6) and standardize the IFAK (G1).
T-60	Hemorrhage and airway	Close Sections B and C to 2s. Run self-application drills (B6, H2). Stand up the rotation log (I1).
T-30	Sustainment and load	Stage 24-hour PCC consumables (F1). Finalize the carry plan (Section G). Quarterly multiple-casualty simulation (H3). Re-score.
T-7	Validation	Seal and date kits (J3). Confirm TCCC Cards in every kit (J1). Final score and command sign-off (page 25).
Post-mission	Learn	After-action medical debrief (A8), data captured (J6), restock to triggers (I5).

Priority gap list

#	GAP (SECTION / ITEM)	OWNER	DUE	DONE
1				
2				
3				
4				
5				
6				

REQUEST A DEPLOYMENT KIT CONSULTATION ›
Government procurement: tactical-medicine.com/pages/government-procurement-solutions

B2B QUOTE REQUESTS ›
Line-item and bill-of-materials quotes: tactical-medicine.com/pages/medical-logistics-rfq-services

Free APO/FPO shipping. Every order. No minimum.

ABOUT

MED-TAC International

MED-TAC International is a Service-Disabled Veteran-Owned Small Business founded, owned, and operated by medical, public safety, and military professionals. Medical SME Veteran-Led, we build and source evidence-based trauma and casualty care equipment — CoTCCC-recommended where applicable — and our kits are assembled in the USA. Complete Tactical Medical Preparedness.

Founder: Marco R. Torres, MD, NRP — physician and medical educator with tactical medic and flight medic experience. U.S. Navy veteran. Founder of MED-TAC International and ALKEONHealth.com.

PROCUREMENT DATA	
Business type	Service-Disabled Veteran-Owned Small Business (SDVOSB)
Registration	SAM Registered
CAGE	9VFL3
UEI	YU3ZMJ44REA5
Kits	Assembled in the USA
Shipping	Free APO/FPO shipping. Every order. No minimum.
Consultation	https://tactical-medicine.com/pages/government-procurement-solutions
B2B quotes	https://tactical-medicine.com/pages/medical-logistics-rfq-services

References

1. Eastridge BJ, Mabry RL, Seguin P, et al. Death on the battlefield (2001–2011): implications for the future of combat casualty care. *J Trauma Acute Care Surg.* 2012;73(6 Suppl 5):S431–S437.
2. Kotwal RS, Montgomery HR, Kotwal BM, et al. Eliminating preventable death on the battlefield. *Arch Surg.* 2011;146(12):1350–1358.
3. Kotwal RS, Howard JT, Orman JA, et al. The effect of a golden hour policy on the morbidity and mortality of combat casualties. *JAMA Surg.* 2016;151(1):15–24.
4. Committee on Tactical Combat Casualty Care. *Tactical Combat Casualty Care (TCCC) Guidelines.* 01 May 2026.
5. Joint Trauma System. *Prolonged Casualty Care Guidelines* (CPG ID 91). 21 December 2021.
6. DD Form 1380, TCCC Card, as referenced in the TCCC Guidelines (documentation).

Use and limits. This is an educational self-assessment. It does not replace unit medical direction, command guidance, scope-of-practice rules, or current TCCC and Joint Trauma System publications, which change. "CoTCCC-recommended" describes inclusion on the Committee on TCCC recommended-device lists; it is not an approval or certification. No unit, command, or government endorsement is implied. © 2026 MED-TAC International Corp. Free to share unmodified within your organization; not for resale.

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CLOSE THE GAPS BEFORE WHEELS UP.

Send us your audit gaps or your unit bill of materials. We build and source deployment kits to the standard in this audit — per-operator IFAKs, team adjuncts, PCC sustainment, and vehicle kits — with line-item quoting for unit and government procurement.

REQUEST A DEPLOYMENT KIT CONSULTATION

https://tactical-medicine.com/pages/government-procurement-solutions ›

B2B QUOTE REQUESTS

https://tactical-medicine.com/pages/medical-logistics-rfq-services ›

FREE APO/FPO SHIPPING. EVERY ORDER. NO MINIMUM.

PER-OPERATOR

Standardized IFAKs: same items, same locations, every operator.

TEAM ADJUNCTS

Junctional, airway, suction, and ventilation kits for a named carrier.

PCC SUSTAINMENT

24-hour consumable packs built to your casualty estimate.

VEHICLE / PLATFORM

Mounted, labeled, inventoried kits with sealed backups.

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GOVERNMENT PROCUREMENT

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