Tactical Medicine: Terms & Definitions

A field guide to TacMed acronyms & roles for medical and non-medical tactical personnel

THE UMBRELLA FIELD & PROGRAMS

TacMed *Tactical Medicine* UMBRELLA FIELD

The medical specialty covering the emergency and preventive care needed to protect the health of military and law enforcement (SWAT) personnel — and others — during high-risk special operations, deployments, and training. Everything below is a piece of this larger discipline.

TEMS *Tactical Emergency Medical Support* LAW ENFORCEMENT

The **medical element/program** embedded in a tactical (SWAT) team — not a certification. TEMS provides preventive, urgent, and emergent care across high-risk, extended, and mission-driven operations, plus medical threat assessment and logistics support. Endorsed by NTOA as a core SWAT team component. NTOA's *Tactical Response & Operations Standard* defines the team it supports — a **SWAT Tier 1** unit — as mission-capable in hostage rescue, barricaded subjects, sniper ops, high-risk warrants, and terrorism response.

TMP *Tactical Medical Provider* LE / MILITARY

The individual clinician who staffs a TEMS unit — an EMT, paramedic, PA, RN, or physician trained in austere medicine plus team tactics and casualty evacuation. Many train through **CONTOMS** (DoD's EMT-Tactical program, est. 1990). Some vendors also brand a named course "TMP" — e.g., SOARescue's 82-hr *Tactical Medical Practitioner*, prepping students for the TP-C exam — same letters, different referent: generic role vs. specific product.

"Medic" *generic LE title — not a certification level* LE

LE agencies routinely call anyone on the medical element a **"Medic"** — but it can mean an EMT *or* a Paramedic, with very different scopes. Ask which certification a "medic" actually holds:

	EMT → BLS Medic	Paramedic → ALS Medic
Training	~150–200 hrs	1,200–1,800+ hrs
Scope	Hemorrhage control, airway positioning, splinting, O2, AED — **no** IV meds/ advanced airway	+ IV/IO access, advanced airway, medications, blood products (protocol-driven)
Tactical cert.	CONTOMS EMT-T · IBSC **TR-C**	IBSC **TP-C** (paramedic-license required)

TR-C (Tactical Responder—IBSC) certifies non-paramedic operators (LE/fire, secondary medical role) in casualty care under threat; **TP-C** (Tactical Paramedic—IBSC) is the parallel board exam open only to licensed paramedics.

TRAINING DOCTRINES — MILITARY VS. CIVILIAN

TCCC *Tactical Combat Casualty Care* MILITARY

Battlefield trauma doctrine developed by the DoD Defense Health Agency's Joint Trauma System. Taught in three tiers by clinical role:

Tier	Course	Audience
1	TCCC-ASM (7 hrs)	All Service Members (non-medical)
2	TCCC-CLS (40 hrs)	Combat Lifesaver — non-medical personnel
3	TCCC-CMC (63 hrs)	Combat Medic/Corpsman — military medical personnel

TECC *Tactical Emergency Casualty Care* CIVILIAN

The civilian counterpart to TCCC — developed by the Committee for TECC (C-TECC), which re-examined every TCCC guideline for civilian appropriateness. Guidance is tiered by provider: **Active Bystanders**; **First Responders with a Duty to Act** (LE/fire — NAEMT's 8-hr **TECC-LEO** course, no medical cert. required); **BLS/ ALS Medical Providers** (NAEMT's 16-hr TECC course); and **Pediatric Care**.

SHARED ASSESSMENT FRAMEWORK

MARCH (TCCC) / **MARCHE** (TECC) — the priority sequence: **M**assive hemorrhage → **A**irway → **R**espiration → **C**irculation → **H**ypothermia/Head injury, plus **E**verything Else in TECC.

MARCH-PAWS extends the sequence into Tactical Field Care, adding **P**ain, **A**ntibiotics, **W**ounds, and **S**plinting once immediate threats are controlled.

Care Under Fire / Hot Zone (Direct Threat Care)

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Tactical Field Care / Warm Zone (Indirect Threat Care)

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Tactical Evacuation Care / Cold Zone (Evacuation Care)

Military term (TCCC) shown left of slash; parallel civilian/EMS term (TECC) shown right — same three-phase model of care under threat.

RELATED, BUT NOT THE SAME: RTF

Rescue Task Force (RTF) — a joint LE + fire/EMS entry team (incl. a paramedic) that enters the warm zone during an active-shooter/MCI response to treat and extract victims to a casualty collection point. A mutual-aid structure built for one incident type — *not* a standing, SWAT-embedded TEMS element.

WHO TRAINS IN WHAT — BY ROLE

Non-Medical Personnel

- **TCCC-ASM** (military) — self/buddy aid for every deploying service member.
- **TECC-LEO** (civilian, 8 hrs) — bleeding control & casualty care for patrol officers/operators with no medical certification.
- **TCCC-CLS** — non-medical troops deploying in direct support of combat operations; deeper skill set than ASM.
- **IBSC TR-C** — board cert. for LE/fire operators with a secondary medical role; non-paramedic scope (see left).

Medical Personnel (Military)

- **TCCC-CMC** — medics, corpsmen, pararescue; full battlefield trauma scope of practice.
- Common titles: **68W** (Army Combat Medic), **Corpsman** (Navy/Marines), **PJ** (Air Force Pararescue) — all trained to CMC level.
- Grounded in NAEMT's *PHTLS Military* textbook, written by the JTS Committee on TCCC.

Medical Personnel (Civilian / LE)

- **TECC course** — EMS & TEMS providers responding within civilian tactical/active-threat environments.
- **TMP ("Medic")** — the on-team Tactical Medical Provider; BLS if EMT-certified, ALS if paramedic-certified (see left).
- **TEMS Medical Director** (physician) — oversees protocols, training, and quality for the TEMS program.

QUICK DISTINCTIONS

If you mean...	...use
The overall discipline	Tactical Medicine (TacMed)
The embedded LE medical program	TEMS
The individual provider on that team	TMP (Tactical Medical Provider)
The military battlefield curriculum	TCCC
The civilian equivalent curriculum	TECC
A "medic" who is EMT-certified	BLS Medic
A "medic" who is paramedic-certified	ALS Medic
A one-off LE+fire/EMS entry team	RTF (not TEMS)

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Sources: ntoa.org • acep.org/talem • naemt.org • c-tecc.org • contoms.chepinc.org • ibscertifications.org • soarescue.com

Tactical Medicine: Program & Operations Reference

Certification pathways, TEMS program components, and zone-of-care operations

CERTIFICATION & TRAINING PATHWAY

Base EMS Certification (EMT-B / EMT-A / Paramedic)

↓

Tactical Add-On Training — CONTOMS EMT-T, IBSC TR-C (non-medic scope), or IBSC TP-C (paramedic scope)

↓

Team Placement — TMP (Tactical Medical Provider) embedded on a TEMS unit, under a TEMS Medical Director's protocols

A paramedic license is required for TP-C; the credential adds tactical competency, not ALS scope. TR-C requires no paramedic license, only a documented secondary medical role.

Credential	Prereq.	Validity
CONTOMS EMT-T	EMT cert.	Course completion
IBSC TR-C	Secondary medical role, non-paramedic	4 yrs
IBSC TP-C	Active, unrestricted paramedic license	4 yrs

Recertification requires continuing education before expiration; lapses require re-exam. CONTOMS permits some LE/non-EMT attendees, but attendance alone never authorizes BLS/ALS skills — that requires state EMS certification.

BLS VS. ALS SKILLS INVENTORY

Category	BLS (EMT)	ALS Adds
Hemorrhage	Tourniquet, wound packing, hemostatic gauze, pressure dressing	Junctional tourniquet, wound clamp
Airway	Manual positioning, OPA/NPA, suction	Supraglottic airway, ET intubation, surgical cricothyrotomy
Breathing / Chest	Vented chest seal, supplemental O2, BVM	Needle decompression (thoracostomy) for tension pneumothorax
Circulation	CPR, AED, spinal motion restriction, splinting, mylar blanket (hypothermia prevention)	IV/IO access, fluid resuscitation, blood products
Medications	None (limited OTC per protocol)	Analgesics, antibiotics, TXA, sedation/RSI agents
Monitoring	Vital signs, pulse ox	Cardiac monitor / 12-lead ECG, capnography

ALS skills are additive to the full BLS scope — every ALS provider is expected to also hold the BLS skill set.

TEMS PROGRAM COMPONENTS

A "real" TEMS capability is more than an assigned medic. It's the surrounding system that makes that provider effective in the field — the seven components below define that system:

1. **Medical Threat Assessment** — pre-mission review of environment, mission profile, and known hazards to anticipate injury patterns before an operation begins.
2. **Preventive Medicine** — fitness/medical screening, heat and environmental illness mitigation, hydration and rest-cycle protocols for operators.
3. **On-Scene Tactical Care** — real-time casualty care embedded with the team, applying MARCH/MARCH-PAWS under threat conditions.
4. **Casualty Evacuation Planning** — pre-identified extraction routes, CASEVAC coordination, and liaison with transporting EMS/MEDEVAC assets.
5. **Logistics & Equipment Sustainment** — IFAK/kit stocking, expiration tracking, and resupply for both operators and the TMP.
6. **Quality Improvement & AAR** — case review, documentation, and protocol refinement after each deployment or training event.
7. **Medical Director Oversight** — a physician holds protocol authority and quality assurance responsibility for everything above.

Agencies evaluating whether they have a genuine TEMS capability — versus just an assigned medic — should be able to speak to each of these components individually, not just point to a person carrying a bag.

PROGRAM MATURITY SCALE

Stage	What it looks like
Ad Hoc	No formal program; a medically trained member is assigned informally, without the components above
Developing	Some components in place, but inconsistent — e.g., no named Medical Director or no recurring QI cycle
Established	All seven components in place, documented, and staffed under a named Medical Director
Sustaining	Established, plus regular training refresh, kit audits, and after-action-driven protocol updates

COMMON PROGRAM GAPS

Agencies auditing their own capability most often find one of these missing, even with a TMP present: no named Medical Director; no formal AAR/QI process; kit stock not tracked for expiration; training treated as one-time, not recurring.

AUTHORIZED CARE BY THREAT ZONE & PROVIDER LEVEL

What a provider may do changes with certification level, not with the tactical environment — the zone changes what's *feasible*, not what's *authorized*. This matrix cross-references both:

	Non-Medical	BLS (EMT)	ALS (Paramedic)
Hot Zone Direct Threat	Self/buddy aid: hemorrhage control, tourniquet (TCCC-ASM, TECC-LEO)	Same non-medical actions only; full BLS scope waits for threat suppression	Same as BLS; full ALS scope waits for threat suppression
Warm Zone Indirect Threat	Continue hemorrhage control, assist drag/carry — no scope beyond first aid	Full BLS: tourniquet/packing, OPA/NPA, chest seal, O2, splinting, AED — no IV, no surgical/advanced airway	Full ALS: BLS actions + IV/IO, supraglottic/surgical airway, needle decompression, medications, blood products
Cold Zone Evacuation	Litter carry, scene security, assist movement	Continue BLS monitoring & care during transport	Continue ALS care, titrate medications, prepare hospital handoff

Non-medical personnel are never authorized for IV medications, advanced airway management, or medication administration, regardless of zone. An embedded TMP may enter the hot zone under threat only if organic to the team and mission profile allows.

An RTF operates only in the warm zone, for a single incident; a TEMS program's TMP operates across all three zones as a standing, mission-embedded capability.

DOCUMENTATION AT ZONE TRANSITIONS

Every zone transition is a documentation point: time of transition, vitals, interventions performed and by whom, mechanism of injury, and precedence assigned — the record behind continuity of care and legal/QA review.

MEDICAL DIRECTION & LIABILITY

TEMS protocols operate under a physician Medical Director; scope-of-practice enforcement is a state EMS office function and varies by state. Standing orders vs. real-time (online) medical control is set by that Director's protocols, not the tactical situation.

Sources: ntoa.org • acep.org/talem • naemt.org • c-tecc.org • contoms.chepinc.org • ibscertifications.org • soarescue.com • army.mil

Tactical Medicine: Evacuation & Communications

CASEVAC vs. MEDEVAC, the 9-Line MEDEVAC request, and evacuation precedence

CASEVAC VS. MEDEVAC

CASEVAC *Casualty Evacuation* NON-MEDICAL TRANSPORT

Urgent movement of a casualty using whatever vehicle or aircraft is available — a truck, transport helicopter, even a tank — without dedicated medical personnel, equipment, or en-route treatment capability. Priority is speed out of danger, not care in transit.

MEDEVAC *Medical Evacuation* MEDICAL TRANSPORT

Evacuation on a dedicated medical platform — ground ambulance or MEDEVAC aircraft — staffed with medical personnel who continue treatment en route. Typically used once the tactical situation allows a secure pickup.

	CASEVAC	MEDEVAC
Platform	Any available vehicle/ aircraft of opportunity	Dedicated ambulance or MEDEVAC aircraft
Medical attendant	Not guaranteed; often none	Yes — medical personnel aboard
En-route care	Minimal to none beyond initial first aid	Continued BLS/ALS care in transit
When used	Immediate extraction under threat	Once secure, or CCP → higher care

In practice, casualties often move CASEVAC first — the fastest available transport out of danger — then transition to MEDEVAC once they reach a secure handoff point, such as a casualty collection point.

WHERE THIS FITS IN THE ZONE MODEL

Referencing page 2's zone matrix: CASEVAC moves a casualty out of the hot/warm zone under threat, before a dedicated medical asset can safely reach them. MEDEVAC picks up from the cold-zone CCP, or an RTF hand-off, and carries the patient to definitive care — confirming which is inbound, and its precedence, is part of Evacuation Planning on page 2.

FLUID RESUSCITATION: RISKS & CONSIDERATIONS

Option	Current Role / Risk
Whole blood	Preferred fluid for hemorrhagic shock; most closely replaces what was lost
Blood components (1:1:1)	Plasma, platelets, red cells together when whole blood isn't available
Plasma alone	Restores clotting factors; used when components/ whole blood are limited
Crystalloids (NS, LR)	Little role in hemorrhagic shock — dilutes clotting factors, worsens hypothermia/acidosis/coagulopathy

TCCC favors **permissive (hypotensive) resuscitation** — targeting a palpable radial pulse or improved mentation, not normal BP, since over-resuscitation can disrupt clot formation. Administration is an ALS/TP-C skill, not BLS scope, and carries its own logistics burden (cold chain, expiration, type compatibility).

CCP CONSIDERATIONS

A usable casualty collection point needs **security** (off the direct threat axis), a clear **marking** method, **access** for litter teams/vehicles, and enough **capacity** for the expected casualty flow.

THE 9-LINE MEDEVAC REQUEST

A standardized nine-line format for requesting evacuation, keeping every element consistent regardless of who transmits or receives it. Lines 1–5 must be sent within 25 seconds and are required to launch the aircraft; lines 6–9 can follow while it's en route.

Line	Contents
1	Location of the pickup site (grid coordinates)
2	Radio frequency, call sign, and suffix
3	Number of patients by precedence: Urgent, Urgent-Surgical, Priority, Routine, Convenience
4	Special equipment required: none, hoist, extraction equipment, ventilator
5	Number of patients by type: litter vs. ambulatory
6	Security at pickup site (wartime) — or number/type of wounds, injuries, illness (peacetime/civilian)
7	Method of marking the pickup site: panels, pyrotechnic signal, smoke, none
8	Patient nationality and status (military only)
9	NBC contamination — nuclear/biological/chemical (wartime) — or terrain description of pickup site (peacetime/civilian)

Unless sent over a secure system, MEDEVAC traffic is encrypted — except the line numbers themselves, which are always stated in clear text.

CIVILIAN / TECC ADAPTATION

Civilian TEMS and TECC programs teach the same nine-line skeleton for calling in air or ground transport, with two lines adapted for peacetime use: **Line 6** becomes the number and type of wounds, injuries, or illness rather than enemy activity, and **Line 9** becomes a plain terrain description of the pickup site rather than a CBRN report. Lines 1–5 and 7–8 stay functionally the same across both contexts, which is why the format transfers cleanly between military and civilian tactical teams.

Many TEMS units pair the 9-line with a short **MIST report** (Mechanism, Injuries, Signs, Treatment given) at patient handoff — the 9-line gets the aircraft moving, the MIST report briefs the receiving team once it arrives.

SAMPLE TRANSMISSION (LINES 1–5)

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"Break, break, [callsign] requesting MEDEVAC, over.
Line 1: Grid 38S MC 12345 67890.
Line 2: 38.500, Tango-6, Foxtrot.
Line 3: One, Urgent-Surgical.
Line 4: None required.
Line 5: One, ambulatory. Over."
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LZ & RADIO QUICK REFERENCE

LZ size: min. ~100×100 ft, clear approach/departure paths, slope under 15°, firm debris-free surface.
Brevity: Break, break (interrupt for urgent traffic) • Say again • Roger • Wilco • Over • Out.
NATO phonetic: Alfa, Bravo, Charlie, Delta, Echo, Foxtrot, Golf, Hotel, India, Juliett, Kilo, Lima, Mike, November, Oscar, Papa, Quebec, Romeo, Sierra, Tango, Uniform, Victor, Whiskey, X-ray, Yankee, Zulu.

EVACUATION PRECEDENCE & PICKUP CONSIDERATIONS

Line 3 of the 9-line assigns a precedence category, driving how aircraft and ground assets are allocated when multiple requests compete for the same resources:

Precedence	Standard	Example
Urgent	ASAP, within 2 hrs	Life, limb, or eyesight threat
Urgent-Surgical	Within 2 hrs, to surgical capability	Requires surgical intervention
Priority	Within 4 hrs	Could deteriorate to Urgent if delayed
Routine	Within 24 hrs	Stable, needs definitive care
Convenience	No fixed timeline	Administrative/minor, no mission impact

Pickup site selection — size and obstacles for the airframe, a reliable marking method, current security status, and working communications with the inbound asset all factor into whether a site is usable, independent of how urgent the patient is.

The TMP is typically the one who calls in the request and assigns precedence — accurate triage at this step directly determines how fast a casualty reaches definitive care.

COMMUNICATIONS BACKUP

Radio traffic can fail or be jammed. TEMS programs plan a redundant method for the 9-line before it's needed — a secondary frequency, a relay through the operations center, or a pre-briefed runner — so the request still reaches the aircraft if the primary channel drops.

Whoever transmits should have the 9-line format written down, not memorized — under stress, a checklist is more reliable than recall, even for personnel who have called it in dozens of times before.

COMMON MISTAKES UNDER STRESS

Burying the Line 3 precedence in extra narrative instead of stating it plainly; skipping the grid or frequency because "they already know"; defaulting everyone to Urgent out of caution, which delays truly urgent patients elsewhere; and transmitting lines 6–9 before 1–5, which delays the launch itself.

REASSESSING PRECEDENCE EN ROUTE

Precedence isn't fixed at first call. If a patient improves or deteriorates before pickup, update the aircraft/dispatch so resources reallocate correctly — an unreported change risks delaying whoever needs it most.

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Field Notes

Space for observations, training takeaways, and post-incident documentation

Date: _____ **Location / Training Event:** _____ **Provider Level:** ☐ Non-Medical ☐ BLS ☐ ALS **Team / Unit:** _____

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