


PATIENT MOVEMENT RECORD													
DATA PROTECTED BY PRIVACY ACT OF 1974						PERMANENT MEDICAL RECORD							
(S) - Information needed to submit patient movement record													
SECTION I PATIENT IDENTIFICATION													
(s) NAME (Last, First, Middle Initial)						(s) SSN			DATE OF BIRTH				
(s) AGE	(s) SEX		(s) STATUS	(s) SERVICE	(s) GRADE	(s) UNIT OF RECORD AND PHONE NUMBER			CITE NUMBER				
	M	F											
SECTION II VALIDATION INFORMATION													
(s) Medical Treatment Facility Origination and Phone Number						(s) Ready Date (Julian Date)		APPOINTMENT DATE		NUMBER OF ATTENDANTS			
(s) Medical Treatment Facility Destination and Phone Number						(s) CLASSIFICATION 1A-5F							
						AMBULATORY		LITTER		(s) PRECEDENCE			
(s) Reason Regulated	Max # Stops	Max # RONS	Altitude Restriction	(s) CCATT Required		Name, sex, weight, rank of attendants:				U	P	R	
				yes no									
SECTION III OTHER INFORMATION													
(s) Attending Physician name, Phone Number and e-mail						(s) Accepting Physician name, Phone Number and e-mail							
(s) Origination Transportation 24 Hour Phone Number						(s) Destination Transportation 24 Hour Phone Number							
(s) Insurance Company	Address			Phone #		Policy #		Relationship to policy holder					
(s) Waivers (med equip, etc)													
SECTION IV CLINICAL INFORMATION													
(s) Diagnosis				(s) Allergies		LABS (Date and time drawn in Zulu)							
						WBC		HGB		HCT		Other Labs	
(s) WEIGHT:		(S) Blood type:		Vital Signs (Date and time taken in Zulu)									
battle casualty		disease		Date	Time (Zulu)	B/P	Pulse	Resp	Pain Level: /10	Last Pain Med:	O ₂ /LPM:	Route:	
non-battle injury													
CLINICAL ISSUES				Baseline O2 Sat If Applicable				Temp					
Infection Control Precautions:				LMP:		SPECIAL EQUIPMENT (Check all that apply)							
Date of last bowel movement:						Suction		Traction		Orthopedic devices		OTHER:	
High Risk for Skin Breakdown				yes no		NG Tube		Monitor		Restraints			
Initial appropriate boxes:						Foley		Trach		Chest Tubes			
						Incubator		IV Pumps		IV Location:			
Yes	No	Yes	No	Cast Location:				Bivalved:		yes no			
				Hearing Impaired				Hypertension					
				Communication Barriers				Dizziness					
				Vision Impaired				Voiding difficulty					
				Cardiac Hx				*Takes long-term meds					
				Diabetes				*Will self-medicate					
				Motion Sickness				Has adequate supply of meds					
				Ears/Sinus Problems				Knows how to take meds (verbalized understanding)					
				Respiratory difficulty				TPN:					
				*Medication listed on physician's orders				Other(specify):					
SECTION V PERTINENT CLINICAL HISTORY (Transfer Summary)													
Physician's Signature						Date/Time							
Signature of Clearing Flight Surgeon						Date/Time							

PATIENT MOVEMENT PHYSICAL ASSESSMENT		
DATA PROTECTED BY PRIVACY ACT OF 1974		PERMANENT MEDICAL RECORD
NAME (Last, First, Middle Initial)	CITE#/SSN	DATE/TIME(ZULU)
Instructions: Assess the patient. Circle/annotate the appropriate findings. Chart "exceptions", ongoing assessments, maximum cabin altitude, and treatments on AF IMT 3899a, Patient Movement Record Progress Note and/or indicated AF IMT.		
Print Provider's Name/Signature/Initials/Unit & Location		Date/Time
1. Initial Vital Signs:		
BP: _____ Pulse _____ Resp _____ Temp _____ Pulse Ox/SaO2 _____		
Use AF IMT 3899 D Patient Movement Hemodynamic/Respiratory Flow Sheet		
2. Neurological: Alert & oriented to person, place & time. Behavior appropriate to situation. Active ROM with symmetry of strength. No paresthesia. Verbalization/speech clear and appropriate. Gag reflex present. Take fluids and solids without choking. YES NO		
Pupils _____ Glasgow Coma Score _____ Head Position: Forward/AFT _____		
Sedated NO YES/Medication _____		
Head Elevated: NO YES/Degrees _____		
Ventriculostomy NO YES/Location/Description _____		
Intracranial Pressure Monitor NO YES/Type/Location/Pressure: _____		
Use AF IMT 3899 H Patient Movement Neurological Assessment or AF IMT 3899 D Patient Movement Hemodynamic /Respiratory Flow Sheet		
3. Cardiovascular: Regular apical pulse. Neck veins flat at 45 degrees. Capillary refill <2 sec. No edema, calf tenderness or chest pain. Peripheral pulses palpable. YES NO		
Cardiac Rhythm/Rate: _____ N/A Last episode chest pain: Date/Time (Zulu) _____		
Heart Sounds: _____ Murmur: YES NO N/A Rub: YES NO N/A		
IV Line(s)/Solution/Location: _____ N/A		
Hemodynamic Monitoring Line: _____ N/A		
Hemodynamic Monitoring Line: _____ N/A		
Hemodynamic Monitoring Line: _____ N/A		
Hemodynamic Monitoring Line: _____ N/A		
Homan's Sign: YES/Location: _____ NO		
Use AF IMT 3899 D Patient Movement Hemodynamic/Respiratory Flow Sheet and/or AF IMT 3899 E Patient Movement Intake/Output Flow Sheet		
4. Respiratory: Respirations regular, even and unlabored. Chest symmetrical; lungs clear. Nail beds & mucous membranes pink. YES NO		
Breath Sounds: _____ Last episode of shortness of breath: Date/Time (Zulu) _____		
ETT: NO YES/Location/size _____ Tracheostomy: NO YES/Size _____		
CO ₂ Indicator: _____ N/A Cuff Pressure: _____ N/A		
Minimal Leak Technique: NO YES/Normal Saline Amount: _____		
Ventilator Settings: _____ N/A		
O ₂ Delivery/Rate/Percentage: _____ N/A		
Sputum: _____ Suction Cough N/A		
Chest Tube(s) YES/Location/Description _____ with Heimlich Valve: YES N/A		
Chest Drainage Unit/Description: _____ cm Suction _____		
Use AF IMT 3899 D Patient Movement Hemodynamic/Respiratory Flow Sheet and/or AF IMT 3899 E Patient Movement Intake/Output Flow Sheet		
5. Gastrointestinal: Tolerates diet without nausea and vomiting. Normal Bowel Sounds present. Having BM within own normal pattern and consistency. Drinking fluids every two hours. YES NO		
Diet: _____		
Abdomen: _____		
NG Tube: NO YES/Size/Description/Suction: _____		
Other Tube(s): NO YES/Location/Description: _____		

PATIENT MOVEMENT PHYSICAL ASSESSMENT (Continuation)	
DATA PROTECTED BY PRIVACY ACT OF 1974	PERMANENT MEDICAL RECORD
NAME (Last, First, Middle Initial)	CITE#SSN
Gastrointestinal: Continued Drain(s): NO YES/Location/Description/Suction _____ Colostomy: NO YES/Location/Assessment: _____ Colostomy Bag Vented for Flight (Required): YES N/A Use AF IMT 3899 E Patient Intake/Output Flow Sheet	
6. Genitourinary: Voiding adequate clear yellow urine; no dysuria YES NO Bladder Distended: YES NO Foley: YES/Appearance: _____ N/A Ileostomy YES/Location/Assessment _____ N/A Other Tube(s): YES/Location/Description _____ N/A Use AF IMT 3899 E Patient Movement Intake/Output Flow Sheet	
7. Musculoskeletal: Moves upper and lower extremities symmetrically. Ambulates without assistance. YES NO Crutches: YES NO Cane: YES NO Muscle Weakness: NO Sedated YES/Location/Description _____ Swelling/Tenderness: NO YES/Location/Description _____ Affected Extremity: Warm, color and sensation normal, no tingling, pulse palpable, capillary refill < 2 sec. YES NO Device/Cast: NO YES: Location/Description: _____ Bivalved NO YES Drain(s): NO YES: Location/Description _____	
8. Integumentary: Skin color within patient's norm. Skin warm, dry and intact. Mucous membranes moist YES NO On litter with Mattress Pad: YES NO Back Rest: YES NO Position Change/Range of Motion Exercises Every Two Hours (Required): YES NO Rashes/Ulcerations: NO YES/Location/Description _____ Dressing(s): NO YES/Location/Description _____	
9. Dressing(s): NO YES/Location(s)/Description: _____ Last Dressing Change (MTF/ASF Only) _____ N/A Reinforced YES NO _____	
10. Pain Management: Sedated: YES NO History of Pain: YES/Location/Description: _____ NO Last pain medication/dose/time: _____ N/A Patient's acceptable level of pain: Verbalizes ___ /10 or Wong-Baker FACES Pain Scale ___ /10 Current level of pain: Verbalizes ___ /10 or Wong-Baker FACES Pain Scale ___ /10 <div style="text-align: center;"> <p>Wong-Baker FACES Pain Rating Scale</p>  <p>From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: <i>Wong's Essentials of Pediatric Nursing</i>, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission</p> </div> <p>Brief word instructions: Point to each face using the words to describe the pain intensity. Ask the child/patient to choose face that best describes own pain and record the appropriate number. Use AF IMT 3899 Patient Movement Medication Record.</p>	
11. Self-Medicates: YES NO N/A Knows Use: YES NO Has Adequate Supply: YES NO N/A Use AF IMT 3899 I Patient Movement Medication Record Medication(s): _____	
12. Ears/Sinus/Teeth: No recent history of cold, sinus infection or dental caries; able to valsalva. YES NO UNKNOWN SEDATED	
Print Provider's Name/Signature/Initials/Unit & Location	Print Provider's Name/Signature/Initials/Unit & Location

PATIENT MOVEMENT HEMODYNAMIC/RESPIRATORY FLOWSHEET (CONTINUATION) PART II

DATA PROTECTED BY PRIVACY ACT OF 1974

PERMANENT MEDICAL RECORD

NAME		CITE #/SSN					
DATE/TIME(ZULU)	MODE/RATE	TV	Fi O2	SaO ₂	PEEP/P/PS	ETCO ₂	OTHER ABGs,Cuff Press, Alarms, etc

PATIENT MOVEMENT PHYSICIAN ORDERS FOR BEHAVIOR MANAGEMENT AND RESTRAINTS			
DATA PROTECTED BY PRIVACY ACT OF 1974		PERMANENT MEDICAL RECORD	
FOR EACH SET OF ORDERS RECORD THE DATE AND TIME, SIGN AND CROSS OUT THE UNUSED LINES.			
PATIENT IDENTIFICATION:			
NAME:		CITE #/SSN	ALLERGIES:
ORIGINATING FACILITY:		DESTINATION FACILITY:	LAST MENSTRUAL PERIOD:
DATE/TIME(ZULU)	Physician Patient Movement Orders For Behavior Management and Restraints		NURSE'S SIGNATURE DATE/TIME
	PRN Orders are prohibited . Attach to DD IMT 3899		
	1. Type of Restraints <input type="checkbox"/> Leather <input type="checkbox"/> Soft <input type="checkbox"/> Other		
	<input type="checkbox"/> 4 Point <input type="checkbox"/> Other		
	<input type="checkbox"/> Posey Vest <input type="checkbox"/> Padded Mitts (Therapeutic Devices)		
	2. Position <input type="checkbox"/> Supine <input type="checkbox"/> Other		
	3. Justification: Danger to: <input type="checkbox"/> Self <input type="checkbox"/> Other		
	<input type="checkbox"/> Too agitated/violent to administer sedatives		
	4. Least Restrictive Means to Attempt:		
	<input type="checkbox"/> Medication Type/Route/Frequency: <i>Required</i> for 1A, 1B		
	<input type="checkbox"/> Other		
	5. Time Limited Orders For Restraints (24 Hours Only)		
	<input type="checkbox"/> 4 hours for ages 18 and older		
	<input type="checkbox"/> 2 hours for children and adolescents age 9 to 17		
	<input type="checkbox"/> 1 hour for patients under age 9		
	Date/Time (ZULU) the restraint application will start:		
	6. Level of Observation for Restraints (Behavior Management)		
	Q15 mins circulation checks of all extremities- <i>Required</i>		
	Line-of-Sight- <i>Required</i>		
	<input type="checkbox"/> One-to-One		
	<input type="checkbox"/> Other:		
	7. Therapeutic Devices <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Q 60 mins circulation check of all extremities- <i>Required</i>		
	Line-of-Sight- <i>Required</i>		
	8. Expected Outcomes		
	Flight Nurse may remove restraints when patient is:		
	<input type="checkbox"/> Calm/Cooperative <input type="checkbox"/> Decreased agitation <input type="checkbox"/> Reliably contracts		
	<input type="checkbox"/> Heavily <input type="checkbox"/> Other		
	9. Will receive a patient care team assessment if in restraints for more than 72 hours.		
	Physician Signature/Date/Time:		
	Initiated by Flight Nurse/Date/Time:		
	Physician (name, location) notified by Flight Nurse/Date/Time(Zulu)		

PATIENT MOVEMENT RESTRAINT OBSERVATION FLOWSHEET			
DATA PROTECTED BY PRIVACY ACT OF 1974		PERMANENT MEDICAL RECORD	
PATIENT NAME		MISSION # /DATE	
CITE #/SSN		TIME APPLIED	PREFLIGHT/ IN-FLIGHT
REASON FOR RESTRAINTS	DANGER <input type="checkbox"/>	TO SELF <input type="checkbox"/>	TO OTHERS <input type="checkbox"/>
OTHER <input type="checkbox"/>			
LEAST RESTRICTIVE MEASURES ATTEMPTED			
<input type="checkbox"/>	VERBAL DE-ESCALATION	<input type="checkbox"/>	VERBAL CONTRACT
<input type="checkbox"/>	FAMILY INTERVENTION	<input type="checkbox"/>	EXPLAINED CONSEQUENCES FOR NOT CHANGING BEHAVIOR
<input type="checkbox"/>	OTHER	<input type="checkbox"/>	
<input type="checkbox"/> MEDICATION / DATE / TIME / INITIALS			
RESTRAINT TYPE	LEATHER <input type="checkbox"/>	SOFT <input type="checkbox"/>	4 <input type="checkbox"/>
			3 <input type="checkbox"/>
			2 <input type="checkbox"/>
			1 <input type="checkbox"/>
			<input type="checkbox"/> MITTS <input type="checkbox"/>
			<input type="checkbox"/> POSEY BELT POINTS
POSITION	<input type="checkbox"/>	SUPINE	<input type="checkbox"/>
		PRONE	<input type="checkbox"/>
		LATERAL	right/left
OBSERVATION	<input type="checkbox"/>	LINE - OF - SIGHT (REQUIRED)	<input type="checkbox"/>
		ONE -TO - ONE	<input type="checkbox"/>
		OTHER	<input type="checkbox"/>
FREQUENCY IF LESS THAN 15 MINUTES			
<input type="checkbox"/> RESTRAINTS FOR MORE THAN 24 HOURS INTAKE AND OUTPUT (REQUIRED)			
EVERY 15 MINUTES OBSERVATION LEGEND FOR PATIENTS WITH BEHAVIORAL HEALTH NEEDS IN LEATHER RESTRAINTS OR SOFT RESTRAINTS			
<p>Will be on a litter unless otherwise noted. For Patients with Behavioral Health needs in Leather Restraints or Soft Restraints Document appropriate number(s) on Page 2. Document abnormal findings, variations and actions taken on AF IMT 3899A.</p>			
1	Neurovascular assessment of all extremities in restraints is adequate pulse is present, no cyanosis, capillary refill is less than two seconds, no loss of sensation, numbness or tingling	8	Wrist restraints off
2	Neurovascular check is abnormal (Requires further documentation)	9	Ambulated to lavatory with assistance
3	Restless/combative, and requires additional physical restraint to maintain safety while on litter (Requires further documentation)	10	Up to seat
4	Restless/loud but does not require additional physical restraint to maintain safety while on litter	11	Restraints removed one extremity at a time to check skin integrity, perform skin care, and range of motion (Required every two hours)
5	Quiet but disoriented/confused and unable to follow directions	12	Drank fluids (Required every two hours)
6	Quiet, cooperative, and follows directions	13	Nutrition, skin integrity, positioning, and toileting needs assessed and attended to (Required every two hours)
7	Sleeping/sedated	14	Eating
		15	Take - off/ landing/ turbulence
Print Name, Unit of assignment		Signature/ Initials	

PATIENT MOVEMENT RESTRAINT OBSERVATION FLOWSHEET					
DATA PROTECTED BY PRIVACY ACT OF 1974		Every 15 Minutes Observations Annotate number (s) and Initial		PERMANENT MEDICAL RECORD	
NAME			CITE #/SSN		DATE
DATE (ZULU) / OBSERVATIONS/ INITIALS		DATE (ZULU) / OBSERVATIONS/ INITIALS		DATE(ZULU) / OBSERVATIONS/ INITIALS	
2400		0800		1600	
0015		0815		1615	
0030		0830		1630	
0045		0845		1645	
0100		0900		1700	
0115		0915		1715	
0130		0930		1730	
0145		0945		1745	
0200		1000		1800	
0215		1015		1815	
0230		1030		1830	
0245		1045		1845	
0300		1100		1900	
0315		1115		1915	
0330		1130		1930	
0345		1145		1945	
0400		1200		2000	
0415		1215		2015	
0430		1230		2030	
0445		1245		2045	
0500		1300		2100	
0515		1315		2115	
0530		1330		2130	
0545		1345		2145	
0600		1400		2200	
0615		1415		2215	
0630		1430		2230	
0645		1445		2245	
0700		1500		2300	
0715		1515		2315	
0730		1530		2330	
0745		1545		2345	
PRINT NAME INITIALS UNIT/ LOCATION/ DSN				SIGNATURE	

DATE		NAME					CITE#/SSN					PERMANENT MEDICAL RECORD						
		TIME(ZULU):																
EYES	Spontaneously	4																
	<input type="checkbox"/> OPEN	To speech	3															
	<input type="checkbox"/> CLOSED	To pain	2															
	<input type="checkbox"/> SWOLLEN	None	1															
BEST VERBAL RESPONSE	Oriented T/P/P	5																
	<input type="checkbox"/> TRACH/ET TUBE PRESENT	Confused	4															
		Inaprop speech	3															
		Incomprehensible	2															
BEST MOTOR RESPONSE	Obeys commands	6																
	<input type="checkbox"/> SEDATED	Localizes pain	5															
	TYPE _____	Withdraws to pain	4															
		Decorticate (in)	3															
	Decebrate (out)	2																
	None	1																
Glasgow Coma Score		Total																
Normal = 15; Stuporous = 11; Severely Obtunded = 10; Coma <=7; Brain Death <=3																		
Pupils	RIGHT	Size	2-9 mm															
		Reaction																
	LEFT	Size	2-9 mm															
		Reaction																
Reaction: Brisk = 2; Sluggish = 1; None = 0																		
MOTOR STRENGTH	RIGHT	Grasp																
		Arm																
		Leg																
	RIGHT	Grasp																
		Arm																
		Leg																
Normal = 5; Lifts against resistance = 4; Lifts against gravity = 3; Moves limb across bed = 2; Slight Movement = 1; Flacid = 0 Grasp code: Strong = 4; Weak = 2; absent = 0																		
RESPIRATIONS		RATE:																
BREATHING PATTERNS	Normal																	
	Hypernia																	
	Cheyne-Stokes																	
	Kussmull																	
	Apneustic																	
PUPIL SIZE																		
		<div style="display: flex; justify-content: space-around; align-items: center;"> 2mm 3mm 4mm 5mm 7mm 8mm 10m </div>																

PATIENT MOVEMENT MEDICATION RECORD

DATA PROTECTED BY PRIVACY ACT OF 1974

PERMANENT MEDICAL RECORD

SECTION I. PATIENT IDENTIFICATION

1. NAME (Last, First, Middle Initial)	2. GRADE	3. CITE#/SSN
4. ALLERGIES	5. ORIGATION MTF	6. DESTINATION MTF

SECTION II. MEDICATION ADMINISTRATION RECORD

7. DATE GIVEN:							9c. PROVIDER IDENTIFICATION Initials/Signature, print first and last name, Title, local Unit of assignment
8. DATE ORDERED	9. SCHEDULED MEDICATION/ IVs	10. SCHEDULE ZULU	11. INITIALS	INITIALS	INITIALS	INITIALS	
							S-A-M/Self-Administered Medication as ordered by physician

PATIENT MOVEMENT MEDICATION RECORD												
SINGLE DOSE AND PRN MEDICATIONS												
SECTION I. PATIENT IDENTIFICATION												
1. NAME (Last, First, Middle Initial)						2. Grade		3. ALLERGIES:			4. CITE #SSN	
SECTION II. MEDICATION ADMINISTRATION RECORD										SECTION III. PROVIDER IDENTIFICATION		
5. MEDICATION/DOSE/ROUTE	6. DATE	7. TIME (ZULU)	8. PROBLEM/ COMPLAINT	9. INI TIAL	10. PATIENT RESPONSE	11. TIME EVAL	12. INI TIAL	PROVIDER IDENTIFICATION Initials/Signature, print last name, Title, Local unit of assignment				

PATIENT MOVEMENT RHYTHM/ HEMODYNAMIC STRIP

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PERMANENT MEDICAL RECORD

PATIENT NAME

CITE #/SSN

ANNOTATE ON STRIP: PATIENT NAME, DATE/TIME(Zulu), PHASE OF TRANSPORT:(FLIGHT,GROUND, STAGING, CABIN ALTITUDE)

PLACE STRIP HERE

PATIENT MOVEMENT/ IN-FLIGHT RESUSCITATION FLOW SHEET						
<i>DATA PROTECTED BY PRIVACY ACT OF 1974</i>				PERMANENT MEDICAL RECORD		
1. Patient's Name (Last, First, Middle Initial)		2. Cite #/SSN	3. Sex	4. Age	5. Date	6. Mission Number/ Destination
7. Diagnosis/ History			8. Type of Arrest	9. Time(Local/Z)	10. BCLS Started (Local/Z)	11. ACLS Started (Local/Z)
			12. Time Intubated	13. Size of ETT	14. ETT Placement verified with EtCO ₂ /auscultate	15. C2/AC Notified (Local/Z)
16. Date/Time (Zulu/Local)	17. Diagnosis/Rhythm	18. Vital Signs BP/Pulse/Resp Rate/SaO ₂	19. INTERVENTIONS (Defibrillation Joules/Medications/Procedures)		20. OUTCOME/ ASSESSMENT	
21. Notes(Continue on page 2)						
22. Outcome of Resuscitation			23. ACLS/BCLS Ceased (Local/Z)		24. Pronounced by (Local/Z)	25. Command Control Notified (Local/Z)
26. Names of ACLS Team Members(Printed)			27. Name/Signature of Recorder		28. Name/Signature of Physician	

	-12.	-11.	-10.	-9.	-8.	-7.	-6.	-5.	-4.	-1.	GMT.	+1.	+2.	+3.	+4.	+5.	+5:30	+7.	+8.	+9.	+9:30.	+10.	+12.
	New Zealand	Mid. West	Hawaii	Elmerford	PST. (US)	MST. (US)	CST. (US)	EST. (US)	Puerto Rico	Azores	Ireland, England	Germany, Italy, Spain	Turkey, Greece, Egypt	Bah. rain	Tehran	Korea, CH.	New. Bell.	Thailand	Taiwan, Philip. Inds.	Japan, Korea	Alice Springs, (AUS)	Qatar, Rich. mond. (AUS)	New. Zealand
	0600	0700	0800	0900	1000	1100	1200	1300	1400	1700	1800	1900	2000	2100	2200	2300	2330	0100	0200	0300	0330	0400	0600
	0700	0800	0900	1000	1100	1200	1300	1400	1500	1800	1900	2000	2100	2200	2300	2400	0030	0200	0300	0400	0430	0500	0700
	0800	0900	1000	1100	1200	1300	1400	1500	1600	1900	2000	2100	2200	2300	2400	0100	0130	0300	0400	0500	0530	0600	0800
	0900	1000	1100	1200	1300	1400	1500	1600	1700	2000	2100	2200	2300	2400	0100	0200	0230	0400	0500	0600	0630	0700	0900
	1000	1100	1200	1300	1400	1500	1600	1700	1800	2100	2200	2300	2400	0100	0200	0300	0330	0500	0600	0700	0730	0800	1000
	1100	1200	1300	1400	1500	1600	1700	1800	1900	2200	2300	2400	0100	0200	0300	0400	0430	0600	0700	0800	0830	0900	1100
	1200	1300	1400	1500	1600	1700	1800	1900	2000	2300	2400	0100	0200	0300	0400	0500	0530	0700	0800	0900	0930	1000	1200
	1300	1400	1500	1600	1700	1800	1900	2000	2100	2400	0100	0200	0300	0400	0500	0600	0630	0800	0900	1000	1030	1100	1300
	1400	1500	1600	1700	1800	1900	2000	2100	2200	0100	0200	0300	0400	0500	0600	0700	0730	0900	1000	1100	1130	1200	1400
	1500	1600	1700	1800	1900	2000	2100	2200	2300	0200	0300	0400	0500	0600	0700	0800	0830	1000	1100	1200	1230	1300	1500
	1600	1700	1800	1900	2000	2100	2200	2300	2400	0300	0400	0500	0600	0700	0800	0900	0930	1100	1200	1300	1330	1400	1600
	1700	1800	1900	2000	2100	2200	2300	2400	0100	0400	0500	0600	0700	0800	0900	1000	1030	1200	1300	1400	1430	1500	1700
	1800	1900	2000	2100	2200	2300	2400	0100	0200	0500	0600	0700	0800	0900	1000	1100	1130	1300	1400	1500	1530	1600	1800
	1900	2000	2100	2200	2300	2400	0100	0200	0300	0600	0700	0800	0900	1000	1100	1200	1230	1400	1500	1600	1630	1700	1900
	2000	2100	2200	2300	2400	0100	0200	0300	0400	0700	0800	0900	1000	1100	1200	1300	1330	1500	1600	1700	1730	1800	2000
	2100	2200	2300	2400	0100	0200	0300	0400	0500	0800	0900	1000	1100	1200	1300	1400	1430	1600	1700	1800	1830	1900	2100
	2200	2300	2400	0100	0200	0300	0400	0500	0600	0900	1000	1100	1200	1300	1400	1500	1530	1700	1800	1900	1930	2000	2200
	2300	2400	0100	0200	0300	0400	0500	0600	0700	1000	1100	1200	1300	1400	1500	1600	1630	1800	1900	2000	2030	2100	2300
	2400	0100	0200	0300	0400	0500	0600	0700	0800	1100	1200	1300	1400	1500	1600	1700	1730	1900	2000	2100	2130	2200	2400
	0100	0200	0300	0400	0500	0600	0700	0800	0900	1200	1300	1400	1500	1600	1700	1800	1830	2000	2100	2200	2230	2300	0100
	0200	0300	0400	0500	0600	0700	0800	0900	1000	1300	1400	1500	1600	1700	1800	1900	1930	2100	2200	2300	2330	2400	0200
	0300	0400	0500	0600	0700	0800	0900	1000	1100	1400	1500	1600	1700	1800	1900	2000	2030	2200	2300	2400	0030	0100	0300
	0400	0500	0600	0700	0800	0900	1000	1100	1200	1500	1600	1700	1800	1900	2000	2100	2130	2300	2400	0100	0130	0200	0400
	0500	0600	0700	0800	0900	1000	1100	1200	1300	1600	1700	1800	1900	2000	2100	2200	2230	2400	0100	0200	0230	0300	0500

ZULU Time Chart: The "clock" at Greenwich, England aka Greenwich Mean Time(GMT) is used as an international reference of time in military activities and patient care that cross time zones. The letter designator for this clock is **Z**. **NOTE:** For those areas that practice Daylight Savings Time; add one hour (+1)

