PCC FIELD MEDICAL TRAINING BATTALION – WEST (FMTB-W) PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

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How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

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Questions

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1. The amount of air moving in or out of the lungs with each respiratory cycle is known as what?

A. Tidal Volume

B. Residual Volume

C. Inspiratory Reserve

D. Expiratory Reserve

2. What is a hallmark of an effective patient handoff to higher-level care?

A. Provide a clear, concise summary of status, interventions, and observed responses for continuity of care.

B. A long narrative with extraneous details.

C. No documentation provided.

D. Only the diagnosis without treatment details.

3. MOI stands for what in casualty assessment?

A. Mechanism of Injury

B. Medical Of Illness

C. Moment Of Injury

D. Mode Of Illness

4. In battlefield antibiotic coverage, what guides the selection of antibiotics?

A. Casualty preference.

B. Medical oversight and local protocols guide antibiotic selection.

C. The cheapest antibiotic.

D. Only hospital guidelines.

5. In handoff to the next level of care, which element most supports continuity of care?

A. Share only the most recent vitals, leaving details of interventions to the receiving team.

B. Provide a clear, concise summary of status, interventions, and observed responses for continuity of care.

C. A verbose narrative of every action taken during transport.

D. No handoff is needed if the patient seems stable.

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6. What is the approximate mean arterial pressure (MAP) for a patient with a blood pressure of 100/50?

A. 66.7 mmHg

B. 75 mmHg

C. 90 mmHg

D. 100 mmHg

7. A patient is brought into the Role 2 after a fall from height. Non-labored respirations, numbness in the upper arm, inability to move the legs, severe hypotension; what condition is most likely suspected?

A. Hypovolemic shock

B. Cardiogenic shock

C. Distributive shock

D. Obstructive shock

8. A patient with BP 100/50, HR 110, temperature 101.6 F, and ±20s respiratory rate, who requires frequent dressing changes and reports 8/10 pain, is best described as what status and how often should a head-to-toe be performed?

A. Unstable; reassess Q4H

B. Stable; reassess Q8H

C. Critical; reassess Q1H

D. Stable; reassess Q24H

9. Which statement most accurately describes responsible handoff to medical forces at the next level?

A. Withhold the detailed summary until requested.

B. Provide a clear, concise summary of status, interventions, and observed responses for continuity of care.

C. Include only the personnel involved in transport.

D. Postpone the handoff to avoid interrupting care.

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10. Casualties with critical burn injuries are at risk of airway obstruction due to inhalation injury and burn-induced swelling and will require an immediate definitive airway.

A. True

B. False

C. Not sure

D. Unknown

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Answers

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1. A
2. A
3. A
4. B
5. B
6. A
7. C
8. A
9. B
10. A

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Explanations

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1. The amount of air moving in or out of the lungs with each respiratory cycle is known as what?

A. Tidal Volume

B. Residual Volume

C. Inspiratory Reserve

D. Expiratory Reserve

Tidal volume is the amount of air moving in or out of the lungs with each normal breath. It reflects the volume exchanged during a typical respiratory cycle at rest. In a healthy adult, this is about 500 mL per breath, though it varies with body size and breathing effort. This distinguishes it from residual volume, which is the air left in the lungs after a full exhale and cannot be expelled in a normal breath; inspiratory reserve is the extra air you can inhale beyond a normal inhale; and expiratory reserve is the extra air you can exhale beyond a normal exhale. Because the question describes the air moved with each regular breath, tidal volume is the best fit.

2. What is a hallmark of an effective patient handoff to higher-level care?

A. Provide a clear, concise summary of status, interventions, and observed responses for continuity of care.

B. A long narrative with extraneous details.

C. No documentation provided.

D. Only the diagnosis without treatment details.

A clear, concise summary of status, interventions, and observed responses enables the receiving team to quickly grasp where the patient stands, what has been done, how the patient has responded, and what needs to be monitored next. This concise snapshot supports continuity of care by reducing ambiguity, preventing missed steps, and guiding the next level of care without forcing them to dig through lengthy or disjointed notes. Long narratives with extraneous detail can obscure critical information, making it harder to act safely. No documentation leaves the next team without a reliable record of what was done and what remains to be done. Providing only the diagnosis omits essential treatment details, monitoring plans, and the patient's actual responses, hindering safe continuation of care.

3. MOI stands for what in casualty assessment?

A. Mechanism of Injury

B. Medical Of Illness

C. Moment Of Injury

D. Mode Of Illness

MOI stands for mechanism of injury—the event and forces that caused the patient's injuries. Understanding MOI helps you anticipate the kinds of injuries that may be present, guide your focused assessment, and set treatment priorities and transport decisions. For example, a high energy fall or a high speed vehicle crash suggests potential serious or multiple injuries and may point you toward looking for hidden trauma like spinal injuries, internal bleeding, or rib fractures, even if the initial vitals aren't alarming. This concept also informs immobilization and scene precautions. The other phrases describe illness or timing rather than how the injury occurred, so they don't fit the context of casualty assessment.

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4. In battlefield antibiotic coverage, what guides the selection of antibiotics?

A. Casualty preference.

B. Medical oversight and local protocols guide antibiotic selection.

C. The cheapest antibiotic.

D. Only hospital guidelines.

In battlefield care, antibiotic selection is guided by medical oversight and locally approved protocols. This ensures empiric coverage is matched to the most likely organisms given the injury pattern, environment, and wound contamination, while also accounting for resistance patterns and the realities of field supply. Local protocols provide clear guidance on which agents are available, appropriate dosing and routes, potential interactions, and when to de-escalate therapy as more information becomes available. This coordinated approach promotes consistent, evidence-based treatment across the unit and supports antimicrobial stewardship in a resource-limited setting. Relying on casualty preference or choosing the cheapest option can lead to suboptimal coverage or inappropriate use, and hospital-only guidelines may not reflect field constraints, so medical oversight with local protocols is the appropriate guide.

5. In handoff to the next level of care, which element most supports continuity of care?

A. Share only the most recent vitals, leaving details of interventions to the receiving team.

B. Provide a clear, concise summary of status, interventions, and observed responses for continuity of care.

C. A verbose narrative of every action taken during transport.

D. No handoff is needed if the patient seems stable.

Effective handoffs rely on conveying a concise, complete snapshot of the patient's current status and what has been done. The element that best supports continuity of care is providing a clear, concise summary of the patient's status, the interventions carried out, and how the patient has responded. This gives the receiving team a true picture of where things stand and what to monitor next, enabling seamless continuation of care and avoiding missed steps. Sharing only vitals omits treatments and responses; a verbose narrative is too lengthy and risks burying critical points; skipping a handoff for a seemingly stable patient would still disrupt the transfer of essential information and potential needs.

6. What is the approximate mean arterial pressure (MAP) for a patient with a blood pressure of 100/50?

A. 66.7 mmHg

B. 75 mmHg

C. 90 mmHg

D. 100 mmHg

Mean arterial pressure represents the average pressure driving blood through the vessels throughout the cardiac cycle. A quick, reliable estimate uses diastolic pressure plus about one-third of the pulse pressure because most of the cycle is spent in diastole. Here, systolic is 100 and diastolic is 50, so the pulse pressure is 50. One-third of 50 is 16.7, and adding to the diastolic 50 gives approximately 66.7 mmHg. Using the exact form MAP = (SBP + 2×DBP)/3 yields (100 + 2×50)/3 = 200/3 ≈ 66.7 mmHg. So the approximate MAP is about 66.7 mmHg.

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7. A patient is brought into the Role 2 after a fall from height. Non-labored respirations, numbness in the upper arm, inability to move the legs, severe hypotension; what condition is most likely suspected?

A. Hypovolemic shock

B. Cardiogenic shock

C. Distributive shock

D. Obstructive shock

Traumatic spinal injury can trigger neurogenic shock, a form of distributive shock. When the spinal cord is damaged, the sympathetic nerves below the injury can no longer maintain vascular tone, so blood vessels dilate widely. This pooling of blood in the venous system drops blood pressure even without major blood loss. The history of a fall with numbness in the upper arm and inability to move the legs strongly suggests spinal cord involvement, which fits neurogenic shock. The non-labored respirations support a problem of circulation rather than a primary respiratory or obstructive issue. So the scenario points to distributive shock due to neurogenic injury.

8. A patient with BP 100/50, HR 110, temperature 101.6 F, and ±20s respiratory rate, who requires frequent dressing changes and reports 8/10 pain, is best described as what status and how often should a head-to-toe be performed?

A. Unstable; reassess Q4H

B. Stable; reassess Q8H

C. Critical; reassess Q1H

D. Stable; reassess Q24H

When a patient shows signs of potential instability—tachycardia, fever, and even a borderline low blood pressure—along with significant pain and a wound that requires frequent dressing changes, the priority is close monitoring and frequent reassessment. These indicators point to a body under stress with risk of rapid change, rather than a stable, routine situation. In this scenario, performing a head-to-toe assessment every four hours provides timely information on any deterioration in perfusion, respiratory status, level of consciousness, or wound progression, so interventions can be started promptly. A stable patient would not typically need such frequent checks; they might be reassessed every eight hours or less often, depending on the protocol and clinical picture. A truly critical state would demand even more frequent monitoring—often hourly or continuous—due to immediate life-threats. So the best fit here is unstable with a head-to-toe reassessment every four hours.

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9. Which statement most accurately describes responsible handoff to medical forces at the next level?

A. Withhold the detailed summary until requested.

B. Provide a clear, concise summary of status, interventions, and observed responses for continuity of care.

C. Include only the personnel involved in transport.

D. Postpone the handoff to avoid interrupting care.

The crucial idea is that a patient handoff is a transfer of responsibility that must carry essential information so the next team can continue care safely. A good handoff gives a clear, concise summary of the patient's current status, what interventions were performed, and how the patient has responded. This continuity lets the receiving team pick up without guessing, adjust plans as needed, and watch for warning signs. In practice, this means briefly outlining who is being transferred, the patient's current condition and vitals (including any trends), what treatments or medications were given and when, any procedures performed, and the observed responses (improvement, stability, or deterioration). It should also include the plan for the next steps and any anticipated needs (labs, imaging, ongoing medications), plus potential red flags to monitor. Using a structured approach helps ensure nothing important is missed. Other options fall short because they withhold important details until asked (creating risk of gaps), limit the handoff to just who is transporting (omitting critical clinical information), or postpone the handoff (interrupting care and delaying safe transfer). Providing a timely, complete, and concise handoff supports safe, continuous patient care.

10. Casualties with critical burn injuries are at risk of airway obstruction due to inhalation injury and burn-induced swelling and will require an immediate definitive airway.

A. True

B. False

C. Not sure

D. Unknown

Airway protection is the priority when burn patients may have inhalation injuries. Inhalation injury damages the airway mucosa and smoke exposure induces edema, which can rapidly worsen. Burned areas on the face and neck further predispose to swelling, and fluid resuscitation can amplify this edema over the first hours. Because airway compromise can develop quickly—even if initially subtle—the safest approach is to secure a definitive airway early, usually with endotracheal intubation, before swelling makes access difficult or impossible. In severe cases, be prepared to switch to a surgical airway if needed. So, in this scenario, immediate definitive airway management is the correct course.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

https://pccfmtbw.examzify.com

We wish you the very best on your exam journey. You've got this!

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