

12 FEBRUARY 2003



Medical Service

**MEDICAL READINESS PLANNING AND
TRAINING**

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

NOTICE: This publication is available digitally on the AFDPO WWW site at:
<http://www.e-publishing.af.mil>

OPR: HQ USAF/SGXT (Maj Catherine I. Sykes)

Certified by: HQ USAF/SGX2
(Col Leo M. Hatstrup)

Supersedes AFI 41-106, 5 September 2000

Pages: 75
Distribution: F

This instruction implements Air Force Policy Directive (AFPD) 41-1, *Health Care Programs and Resources* and DoD Instruction (DoDI) 1322.24, *Medical Readiness Training*. It sets procedures for medical readiness planning and training for wartime, humanitarian assistance, homeland security/defense, and disaster response contingencies. This instruction may be supplemented by headquarters (HQ), Air Reserve Component (ARC), and major command (MAJCOM) specific guidance. **NOTE:** ANG is considered a MAJCOM throughout this instruction. References to medical treatment facility (MTF) are for active duty only. Maintain and dispose of records created as a result of processes prescribed by this instruction IAW AFMAN 37-139, *Records Disposition Schedule*, and AFI 33-332, *Air Force Privacy Act Program*.

This instruction requires collecting and maintaining information protected by the Privacy Act of 1974 authorized by Title 10, United States Code, Section 8013. System of Records notice F036 AF PC C, Military Personnel Records System, applies.

SUMMARY OF REVISIONS

This document is substantially revised and must be completely reviewed.

All chapters and attachments have been substantially changed to reflect current requirements for the execution, documentation and reporting of medical readiness planning and training.

Chapter 1— FUNCTIONAL AREA RESPONSIBILITIES	4
1.1. United States Air Force Surgeon General (HQ USAF/SG).	4
1.2. Air Force Inspection Agency (HQ AFIA/SG).	4
1.3. Major Command Surgeons (MAJCOM/SG) and Air National Guard (ANG) Air Surgeon (ANG/SG).	4

- 1.4. Air Education and Training Command Surgeon (HQ AETC/SG), 882nd Training Group (TRG), Air Force Materiel Command Surgeon (HQ AFMC/SG), and United States Air Force School of Aerospace Medicine (USAFSAM). 5
- 1.5. Air Force Personnel Center Medical Directorate (HQ AFPC/DPAM). 6
- 1.6. Medical Unit Commander. 6
- 1.7. Medical Readiness Officer (MRO), Medical Readiness Non-Commissioned Officer (MRNCO), and Medical Readiness Manager (MRM), henceforth called the MR Office unless a paragraph addresses one specifically. 8
- 1.8. Medical Intelligence Officer (MIO/MINCO). 9
- 1.9. Nuclear, Biological, Chemical (NBC) Medical Defense Officer/NCO (MDO) 10
- 1.10. NBC Casualty Management Officer (CMO). 11
- 1.11. Medical Exercise Evaluation Team (EET) Chief. 12

- Chapter 2— MEDICAL READINESS STAFF FUNCTION (MRSF) 13**
 - 2.1. MRSF purpose: 13
 - 2.2. Minimum Standard Agenda Items. 13
 - 2.3. MRSF Minutes. 14
 - 2.4. Required MRSF Membership. 14

- Chapter 3— CONTINENTAL UNITED STATES (CONUS) MEDICAL SUPPORT 15**
 - 3.1. Wartime Mission of the CONUS Air Force Medical System. 15
 - 3.2. Concept of Operations. 15
 - 3.3. Affiliated Organizations for CONUS Medical Support. 16

- Chapter 4— MEDICAL UNIT PLANNING PROCESS 18**
 - 4.1. Planning Responsibilities. 18
 - 4.2. Medical Contingency Response Plan (MCRP) and Emergency Management Plan (EMP). 19
 - 4.3. Maintenance and Distribution of the MCRP and Supporting Checklists. 19

- Chapter 5— INITIAL AND SUSTAINMENT TRAINING 21**
 - 5.1. Purpose and Objective. 21
 - 5.2. AFSC-specific Sustainment Training. 22
 - 5.3. Field Training. 23
 - 5.4. SORTS T-Level Measurement Training Requirements. 25
 - 5.5. Training Documentation. 25

5.6.	Medical Unit Readiness Training (MURT) Equivalency Credit.	26
5.7.	Unit Mission Briefing.	26
5.8.	MCRP/EMP and Unit Disaster Response Training.	27
5.9.	UTC-specific Team Training.	28
5.10.	NBC Defense and NBC Defense Task Qualification Training (TQT).	29
5.11.	Combat Arms Training.	29
5.12.	Air Reserve Component (ARC) Training.	29
Chapter 6— ASSESSMENTS/EVALUATION AND MEDICAL REPORTING		32
6.1.	Assessment Objective.	32
6.2.	Medical Readiness (MR) Validators.	32
6.3.	Inspector General Exercises (IGX), Operational Readiness Inspections (ORI), Operational Readiness Exercises (ORE), and NATO Tactical Evaluations (TacEval).	32
6.4.	Exercise Objective.	32
6.5.	Exercise Requirements.	32
6.6.	Readiness Exercises.	34
6.7.	Integration of Medical/Aeromedical Evacuation Operations into Air Base Operations.	34
6.8.	Deployed Medical Reporting.	35
6.9.	After-Action Reports RCS: HAF-SGX(AR)7901.	35
Attachment 1— GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION		37
Attachment 2— FORMAT FOR THE MEDICAL CONTINGENCY RESPONSE PLAN (MCRP)		47
Attachment 3— MEDICAL UNIT READINESS TRAINING (MURT) MATRIX		55
Attachment 4— MURT EQUIVALENCY MATRIX1		60
Attachment 5— MINIMUM WEAPONS REQUIREMENTS FOR DEPLOYING AFMF UTCS		63
Attachment 6— SAMPLE FIELD TRAINING SCHEDULE FOR MEDICAL UNITS		68
Attachment 7— SUMMARY OF READINESS EXERCISES		69
Attachment 8— CLINICAL AFSC LISTING		71

Chapter 1

FUNCTIONAL AREA RESPONSIBILITIES

1.1. United States Air Force Surgeon General (HQ USAF/SG). This individual will:

- 1.1.1. Establish medical policy.
- 1.1.2. Obtain and allocate resources.
- 1.1.3. Evaluate Air Force Medical Service (AFMS) support capabilities.
- 1.1.4. Ensure establishment of the Readiness Training Oversight Committee (RTOC) by charter to review AFMS medical readiness training programs to ensure such programs are adequately designed to fulfill defined medical readiness training requirements.
 - 1.1.4.1. This committee will meet at least semi-annually. The committee will update the medical readiness training community on current training initiatives and function as a forum to discuss and make recommendations for resolution of medical readiness training issues.
 - 1.1.4.2. The membership of the RTOC is established by charter. The voting membership will consist of, at a minimum, one representative for each MAJCOM/SG (ACC, AETC, USAFA, AFMC, AFRC, AFSOC, AFSPC, AMC, ANG, PACAF, USAFE) and the RTOC Chair (HQ USAF/SGXT). Other non-voting members can be added at the discretion of the committee.

1.2. Air Force Inspection Agency (HQ AFIA/SG). This agency will:

- 1.2.1. Assess medical unit compliance to respond to wartime, humanitarian assistance and disaster response contingencies in accordance with (IAW) unit Status of Resources and Training (SORTS) Designed Operational Capability (DOC) Statements (AF Form 723, **Sorts DOC Statement**) and local plans.
- 1.2.2. Evaluate medical unit implementation of HQ USAF/SG and MAJCOM medical readiness policies and procedures.
- 1.2.3. Provide oversight and guidance to MAJCOMs that inspect using AFIA standards.

1.3. Major Command Surgeons (MAJCOM/SG) and Air National Guard (ANG) Air Surgeon (ANG/SG). These individuals will:

- 1.3.1. Provide policy to all subordinate commands and medical unit commanders on all aspects of medical readiness.
- 1.3.2. Ensure that medical units are properly organized, trained, and equipped to carry out all aspects of their wartime, humanitarian assistance, homeland security/defense, and disaster response missions. (For ARC units, this is additionally a Gaining MAJCOM (GMAJCOM) responsibility IAW AFI 10-301, *Responsibilities of Air Reserve Component (ARC) Forces*.)
- 1.3.3. Evaluate and monitor adequacy of medical plans, readiness and the training status of units. (For ARC units, this is additionally a GMAJCOM responsibility IAW AFI 10-301.)
- 1.3.4. Ensure that medical units comply with this instruction, USAF War and Mobilization Plan, Vol 1 policy, Operation Plan (OPLAN) requirements and other applicable directives.

- 1.3.5. Ensure force health protection guidelines for each area of responsibility (AOR) and for operations and exercises are available to subordinate units.
- 1.3.6. Assist unit level medical readiness officers (MRO), medical readiness noncommissioned officers (MRNCO) and civilian medical readiness managers (MRM) in resolving problems with their unit's readiness program.
- 1.3.7. Publish and review SORTS DOC Statements (AF Form 723) IAW AFI 10-201, *Status of Resources and Training System*.
- 1.3.8. Review the Medical Contingency Response Plan (MCRP) prior to publication, as specified in paragraph 4.2.5. ANG Units will prepare an Emergency Management Plan, IAW HQ ANG/SG guidance. (Not applicable to AFRC.)
- 1.3.9. Ensure each assigned medical unit's Extended Unit Manning Document (EUMD) is postured to balance readiness, business-case and clinical currency requirements. Intra-command fragmentation of unit type code specialties will conform to current United States Air Force and Air Force Medical Service (AFMS) policies.
- 1.3.10. Grant waivers, as needed, of up to one Air Expeditionary Forces (AEF) training cycle for all medical training requirements identified in this instruction, with the intent that the unit will aggressively seek to meet requirements through alternate training opportunities. Units must maintain documentation of all waivers granted by the MAJCOM. MAJCOMs will forward a copy of all waivers to HQ USAF/SGXT for tracking.
- 1.3.11. Program and plan for Joint Chiefs of Staff (JCS), service and MAJCOM exercises and training, other than formal training (with the exception of formal Air Force Specialty Code (AFSC) and other formal course training).
- 1.3.12. Input, review, and monitor Air Force World-Wide Unit Type Code (UTC) Availability System (AFWUS) to ensure the UTCs are accurately assigned.
- 1.3.13. Compile, validate, and advocate for medical nuclear, biological and chemical (NBC) defense resource requirements through the budget and Program Objective Memorandum (POM) process, assess command NBC medical capability, maintain a master command NBC detection inventory, and serve as the medical HAZMAT point of contact.
- 1.3.14. Appoint the Command Bioenvironmental Engineers as the MAJCOM NBC Medical Defense Officer (MDO). Responsibilities include planning and coordinating the medical NBC program in conjunction with MAJCOM/SGX and Civil Engineering Readiness, and participation in MAJCOM Force Protection Councils.
- 1.3.15. Appoint the Command Public Health Officer (PHO) as the functional expert for Biological Warfare (BW) Disease Surveillance and Epidemiological response.
- 1.3.16. Appoint a trained provider as the MAJCOM NBC Casualty Management Officer (CMO). This officer is responsible for providing technical assistance to the unit NBC CMOs and coordinating training requirements with the MAJCOM NBC MDO for inclusion in program submissions.

1.4. Air Education and Training Command Surgeon (HQ AETC/SG), 882nd Training Group (TRG), Air Force Materiel Command Surgeon (HQ AFMC/SG), and United States Air Force School of Aerospace Medicine (USAFSAM). These individuals/organizations will:

- 1.4.1. Obtain approval of curriculum content for any formal medical readiness training course from the USAF/SG through the RTOC prior to implementation.
- 1.4.2. Develop and make available current core medical readiness training lesson plans to all medical units.
- 1.4.3. Provide all SORTS reportable Medical Unit Readiness Training (MURT) during formal medical readiness courses.

1.5. Air Force Personnel Center Medical Directorate (HQ AFPC/DPAM). The directorate personnel will:

- 1.5.1. Maintain published guidance outlining the process for submitting applications for Category I continuing medical education (CME) and continuing education credit for medical readiness training courses.
- 1.5.2. Review and approve applications for Category I CME and continuing education credit when content meets the appropriate criteria.

1.6. Medical Unit Commander. The commander will:

- 1.6.1. Establish, evaluate and maintain the capability to provide and/or arrange for emergency care and transport of casualties resulting from wartime, humanitarian assistance, homeland security/defense, and disaster response contingencies that are consistent with the unit's mission.
 - 1.6.1.1. Ensure completion of all exercise and training requirements in this instruction.
 - 1.6.1.2. Appoint, in writing, an AFSC-specific Functional Training Manager for each AFSC assigned to the unit. These individuals are responsible for AFSC-specific training as described in section 5.2.
 - 1.6.1.3. Ensure personnel are assigned to UTCs identified to support OPLAN requirements, AEF taskings, and homeland security/defense maintain training currency.
- 1.6.2. Develop and publish a MCRP/EMP IAW **Chapter 4** of this instruction, and provide medical input to base-level mission planning documents.
 - 1.6.2.1. AFRC medical and Aeromedical Evacuation (AE) units (active duty and AFRC) need not prepare the MCRP, but should be listed as manpower resources in the MCRP of co-located active duty medical units. Unit capability (i.e. number of personnel by AFSC, UTCs available, etc.) should be identified to support the co-located active duty unit MCRP. Non co-located AFRC units reflect their disaster response capability in applicable base-level plans. All AFRC units will document their wartime missions in the parent wing mobilization plan.
- 1.6.3. Ensure all medical personnel, regardless of component or status (i.e. ARC, Squadron Medical Element (SME), Active Component (AC), Independent Duty Medical Technicians (IDMTs)) receive the same opportunity for unit-level training.
- 1.6.4. Establish and chair an executive oversight committee IAW paragraph 2.1.: Medical Readiness Staff Function (MRSF) for AC, and Executive Management Committee (EMC) for ARC.
- 1.6.5. Appoint, in writing, a MRO, MRNCO, and/or MRM, as applicable. The appointment letter should include assignment as the certification official for medical readiness training (excluding indi-

vidual AFSC-specific training). Ensure appointees apply through applicable channels (i.e. Formal Training/MAJCOM) for course J3OZR4000-005, Medical Readiness Planners Course immediately upon appointment. Training status will be documented in the MRSF/EMC minutes until training is complete. Medical Service Corps (MSC) officers who are appointed to this position and received medical readiness training during Comprehensive Functional Area Training at the Health Services Administration Course are considered trained. To maintain program continuity, personnel will remain in their position for a minimum of 24 months. Where possible, every effort will be made to avoid placing additional duties on the MRO/MRNCO/MRM unrelated to readiness. (Not applicable to the ANG.)

1.6.6. Appoint, in writing, a Medical Intelligence Officer/NCO (MIO) IAW paragraph 1.9. Training status will be documented in the MRSF/EMC minutes until training is complete. (Not applicable to AE units.)

1.6.7. Appoint, in writing, a NBC Medical Defense Officer/NCO (MDO) IAW paragraph 1.10.

1.6.8. Appoint, in writing, a provider who possesses the appropriate level of experience as the NBC Casualty Management Officer (CMO) IAW paragraph 1.11.

1.6.9. Establish an in-house, decontamination capability IAW local requirements and AFI 10-2501, *Full Spectrum Threat Response (FSTR) Planning and Operations*. Assign unit personnel as necessary, to train and exercise patient/casualty decontamination procedures IAW unit plans and policies. Units must be able to sustain an initial response based on the existing baseline capabilities until additional assistance can be mobilized.

1.6.9.1. Units will establish a patient decontamination capability at the unit if they plan to receive and treat casualties from a NBC or hazardous material (HAZMAT) event. A graduate of the Contingency/Counter-Terrorism Casualty Decontamination Course, course #B3AZYDECON-000, will lead and train this team. The team will be staffed to ensure the capability is readily available during all hours of unit operations. The MCRP Annex N will address operation of this team.

1.6.10. Ensure a process is in place to verify that pre-deployment medical screening and immunization requirements for all deploying forces (medical and non-medical) are identified and completed. This includes, but not be limited to, Preventive Health Assessment (PHA), DNA sampling, HIV testing, tuberculin skin testing, and medical/dental and mental health screening.

1.6.10.1. The PHA, Individual Medical Readiness (PIMR) Program is the current software program to manage these requirements, with the exception of mental health screening.

1.6.10.2. The Public Health office has the primary responsibility for pre and post deployment screening.

1.6.11. Appoint, in writing, a medical Exercise Evaluation Team (EET) Chief and representatives to the Wing EET IAW local requirements. The MRO, MRNCO, or MRM will not be the sole exercise evaluation team members. The medical readiness staff will identify exercise goals and objectives to the EET chief who develops the scenario, executes the exercise, and evaluates results in order to fully test medical readiness and fulfill exercise requirements, as outlined in this instruction. The team chief should have full knowledge of exercise requirements for medical personnel.

1.6.12. Review and initial the SORTS DOC statement (AF Form 723) annually and as changes occur, IAW AFI 10-201, *Status of Resources and Training System*.

- 1.6.13. Appoint, in writing, a unit SORTS monitor and alternate IAW AFI 10-201.
- 1.6.14. Review, certify, and approve unit SORTS reports IAW AFI 10-201.
- 1.6.15. Appoint, in writing, the installation Self-Aid and Buddy Care (SABC) Monitor IAW AFI 36-2238, *Self-Aid and Buddy Care Training*. (Not applicable to AE units.)
- 1.6.16. Review Medical Readiness Decision Support System (MRDSS) data monthly. AFRC will review Web Based Integrated Training System (WBITS) training data and MRDSS Status Report monthly.
- 1.6.17. Provide commander's UTC readiness assessment comments monthly for certification by the wing commander and reporting in the AEF UTC Reporting Tool (ART). Information submitted should follow wing guidance and AFI 10-244, *Reporting Status of Aerospace Expeditionary Forces*.
- 1.6.18. Chair the MRSF/EMC.
 - 1.6.18.1. Approve the agenda and meeting minutes.
 - 1.6.18.2. Ensure required attendance and determine additional participants.
 - 1.6.18.3. Identify training and exercise funding requirements/needs to wing commander and MAJCOM/SG.
- 1.6.19. Approve medical readiness support agreements with agencies on and/or off-base, military and/or civilian, as appropriate, in order to fully execute the MCRP/EMP.
 - 1.6.19.1. Direct the MRO/MRNCO/MRM to provide, develop, and coordinate the agreements with the appropriate federal, civilian and base agencies.
- 1.6.20. Establish, organize, and maintain the Medical Control Center (MCC) IAW MCRP/EMP guidance and AFI 10-2501, *Full Spectrum Threat Response (FSTR) Planning And Operations*.
- 1.6.21. Establish a process for conducting daily disease surveillance to provide early detection of unusual disease trends that may suggest a suspected or confirmed covert biological attack. Ongoing medical surveillance may provide the first indication of attack. Liaison with other MTFs in local area that treat beneficiaries to obtain disease incidence data. (Not applicable to ARC.)
- 1.6.22. Receive a medical intelligence briefing from the MIO at least quarterly. Document completion in the MRSF/EMC minutes. (Not applicable to ARC.)

1.7. Medical Readiness Officer (MRO), Medical Readiness Non-Commissioned Officer (MRNCO), and Medical Readiness Manager (MRM), henceforth called the MR Office unless a paragraph addresses one specifically. These individuals will:

- 1.7.1. Serve in the position for a minimum of 24 months. (Not applicable to the ANG.)
- 1.7.2. Attend J3OZR4000-005, Medical Readiness Planners Course (MRPC) within 12 months of assignment to MRO/MRNCO/MRM duties. Track attendance as directed in paragraph 1.6.5. (Not applicable to the ANG.)
- 1.7.3. Manage the preparation, coordination and publication of the MCRP/EMP and medical input to other applicable base-level plans. (MCRP not applicable to AFRC.)
- 1.7.4. Coordinate with medical logistics staff to ascertain the deployability status of War Reserve Materiel (WRM) assemblages.

1.7.5. Provide the medical information needed for base-level mission planning documents. With the assistance of the MIO, ensure the medical input includes the current and potential medical intelligence risks or threats.

1.7.6. Ensure that training programs are developed, conducted and properly documented.

1.7.7. Ensure MRDSS data (including every available data element) is updated each month, or as significant changes occur (defined as 25 percent or greater), in MRDSS or the current reporting system. Present this information monthly to the unit commander. ANG and AFRC members will provide their MRDSS information to the EMC at least quarterly. AFRC will interface with MRDSS through WBITS, or its replacement reporting system. AFRC medical units will update the reporting system monthly.

1.7.8. Integrate the medical readiness portion of the AFIA/SG Health Services Inspection (HSI) Guide into the unit self-inspection program. Brief the MRSF/EMC as appropriate. AE will use applicable portions of the HSI guide.

1.7.9. Develop and coordinate medical readiness Memorandums of Agreement (MOA) or Memorandums of Understanding (MOU) with the appropriate federal, civilian and base agencies to include collocated units IAW paragraph 4.1.3.3. of this instruction. Do not duplicate support agreements with base agencies listed in the Wing/Base Inter-Service Support Agreement (ISSA). Instead, denote the support provided under the ISSA in the Basic Plan. Should support be required from a base agency not be listed in the ISSA, MOAs/MOUs are required. When drafting these documents, ensure they are compliant with applicable Department of Defense, Federal, State, and local directives. When coordinating the MCRP/EMP with supporting entities, use AF Form 1768, **Staff Summary Sheet (SSS)**, to clearly outline what support is required. Signature of agencies on the SSS (AF Form 1768) denotes understanding and commitment. Copies of all coordination SSS (AF Form 1768) and MOAs/MOUs listed in the MCRP/EMP will be kept in the medical readiness office. Ensure the Executive Staff, MRSF/EMC, Wing/XP, Wing/JAG, and other agencies as appropriate, conduct initial and annual review of all agreements. **NOTE:** ARC will accomplish this through the Base Support Plan (BSP).

1.7.10. Develop a master MURT and exercise plan IAW the frequency of training and exercises denoted in **Attachment 3** and **Attachment 7**, and based on the AEF cycles. Ensure plan outlines training subject requirements, such as to whom it applies, responsibilities for conducting it, and how make-up training will be accomplished. Additionally, provide a brief definition of exercise requirements listed in **Attachment 7**. Prior to the beginning of each calendar year, submit MURT/exercise plan to MRSF/EMC for approval. Forward approved MURT/exercise plan to the MAJCOM/SG for information only. AFRC units submit to appropriate NAF RSG/SG. ANG units will only submit upon request of ANG/SGX or GMAJCOM/SGX.

1.7.11. Prepare and submit SORTS report IAW AFI 10-201.

1.7.12. Schedule MRSF meetings. (Not applicable to ARC.) ARC MRO/NCO will ensure required material is provided to the EMC at least quarterly.

1.8. Medical Intelligence Officer (MIO/MINCO). This individual will (not applicable to AE):

1.8.1. Hold the AFSC of a Public Health Officer (PHO) (43HX)/Public Health NCO (PHNCO) (4E0XX). For units without a PHO/PHNCO, contact the Command PHO for guidance. **NOTE:** ARC units tasked with the Aerospace Medicine Function (UTC FFDAE for AFRC and UTC FFGK1 for ANG) will be responsible for this duty.

1.8.2. Immediately upon assignment to this position, apply for the Contingency Operations Course, course #B3OZYCONOP-000, if haven't previously attended. The MIO/MINCO will also apply to their MAJCOM/SGX for instructions on registering to attend the Introduction to Medical Intelligence Course located at Armed Forces Medical Intelligence Center (AFMIC), Ft. Detrick, MD. The Public Health Apprentice, Officer, or AFMIC course may be attended in lieu of the Contingency Operations Course for ARC personnel assigned as MIO/MINCO.

1.8.3. During the pre-deployment phase, work with line intelligence, collocated MTF, MIO, or MAJCOM/SGPM personnel, to obtain a medical intelligence assessment to include disease risks, environmental health hazards, host nation medical capabilities/facilities, cultural-specific health issues unique to the host nation population, host nation chemical and biological warfare medical defense capabilities. Use all medical intelligence sources available to prepare and present the medical threat assessments at deployment locations so that medical risks are included in pre-deployment medical threat briefs to all deploying forces.

1.8.4. Provide, or arrange for, the provision of medical intelligence briefings to deploying personnel.

1.8.5. During the post-deployment phase, work with medical personnel to complete the After Action Report IAW paragraph 6.9.

1.8.6. Provide the medical unit commander and his/her executive staff a quarterly medical intelligence briefing at the MRSF. This briefing will include assessment of local threats, threats to potential deployment sites, current information on vaccines and antidotes, possible disease surveillance trends, capabilities to identify chemical or biological agent threats, and limitations to protective measures, if any. Utilize appropriate procedures for disseminating classified information.

1.9. Nuclear, Biological, Chemical (NBC) Medical Defense Officer/NCO (MDO) . This individual will:

1.9.1. Be a Bioenvironmental Engineer (BEE) (43E3X) or a Bioenvironmental Engineering Technician (4B0X1). For units without a BEE/NCO, contact the Command BEE for guidance. The NBC MDO will be the unit functional for NBC issues. The PHO will be the unit consultant on Disease Surveillance and Epidemiological response.

1.9.2. Be a functional resource to the medical readiness office during the planning and execution of unit NBC training. In concert with the medical readiness office, orchestrate unit medical NBC programming and budgeting. Assist the medical readiness office with tracking and documenting NBC unit training.

1.9.3. Immediately upon assignment to this position, apply for the Bioenvironmental Engineering Nuclear, Biological and Chemical Operations Course, course #B3AZY4B0X1 017, if not previously attended and appropriate for individual's AFSC.

1.9.4. Assist NBC CMO to identify and make known to clinicians/providers, trainers, and/or other medical operational personnel (including NCOs), applicable formal training opportunities for which they can apply.

1.9.5. Provide the NBC Casualty Management Officer (CMO) threat assessment information necessary for planning the clinical response to an NBC or WMD event. This assessment must include consideration for intentional and unintentional releases from local industrial facilities (toxic industrial

chemicals/materials). The PHO will assist the NBC CMO in the development of clinical response to BW events.

1.9.6. Evaluate NBC aspects of unit-level medical plans, to include the MCRP/EMP and applicable MOUs/MOAs with local health care facilities.

1.9.7. Work closely with base Civil Engineering (CE) Readiness Flight personnel to verify that base NBC training and medical NBC training provide consistent instruction.

1.9.8. Assist CE Readiness Flight in the development of the installation NBC detection plan. The NBC MDO will serve as functional expert to the Wing Survival Recovery Center (SRC) and to the Wing NBC Cell and NBC Reconnaissance Teams. Assist CE Readiness Flight in the development of the installation NBC detection plan, and will perform NBC surveillance in conjunction with CE readiness. (Not applicable to AE units.)

1.9.9. Provide subject-matter expertise to installation commanders on NBC effects, health-based risk assessment and operations in NBC environments, in coordination with the PHO.

1.9.10. Inspect all medical unit NBC detection equipment for proper maintenance. Train medical personnel designated to operate the equipment prior to use.

1.9.11. Coordinate with the base CE Squadron, base fire department, assigned healthcare clinician/provider and BEE concerning peacetime HAZMAT response. The NBC MDO is the primary medical focal point on HAZMAT issues. Determine procedures for receiving patients after gross field decontamination by base HAZMAT (fire department) personnel, and personnel who may bypass scene control and arrive directly at the medical unit. Assist the medical readiness office and medical unit leadership in incorporating procedures for managing contaminated patients in unit plans and policies.

1.9.12. Act as the medical unit POC for base and unit Force Protection Working Groups and Vulnerability Assessment Teams (PHO is additional POC). See AFI 10-245, *Air Force Antiterrorism (AT) Standards*.

1.9.13. Ensure medical first responders receive the appropriate level of Hazardous Waste Operations and Emergency Response (HAZWOPER) training IAW the requirements established in AFI 10-2501, *Full Spectrum Threat Response (FSTR) Planning and Operations*.

1.9.14. Conduct an assessment of local industrial facilities (on and off base) that may be of consequence to base operations if toxic industrial chemical/toxic industrial material (TIC/TIM) materials released. Inform the MRSF and Wing Force Protection Working Group of the results of this analysis.

1.10. NBC Casualty Management Officer (CMO). This clinician/provider will:

1.10.1. Assist the NBC MDO with the assessment of the clinical capability and the impact of a NBC threat, recommend appropriate actions to protect forces, and is the medical POC for the treatment portions of the MCRP Annex N and the EMP.

1.10.2. Coordinate with the PHO on BW related planning, training, epidemiological response and to obtain medical surveillance data.

1.10.3. Assist unit training manager in developing and implementing a clinician/provider focused NBC treatment training program. Seek formal training course quotas from the MAJCOM readiness training POC. Identify and make known to physician trainers, physicians, and/or other medical operational personnel (including NCOs), applicable formal training opportunities for which they can apply.

This includes courses on prevention and/or treatment of casualties of Weapons of Mass Destruction (WMD) to include nuclear, biological, and chemical agents. Formal courses are available through: United States Army Medical Research Institute of Infectious Diseases (USAMRIID), Ft. Detrick, MD, United States Army Medical Research Institute of Chemical Defense (USAMRICD), Aberdeen Proving Grounds, MD, and Armed Forces Radiobiology Research Institute (AFRRI), Bethesda, MD. Formal courses are available in residence, locally, where trainers are available, or through distributed learning programs. Ensure appropriate training materials are available to local AFSC-specific training programs.

1.10.4. Attend NBC training, i.e., Medical Management of Biological, Chemical and Radiation Warfare courses, in-residence when central funding available, or by satellite broadcast, or through distance learning.

1.10.5. Ensure all clinicians/providers receive medical NBC training IAW [Attachment 3](#). Coordinate training and training plan with the NBC MDO and MR Office as outlined in paragraph [1.10.2](#).

1.11. Medical Exercise Evaluation Team (EET) Chief. This individual will:

1.11.1. Select EET members to assist in the evaluation of medical play during unit and wing exercises.

1.11.2. Attend EET training as required by the wing XP office.

1.11.3. Coordinate exercise goals and objectives with the MRO and the MRSF.

1.11.4. Develop exercise scenarios that fully test medical readiness capability..

1.11.5. Direct exercises according to exercise schedule of events.

1.11.6. Evaluate exercises using established criteria.

1.11.7. Provide unit and wing commander detailed report of exercise outcome/evaluation within 7 days of end of the exercise. This evaluation will be included in the exercise After Action Report (AAR).

Chapter 2

MEDICAL READINESS STAFF FUNCTION (MRSF)

2.1. MRSF purpose: To provide executive oversight for all medical readiness issues to include the organizing, training and equipping of all assigned personnel, and to ensure the unit is able to meet their assigned wartime, humanitarian assistance, homeland security/defense, and disaster response missions. Oversight includes the processes, as identified in **Chapter 1** of this instruction, involved in support of the installation readiness missions. ARC MRSF responsibilities are fulfilled through the EMC with medical readiness being on the agenda at least quarterly. Paragraph **2.2.** provides a list of items that should be reviewed at the MRSF/EMC.

2.1.1. MRSF meetings will be conducted, at a minimum, quarterly. AFRC will report medical readiness issues quarterly through the EMC.

2.1.2. The ANG EMC function will occur IAW HQ ANG supplemental guidance.

2.2. Minimum Standard Agenda Items.

2.2.1. Status report of open items from previous minutes.

2.2.2. SORTS/MRDSS, update as applicable. Classified material not required, but if given must be to the attendees classification levels. Include UTC manning, training, and WRM status, as applicable.

2.2.3. Training and exercise schedule update.

2.2.4. Deployment After Action Reports, to include discrepancies and status of follow-up until closure, as applicable.

2.2.5. Results of inspections (i.e., self-inspections, Operational Readiness Inspections (ORI)/Operational Readiness Exercises (ORE), HSIs, Staff Assistance Visits (SAV), Aircrew Standardization Evaluation Visits (ASEV), etc.).

2.2.6. Post-exercise or incident summaries review and follow-up activities. Exercise findings/deficiencies will be tracked as open items until corrective action(s) have been implemented and tested.

2.2.7. Status of Medical Unit Readiness Training. At a minimum, this training must include core, deployment, field, and just-in-time (JIT) readiness training requirements as applicable to unit mission. Other items may include Combat Arms Training and SABC statistics, MRO/NCO and MIO/NCO training, and other locally generated requirements. See **Attachment 3**.

2.2.7.1. AFSC-specific training status. Include a review of elements that exceed unit-training capabilities and therefore cannot be satisfied at the unit. Validation by the MRSF must be documented.

2.2.8. Review required plans and MOUs/MOAs.

2.2.9. Team training status (i.e., Disaster teams, UTC-specific team training, etc.).

2.2.10. Status of deployed personnel.

2.2.11. Quarterly MIO briefing (not applicable to AE).

2.2.12. Additional MAJCOM requirements, as directed.

2.3. MRSF Minutes.

2.3.1. Meeting minutes will provide a clear, concise summary of discussions and events. This document will include enough detail and explanation of historical events to fully describe all issues being discussed. Use MRSF minutes to document unit MCRP/EMP review and approval, as well as MURT training and exercise schedule coordination and approval. Attachments must include copies of post-exercise or incident summaries, AAR and other documents as directed by MAJCOM.

2.3.2. Copy of MRSF minutes will be sent to MAJCOM/SGX for review IAW MAJCOM guidance. EMC minutes are not required to be sent to AFRC/ANG.

2.4. Required MRSF Membership.

2.4.1. Unit Commander (chairperson)

2.4.2. MRO/MRNCO/MRM (Action Office)

2.4.3. Executive management team

2.4.4. NBC MDO

2.4.5. NBC CMO

2.4.6. Medical Logistics Officer

2.4.7. MIO

2.4.8. Medical EET Chief

2.4.9. Reserve Affairs Liaison, when appointed

2.4.10. Other individuals as directed by the chairperson, e.g., RMO, MCRP/EMP team chiefs, Unit Deployment Manager (UDM), UTC team chiefs, AFSC-specific functional managers, etc.

Chapter 3

CONTINENTAL UNITED STATES (CONUS) MEDICAL SUPPORT

3.1. Wartime Mission of the CONUS Air Force Medical System. All CONUS-based medical units will continue to arrange for medical services for all eligible beneficiaries, unless their MAJCOM informs them otherwise. When directed by official decree of the President of the United States or the Secretary of Defense, Joint Forces Command (JFCOM) will integrate the Services' as well as other governmental, and non-governmental agencies' CONUS medical resources to assist in the mobilization and deployment of forces to support Outside CONUS (OCONUS) Combatant Commanders and to provide evacuation and treatment for patients returning to CONUS from major theater wars. Within 72 hours of receipt of an Execute Order (EXORD), JFCOM Service Component Commanders (Air Combat Command) will coordinate to ensure that all DoD MTFs discharge or transfer current inpatients as appropriate; obtain material and staffing necessary; and take other actions as required to provide the operating bed capabilities. Services and DoD Lead Agents are required to continue to provide peacetime levels of healthcare to the beneficiary population. Typically, if the local MTF cannot provide adequate medical care to beneficiaries with remaining staff, the MTF will arrange for care through the civilian sector, including Department of Veterans Affairs, under existing agreements and as designated through the TRICARE Regional Directors for their respective regions, and through the expansion of the hours worked by the remaining staff (usually 60 hour work weeks). While voluntary ARC support may be utilized, involuntary ARC mobilization should be used only as a last resort, paying close attention to current HQ USAF/XO and SG requirements and policies. IAW AFI 10-802, *Military Support to Civil Authorities*, ANG forces acting under State orders (State Militia or USC Title 32 status/not in Federal Service), have primary responsibility for providing military assistance to State and local government agencies in civil emergencies.

3.2. Concept of Operations.

3.2.1. Joint Forces Command's Integrated CONUS Medical Operations Plan (ICMOP) provides direction and time phasing of required augmentation forces to support CONUS-wide health services. Medical planners at all levels will use the ICMOP as a source document when developing supporting plans.

3.2.2. As identified in the ICMOP and programmed in the Medical Resource Letter (MRL), ARC unit personnel will provide expansion/reconstitution for medical facilities designated in the MRL for reconstitution. Other facilities not identified in the MRL for reconstitution will have to depend on the ARC personnel on the FFGK1 and FFDAE UTCs as a manpower pool.

3.2.3. AE Units will provide CONUS casualty redistribution in support of the ICMOP as directed by the United States Transportation Command (USTRANSCOM) and Tanker Airlift Control Center (TACC).

3.2.4. Individual Mobilization Augmentees (IMA) and Pre-trained Individual Manpower (PIM), consisting of the Individual Ready Reserve, Retired Reserve, Standby Reserve, and Retired Regular, will be utilized as needed.

3.2.4.1. Air Force wartime requirements are the basis of medical IMA Ready Reserve authorizations. Assignments in the IMA program are authorized as positions managed by HQ ARPC/SG, Denver CO with training attachments located at various active duty Air Force units.

3.2.4.2. In peacetime, medical IMAs complete medical readiness and peacetime mission support training at their attached/assigned active duty unit.

3.2.4.3. During wartime, humanitarian assistance, and disaster response contingency missions, CONUS MTFs employ medical IMAs as replacements for MTF personnel who have deployed. IMAs will mobilize as directed by AFRC/CC. Although they can deploy, medical IMAs normally are not assigned to a specific deployment position.

3.2.5. Each MTF or unit designated to receive personnel reconstitution will include information in the MCRP/EMP that outlines reception, training, and support requirements for these personnel. The medical unit will develop the MCRP/EMP as directed in [Chapter 4](#). The ARC will incorporate the contingency plan into the Unit Mission Briefing.

3.3. Affiliated Organizations for CONUS Medical Support.

3.3.1. Department of Veterans Affairs (VA). The VA health care system is the primary backup to the DoD in time of war or national emergency. The VA and DoD must jointly plan and establish procedures to implement contingency operations. Air Force MTFs identify wartime medical support requirements and areas where they may need VA support. Specifically, they identify any requirements that may be beyond the MTF capability and then inform the nearest VA medical facility. The designated VA facility and MTF jointly plan for using available VA resources during wartime or emergency situations. Local plans and agreements and MOU/MOA document VA support. MAJCOMs should review plans annually, including MOU/MOAs.

3.3.2. The National Disaster Medical System (NDMS). The NDMS is an integrated Federal, State, local and private sector medical response system for medical support during wartime or major United States domestic disasters. NDMS provides DoD with medical care resources from the civilian sector to backup the VA and DoD medical contingency arrangement.

3.3.2.1. Specific Air Force MTFs are designated as NDMS Federal Coordinating Centers (FCC). They will:

3.3.2.1.1. Develop, maintain, and exercise an NDMS operations and patient reception plan for the assigned area in conjunction with other Federal, State and local agencies, offices of emergency services, media, and other agencies, as required. If designated on the MRL, Military Patient Administration Teams (MPAT) should be designated as MCRP disaster response teams. All MCRP team training and exercise requirements apply. In addition, each exercise will include a review of local procedures for MPAT and verify supporting military unit MPATs are staffed and trained, as applicable.

3.3.2.1.2. Establish and maintain MOUs/MOAs on approved Federal Emergency Management Agency (FEMA) form with local hospitals for participation in NDMS, as well as with those providing support as detailed in the MCRP. MOUs/MOAs identify the types of support and the conditions under which that support becomes available and will be revalidated with each facility annually.

3.3.2.1.3. Attend State, county, and regional conferences concerning NDMS issues when funding available. Participate whenever possible in continuing education programs with State, county, and community offices of emergency services and other health care organizations.

3.3.2.1.4. Plan and implement at least one annual NDMS area exercise. Accomplish planning with all participating facilities to encourage maximum participation and ensure the existing plan is tested to the fullest possible extent. After-action reports will be forwarded to MAJCOM/SGX.

3.3.2.1.5. Identify NDMS resource requirements, to include training and exercises, through the existing MTF budget process.

3.3.2.1.6. Provide the MAJCOM/SGX NDMS representative with the name, rank, address, office symbol, duty title, Defense Switched Network (DSN) telephone number, e-mail address, commercial telephone and FAX numbers of the individual POC assigned to units that have FCC responsibilities. Provide an information copy to HQ USAF/SGXO.

3.3.2.1.7. Report minimum and maximum bed numbers for each NDMS participating hospital as required by HQ USAF/SGXO and HQ USTRANSCOM. Request of bed information is licensed under Report Control Symbol (RCS): HAF-SGX(AR)8602, Medical Report for Emergencies, Disasters and Contingencies (MEDRED-C). During emergency situations, the report is designated emergency status and precedence code C-1, Continue under emergency conditions, Priority. Transmit during MINIMIZE, when necessary.

Chapter 4

MEDICAL UNIT PLANNING PROCESS

4.1. Planning Responsibilities.

4.1.1. Air Force Medical Service (AFMS). The AFMS is responsible for organizing, training and equipping the medical support forces necessary to sustain maximum mission capability and effectiveness. The medical planning process must encompass all aspects of medical support for wartime, humanitarian assistance, homeland security/defense, and disaster response contingencies.

4.1.2. MAJCOM/Air Component Planning Process:

4.1.2.1. Planning. MAJCOM medical planners provide guidance to medical support personnel operating at base level on all aspects of medical readiness planning and training, as well as provide medical readiness functional expertise to the command leadership. The primary focus is the timely provision of medical personnel prepared to respond to any wartime, humanitarian assistance, homeland security/defense, or disaster response contingencies. This is done through the management and oversight of unit medical readiness programs (personnel and materiel). Key roles include, but are not limited to, UTC and WRM allocation, SORTS DOC statement (AF Form 723) issuance, exercise planning, and manning the Crisis Action Team (CAT)/Battle Staff/Contingency Support Staff (CSS).

4.1.2.2. Training. Staff training opportunities include: Armed Forces Medical Intelligence Center (AFMIC) Introduction to Medical Intelligence Course, Contingency Wartime Planners Course (CWPC), Global Command and Control System (GCCS), Joint Operation Planning and Execution System (JOPEs), Joint Medical Planner's Course (JMPC) Basic, JMPC Advanced, National Inter-Agency Civil-Military Institute (NICI), Area Of Responsibility (AOR) Specific Orientation Courses and appropriate continuing education.

4.1.3. Base-level Planning Process:

4.1.3.1. Planning. Base-level planners assess the medical unit's capabilities to support wartime, humanitarian assistance, homeland security/defense, and disaster response contingencies. Assessment of proper response is developed and implemented through publication of the MCRP/EMP and input to the Base Support Plan, Disaster Preparedness and other plans as required by the Wing Plans Offices.

4.1.3.2. Training. AF Medical Readiness Planner's Course is required for the MRO/MRNCO/MRM, as identified in paragraph 1.6.5. Other training includes SORTS, MRDSS, Base/Wing specific training and Disaster Preparedness, as needed. Specific unit mission requirements may include attendance of the CWPC or JMPC. Continuing education may include the Medical Readiness Planners Symposium (J5OZO4000-005) and other civilian courses.

4.1.3.3. MOU/MOA. Coordinate in writing with all civilian/non-federal agencies, and DoD/federal agencies, both on-base and off-base, agreeing to support the MTF. The MOU/MOA should state all specific details associated with the agreement, for example, the number of beds, types of specialties, levels of care, transport support, and reimbursement methods (if any), especially when working with civilian health care providers. Since various disasters call for different levels of support, incorporate as much detail as possible. Do not duplicate healthcare support services provided

under the Managed Care Support Contracts, which are to be addressed in the MCRP Annex W, TRICARE.

4.2. Medical Contingency Response Plan (MCRP) and Emergency Management Plan (EMP). The MCRP/EMP establishes procedures for wartime, humanitarian assistance, homeland security/defense, and disaster response contingencies as well as provides medical policy and local procedures for the BSP. (MCRP format is in [Attachment 2](#)). All MTFs (including deployed medical units) will develop a MCRP that describes medical responses to the predetermined contingency scenarios listed in [Attachment 2](#). AFRC units not co-located with an AC MTF will describe their disaster response in applicable base plans. AFRC generation medical units follow higher headquarters guidance upon mobilization. ANG medical units will follow wing, state and higher headquarters guidance when applicable. Non-MTF AC and AFRC medical units co-located with an AC MTF are listed as manpower resources within the local MTF's MCRP when present for duty. MTFs can identify and train co-located medical unit personnel to augment specific MCRP teams.

4.2.1. Using AFMAN 10-401V2, *Planning Formats and Guidance*, Enclosure D, as an example, format the MCRP addressing the following parts: cover page, letter of transmittal, security instructions, record of changes, plan summary, basic plan, annexes and distribution list. All annexes outlined in [Attachment 2](#) must be addressed. If a particular annex does not apply, annotation must be made in the annex as "Not Applicable". Any annex deemed not applicable must also be addressed in the MRSF minutes stating the justification for this decision. Compliance with the format, as prescribed, will be instituted with the next MCRP complete rewrite.

4.2.2. Responsibilities, missions and tasks will be included in the plan. Reference the BSP and include base operations support not outlined in the BSP.

4.2.3. If an off-base or non-military agency is identified in the MCRP/EMP to provide any degree of support, a MOU/MOA must be established, as described in paragraph [4.1.3.3](#), and a copy maintained by the MR office. For on-base agencies, coordinate the MCRP/EMP with the supporting entity using as AF Form 1768, **Staff Summary Sheet (SSS)**. Clearly outline what support is required.

4.2.4. The MCRP/EMP will be reviewed by the MRSF/EMC annually. Documentation of the review will be maintained in the medical readiness office. Minor changes to the MCRP/EMP may be pen and ink, not requiring complete rewrite. Minor changes must be coordinated by the applicable agencies. Once coordinated, the changes will be approved by the MRSF/EMC, but do not require MAJCOM review. All changes will be reviewed by the MRSF and must include the date of the original plan. The MCRP will be rewritten every three years or when the number of changes is significant (35% of the document). The EMP will be rewritten based on State requirements.

4.2.5. Submit the MCRP/EMP rewrites to the MAJCOM for review prior to publication and after full coordination with applicable agencies. Plan reviews will be accomplished by MAJCOMs within 60 days. Concurrence is implied, if no response from the MAJCOM is received within that time period.

4.3. Maintenance and Distribution of the MCRP and Supporting Checklists. The MR office will manage the preparation, coordination and publication of the MCRP. Distribution of this information will occur as follows: (Not applicable to ARC.)

4.3.1. Distribute copies of the MCRP and all supporting checklists to the following individuals or organizations:

- 4.3.1.1. The medical unit commander and deputy commander.
 - 4.3.1.2. The MR office including additional copies for transfer to the shelter, alternate medical facility, SRC and deployment location, as applicable.
 - 4.3.1.3. Medical Control Center (MCC).
 - 4.3.1.4. Disaster team chiefs. Team chiefs will review and, if necessary update their respective annexes and checklists at least once a year.
 - 4.3.1.5. Parent MAJCOM.
 - 4.3.1.6. Contributing organizations or units (including ARC) listed in the plan.
 - 4.3.1.7. Base CE Readiness Flight.
 - 4.3.1.8. Wing plans office.
 - 4.3.1.9. Battle Staff/CAT.
 - 4.3.1.10. Medical EET Chief.
- 4.3.2. Each medical unit tasked to support an OPLAN or augment an overseas unit may request a copy of the deployed location MCRP.
- 4.3.3. Maintain master checklist set for distribution with the MCRP.

Chapter 5

INITIAL AND SUSTAINMENT TRAINING

5.1. Purpose and Objective. Emerging national and military strategies in support of wartime, humanitarian assistance, homeland security/defense, and disaster response contingencies are the driving forces behind the training requirements to provide initial and sustainment training for all AFMS personnel.

5.1.1. All medical readiness training requirements are divided into four categories; Core, Deployment, Field and JIT. The frequency of the training requirements in each category is identified in the Medical Unit Readiness Training (MURT) Matrix **Attachment 3**.

5.1.1.1. Core Requirements: All AFMS personnel, with a fully qualified medical AFSC, must complete within six months of being assigned to a unit or as AEF requirements dictate. Currency will be maintained as required by **Attachment 3**. This also includes all medical personnel assigned to deployable UTCs in non-medical units such as the SMEs and IDMTs. For ARC, the six months begin after Basic Military Training (BMT) or the AFSC awarding technical school.

5.1.1.2. Deployment Requirements: Established by agencies outside of the AFMS in order to deploy to a theater of operation, e.g., Combat Arms training, NBC Defense, Explosive Ordnance Reconnaissance (EOR), and Deployment Process, and are accomplished IAW **Attachment 3**. **NOTE:** Wing/Base disaster preparedness office (CEX) has primary responsibility for NBC Defense training.

5.1.1.3. Field Requirements: Are ideally suited for instruction in a field environment and accomplished IAW **Attachment 3**, e.g., shelter assembly, low-light operations. AFRC UTCs assigned a reconstitution/expansion mission are allowed to do hospital training with the attached MTF in lieu of field training. The following AFRC UTCs do not require field training: FFGK1, FFDAE, and FFGAA. All other UTCs within the ANG, AFRC and AC are subject to field training.

5.1.1.4. JIT Requirements: Completed just-in-time or with short notice based on an actual deployment location.

5.1.2. Enlisted personnel receive initial medical readiness training, through the Expeditionary Medical Readiness Course (EMRC) at Sheppard AFB or Basic Expeditionary Medical Readiness Training (BEMRT) at Brooks AFB, in conjunction with their AFSC-awarding courses. Officers receive initial training by attending the Commissioned Officer Training (COT)/Reserve Commissioned Officer Training (RCOT) course, or through a commissioning program such as a service academy, Reserve Officer Training Course (ROTC) or Officer Training School (OTS). All personnel that do not receive medical readiness training through these accession programs must be trained at the unit level within six months of their assignment IAW **Attachment 3**. In the ARC, the six-month window begins upon their return from BMT or the AFSC-awarding technical school.

5.1.2.1. Initial training will include all components of core (excluding Unit Mission Brief, AFSC-specific and MCRP/EMP training), deployment (excluding Combat Arms and UTC training) field, and just-in-time training identified in **Attachment 3**.

5.1.3. Interns, residents, and personnel in fellowship training status who are assigned to a deployable UTC must complete MURT IAW paragraph **5.1.1**. and its subparagraphs.

5.1.4. Students enrolled in the Health Professions Scholarship Program must participate in MURT, when available, during their 45-day annual tour of duty at an Air Force MTF. This includes participating with other medical unit personnel in MURT and exercises scheduled during their tour as their duty schedule permits.

5.1.5. MURT is recommended for all chaplain service personnel assigned to a MTF or to a chaplain readiness team with a deployment tasking. The base senior chaplain ensures that the chaplain readiness officer coordinates with the medical unit MRO/MRNCO/MRM to arrange for chaplain service personnel to participate in MURT. MAJCOMs and Field Operating Agencies may provide additional guidelines.

5.1.6. SME/Geographically Separated Unit (GSU) medical personnel and non-medical personnel assigned to medical elements will complete the requirements in this chapter as well as specialized training in support of unique medical missions. **NOTE:** If these personnel are not assigned to a deployable UTC, JIT standards will apply. The host medical unit will monitor the MURT status of all medical personnel assigned to their base, and non-medical personnel assigned to their medical UTCs, e.g., communications and CE personnel assigned to Aeromedical Evacuation (AE) UTCs. The MURT status of medical personnel assigned to non-medical UTCs will be forwarded monthly to the unit's MAJCOM (the training is applicable to ARC, but the reporting is not). AFRC will monitor status through periodic WBITS review.

5.1.6.1. Higher headquarters/MAJCOMs will complete the requirements in this chapter, and as specified in [Attachment 3](#). A unit readiness training monitor will be appointed for the purposes of tracking unit staff training.

5.1.7. Non-medical personnel (non 4XXXX AFSC) assigned to a deployable medical UTC will satisfy all of the applicable requirements described in this instruction.

5.1.8. Computer-based training (CBT) may be utilized to deliver knowledge-based MURT training. Mechanisms to ensure information is assimilated, such as post-tests, will be instituted when using CBT.

5.2. AFSC-specific Sustainment Training. AFSC sustainment training (Readiness Skills Verification Program (RSVP)) is designed to ensure all members with a fully qualified AFSC maintain adequate skills to perform their duties in a deployed/employed setting. All personnel assigned to deployable UTCs must participate in appropriate AFSC-specific training. MAJCOMs may provide supplemental guidance for all other medical personnel (non-deployable UTCs, in-place/generation/forward deployed units, CONUS reception/expansion, and those not assigned to UTCs) to complete AFSC-specific training as based on readiness missions. Enlisted personnel enter into the sustainment training upon award of the 5-skill level. Officers enter sustainment training after completion of unit orientation program and completion of a fully qualified AFSC. If the unit commander decides to assign a member to a UTC prior to attaining their fully qualified AFSC (5-level or fully qualified for officer), they must be trained on RSVP tasks as if they were fully qualified. The RSVP training database, maintained by the HQ USAF/SGXT (WAR-MED PSO), is the primary guide for AFSC-specific medical readiness training. Specific skill set requirements are developed by the appropriate Career Field Manager or SG Consultant. Units will use AFSC-specific training RSVP requirements as part of their annual medical readiness training plan to ensure that every opportunity to conduct training is identified, planned, and documented appropriately. Training tasks, which are identified in the RSVP database, are the catalyst for training program development (the database can be found by selecting SGXT from the organizational chart at the following website

<https://www.afms.mil/sgx/>). (AFRC units will train to the AFSC-specific training requirements identified in WBITS.)

5.2.1. The medical unit commander will appoint, in writing, a functional training manager as office of primary responsibility (OPR) for each AFSC assigned to the unit. These individuals will have the following responsibilities:

5.2.1.1. Must coordinate with unit medical readiness and education and training office staff to determine an appropriate training methodology and timeline for completion of AFSC-specific training. **NOTE:** ANG: functional training managers are only required to coordinate with the education and training office. The MRO is not expected to be involved with AFSC-specific sustainment training.

5.2.1.2. Review training requirements for their respective AFSC utilizing the RSVP database.

5.2.1.3. Identify AFSC-specific sustainment skills that are satisfied during daily practice, routine in-services, exercises, etc.

5.2.1.3.1. Maintain a continuity folder on the AFSC training program that records, at a minimum, who receives training, what training has been completed, when it was completed (all must be verifiable), and what training elements could not be trained within unit capabilities/resources. Locally generated automated tracking systems are acceptable alternatives to continuity folders. AFRC will utilize WBITS to track this information.

5.2.1.4. Provide the MRSF/EMC with a written report of those skills that cannot be accomplished by the unit. The report will include reasons this training cannot be accomplished and will be attached to the MRSF/EMC minutes.

5.2.1.5. Document training on an AF Form 1098, **Special Task Certification and Recurring Training** (may use equivalent automated resources when available), and maintain in the appropriate individual training record, e.g., the Career Field Education and Training Plan for enlisted and training folder for officers. Individual training reports should be provided to members upon permanent change of station or deployments.

5.2.2. Combine training events as much as possible in order to satisfy the elements required by this instruction and other directives.

5.3. Field Training. All personnel assigned to deployable UTCs will complete field training. This training will be conducted over two days in the field, to include the principles of low-light operations. Training will include, at a minimum, the items identified under the field requirements category of the MURT Matrix, **Attachment 3**. See **Attachment 6** for a sample field-training schedule. Safety should not be jeopardized in any phase (pre-deployment, trans-deployment, deployment and post-deployment) of field MURT. Lesson plans are available for many of these topics at the HQ USAF/SGXT (WAR-MED PSO) website (select SGXT from the organizational chart at the following website:

<https://www.afms.mil/sgx/>). **NOTE:** Emergency Medical Services will be accessible during all field training.

5.3.1. Appropriate shelter set up, field sanitation and hygiene, disease and injury prevention, and low light/black out procedures must be accomplished during field training. Field training will include a scenario-based exercise that challenges the UTC capabilities. Review of the UTC Mission Capabilities Statements (MISCAPs) and Concept of Operations (CONOPS) will aid in developing the exer-

cise. Core and deployment training requirements can be accomplished in the field at the discretion of the medical unit commander.

5.3.2. The ARC UTC field training program is based on a stable AEF training cycle. Training will be completed at a site approved by the component (ANG or AFRC) MAJCOM/SG. Components may grant credit for participation in real world deployments and exercises for a given AEF training cycle IAW paragraph 5.6.

5.3.3. Further guidance for annual tour (AT) training for AFRC is found in AFRCI 10-204, *Air Force Reserve Exercise and Deployment Program*. AFRC attendance at the Reserve Medical Readiness Field Training (RMRFT) site, Sheppard AFB, TX is required for the following UTC missions: Small Portable Expeditionary Aeromedical Rapid Response (SPEARRE) Team, Expeditionary Medical Support (EMEDS) Basic, EMEDS +10, EMEDS +25, AFTH, and Aeromedical Staging Squadron (ASTS) increments. Other mission types may attend on a space available basis.

5.3.4. The AE unit training must focus on establishing and maintaining command, control and communications over aeromedical evacuation assets and on maintaining mission-ready crews. Training emphasizes the integration of all UTCs to create a functional AE system.

5.3.5. AE personnel, both air and non-crew members (excluding ASTS personnel who attend the formal ASTS course) must meet the following training requirements:

5.3.5.1. Active component personnel will complete the initial Aeromedical Evacuation Contingency Operations Training (AECOT) course within 12 months of assignment to an AE unit. Newly accessed non-crew ARC personnel will complete initial AECOT course within 18 months of completion of Basic Military Training/Commissioned Officer Training and AFSC formal course training. Crewmembers and ANG CCATTs will complete initial AECOT within 18 months of flight qualification for their primary mission design series (MDS) aircraft or formal CCATT Course attendance. Personnel that have never attended AECOT are required to attend within four AEF training cycles (not to exceed 60 months) from the date of this publication.

5.3.5.2. Subject Matter Experts teaching AECOT will participate in all aspects of the course and will receive course credit based on the recommendation of the AECOT course supervisor.

5.3.5.3. Completion of Theater Aeromedical Evacuation System (TAES) sustainment training (not including AFSC-specific sustainment training) is required every four AEF training cycles (not to exceed 60 months).

5.3.5.4. Initial AECOT training may be waived at the unit commander's discretion, based on experience gained/roles played in a ground UTC during assignment to a deployed TAES, Joint Readiness Training Center (JRTC), or participation in an exercise that encompassed a fully deployed TAES. A copy of the commander's approved waiver will be forwarded to the unit's ground training or readiness office, MAJCOM/SGX and AMC/SGX. This waiver does not include the Deployment Requirements of MURT, i.e., Combat Arms or NBC Defense, etc.

5.3.5.5. All Critical Care Air Transport Team (CCATT) UTCs (FFCCT, FFCCP, FFCCE, FFCCN) will attend the initial CCATT course at USAFSAM (course number B3OZYCCATT-000). Personnel may not be employed or deployed as CCATT members until they have completed the CCATT course. All CCATT personnel must also complete AECOT, IAW paragraph 5.3.5.1. In addition, all CCATT personnel must complete sustainment training and operational support flyer status requirements, once each AEF training cycle, beginning with the cycle

following the one in which they completed the CCATT course. HQ AMC determines the sustainment training and operational support flyer status requirements/frequency. Every attempt should be made to maintain team integrity while attending formal training.

5.4. SORTS T-Level Measurement Training Requirements. AFI 10-201, *Status of Resources and Training System* and supplements contain specific MAJCOM/DRU/ARC guidance on SORTS reporting. The SORTS report is an indicator of a unit's ability to accomplish its OPLAN taskings. Units that are assigned OPLAN tasked UTCs are required to initiate and complete a SORTS report on a monthly basis. Only personnel assigned to deployable UTCs are used to calculate SORTS T-Level percentages, unless directed otherwise by parent MAJCOM.

5.4.1. For SORTS reporting purposes, medical personnel tasked to deploy are considered trained if they maintain currency in all the specific portions of the MURT program as described below. Again, all portions must be complete in order to be counted as trained. See **Attachment 3** for frequency. (For AFRC generation units/UTCs (FFDAE), training requirements in **5.4.1.1.** and **5.4.1.4.**, will be used for SORTS calculations—individuals must be current in both elements to be counted as trained.)

5.4.1.1. Medical effects of NBC warfare

5.4.1.2. UTC-specific team training. Allowance standard (AS) and CONOPS review at a minimum for those units who do not possess corresponding equipment assemblages. Attendance at course B3OZYCCATT-000 is mandatory for all CCATT UTC members, as identified in paragraph **5.3.5.5.**, to be counted as SORTS trained. CCATT training waiver may be granted by AMC/SG.

5.4.1.3. Field Sanitation and Hygiene

5.4.1.4. Wound Care and Casualty Management/SABC

5.4.1.5. NBC Defense

5.4.1.6. NBC Defense Task Qualification Training (TQT)

5.4.1.7. Disease Prevention

5.4.2. Personnel who are assigned to a deployable UTC for the first time will be provided training IAW **Attachment 3**. Deployment training will be accomplished immediately upon initial UTC assignment. Field MURT will be provided at the next available opportunity. They will not be considered fully trained for SORTS purposes until all the requirements in paragraphs **5.4.1.1.** through **5.4.1.7.** are met.

5.5. Training Documentation.

5.5.1. Document MURT on any locally developed tracking form such as an AF Form 1098, **Special Task Certification and Recurring Training**, or by using an equivalent automated tracking system. AFRC units will use WBITS.

5.5.2. Maintain documentation for the current and previous AEF training cycle in order to validate training currency to include the following documents:

5.5.2.1. AF Form 522, **USAF Ground Weapons Training Data** (for deployable personnel).

5.5.2.2. AF Form 1098 or a computer generated summary of the MURT accomplished from the previous unit of assignment.

5.5.2.3. Military or civilian MURT certificates of completion.

5.5.2.4. Training waiver letters.

5.5.3. MURT documentation for credentialed providers must be recorded in the Centralized Credentials Quality Assurance System (CCQAS) IAW DoDI 1322.24, *Medical Readiness Training*.

5.5.4. Current MURT data must accompany each AFMS member upon permanent change of station or transfer to another medical unit and be presented to the medical readiness office during unit in-processing.

5.5.4.1. The Readiness Office will provide all personnel departing the unit with a letter, AF Form 1098, or computer summary indicating all training completed and, as applicable, a deployment folder. These documents will be signed by the appropriate unit medical readiness office staff to verify training completed and to provide necessary training documentation for the gaining unit.

5.6. Medical Unit Readiness Training (MURT) Equivalency Credit. Formal courses, special training events, and deployments.

5.6.1. Personnel may be given MURT credit for completing one or more training elements listed in the MURT Equivalency Matrix when they attend selected formal courses. See [Attachment 4](#).

5.6.2. Credit can also be granted for participation in operational deployments, a major JCS exercise, or a Joint Combined or Service Exercise Training. Participation is defined as active performance of AFSC-related medical duties for the majority of the exercise or deployment. Commanders can grant personnel an AEF training cycle exemption from the field training portion of MURT if the exercise or deployment was relevant to the unit's deployment missions. Documentation must be maintained on file in the medical readiness office. Any other training that may occur during the exercise must be well documented and maintained on file.

5.6.3. The medical unit commander may request a credit for the field training portion of MURT from the MAJCOM/SG or designee, for unit personnel that actively participate in base/wing or other MAJCOM sponsored exercise such as, an ORE or ORI, or an Inspector General Exercise (IGX). The training event must satisfy the field training requirements delineated in paragraph [5.3](#). of this instruction. Credit will be granted for one AEF training cycle only. Submit the request for field MURT credit waiver to the MAJCOM/SGX training POC. The request should contain the following information: 1) trainee profile (i.e., name, rank, unit designation, title, and UTC), 2) type of training accomplished, 3) method used to accomplish training (i.e., IGX, ORI, etc.), 4) justification (describe how the training requirement will be satisfied), and 5) unit POC and contact information.

5.6.4. The medical readiness office POC verifies course completion or MAJCOM credit waiver approval and documents the field MURT credit granted on the individual's training record.

5.6.5. Guidelines and specific information regarding attendance of formal courses is available through the Education and Training Course Announcements website at <https://etca.randolph.af.mil/>.

5.7. Unit Mission Briefing. The purpose of this training is to ensure unit personnel understand the roles and responsibilities of their unit's wartime, humanitarian assistance, homeland security/defense, and disaster response contingency missions. This briefing provides unit personnel with an excellent opportunity to learn about the unit's mission from a tactical and strategic perspective. By understanding the "big picture", unit personnel are better able to visualize how their participation in various activities contribute

toward the unit's mission. This briefing is required for personnel upon assignment to the unit and every other AEF training cycle thereafter. Ensure unit mission briefings are included in the master MURT and exercise training plan. The unit mission brief training will include the following components:

5.7.1. Medical wartime mission. Outline the AEF concept and vulnerability window for the unit, and the wartime concept of operations as described in the unit MCRP/EMP, tasking OPLANs and appropriate BSPs.

5.7.2. The disaster response mission. Provide an overview of MCRP/EMP operations.

5.7.3. Humanitarian assistance mission. Explain the unit's potential response capability to humanitarian assistance operations.

5.7.4. Other medical missions or support. Provide an overview of any other medical missions or support required in MAJCOM or installation plans, including specific items identified in base-level programs such as the Disaster Preparedness program, the Air Base Operability Program, and the Continuity of Operations Program (COOP). (See AFI 10-2501, *Full Spectrum Threat Response (FSTR) Planning and Operations*, AFI 10-212, *Air Base Operability*, AFI 10-208, *Continuity of Operations (COOP) Program*, AFI 10-802, *Military Support to Civil Authorities*, and NGR 500-1, *Military Support to Civil Authorities (MSCA)*).

NOTE: The unit mission brief will be incorporated into the unit's orientation program to educate newly assigned personnel to the medical unit regarding the information above.

5.8. MCRP/EMP and Unit Disaster Response Training.

5.8.1. Annually, each team must train IAW the team's respective annex. Each team chief will identify the training requirements and develop an annual team training plan. The annual team training plan will be submitted to the MRO for inclusion into the unit master MURT plan. The MCRP will include WMD response procedures in Annex N. (A MCRP is not required for AFRC or co-located AE units nor is the requirement to exercise it annually. However, the basic guidelines here are applicable and should be used to assist with Unit Disaster Response Training. Exercises should be incorporated to evaluate the viability of the training program).

5.8.2. Disaster response training will be driven by local base/wing requirements. MTFs should scale training requirement to meet identified vulnerabilities/threats and planned response. Medical support to wing assets will be the primary focus of the training. BSPs and the MCRP will reflect the degree of support provided by the medical unit. Training topics should be scheduled/coordinated with the unit's exercise schedule in order to better prepare members for appropriate response (training before exercising).

5.8.3. MCRP training documentation requirements are as follows:

5.8.3.1. Team chiefs will conduct, document, and track team training for both MCRP and UTC teams. Lesson plans will be maintained by the team chief and reviewed annually, prior to instruction. Copies of the team training will be sent to the medical readiness office. The format for this documentation will include dates of training, subjects covered, attendee(s) name and instructor's signature. In addition, team chiefs will ensure make-up training is accomplished and documented for personnel who missed scheduled training.

5.8.4. ARC personnel assigned to augment AC teams must be included in the development of the MCRP team training schedule process and participate in the scheduled training activities accordingly.

Designated training will be coordinated between the team chiefs, the medical readiness office and all affected reserve component personnel.

5.9. UTC-specific Team Training.

5.9.1. Units tasked with a deployable personnel UTC and its associated medical WRM assemblage must, at a minimum, set-up and inventory this material every AEF training cycle and exercise this materiel every other AEF training cycle. The exercise will include marshaling, staging and assemblage set-up (includes checking operability of all equipment, including generators, heaters, lighting systems, and appropriate fuel sources, as well as performing a complete inventory of equipment/supplies with special emphasis on dated item assessment and re-sterilization check). The exercise should be used to accomplish the annual inventories IAW AFMAN 23-110, Volume 5, Chapter 15, *USAF Supply Manual, Medical Service War Reserve Materiel (WRM) Program*.

5.9.1.1. Air Transportable Clinics (ATC) and EMEDS assemblages must be exercised once every AEF training cycle, by assigned personnel as described above. At prepositioned sites, sourced lead units are required to exercise at least one of each ATC, or EMEDS once every two AEF training cycles. At active bases, if more than one ATC, or EMEDS is maintained on a base, only one must be exercised each AEF training cycle. Other ATC/EMEDS assemblages must still be inventoried and periodic preventive maintenance performed. Forward exercise and inventory schedules to MAJCOM/SGX by 7 January each year. An After Action Report, as described in [Chapter 6](#), and summary of annual inventories will be forwarded to the MAJCOM NLT 30 days after the completion of unit exercises/annual inventories.

5.9.2. Units tasked with managing pre-positioned assets with no deployable personnel UTC must conduct annual inventories IAW AFMAN 23-110, Volume 5, Chapter 15 and support exercise of WRM assemblages as directed by parent MAJCOM.

5.9.3. Units that do not possess the associated medical WRM assemblage necessary to conduct UTC-specific team training will, at a minimum, review the applicable CONOPS and the WRM AS to become familiar with the UTC operational requirements and the equipment the team is expected to utilize. However, the unit MRO is strongly encouraged to make every effort to coordinate and schedule UTC-specific team training with a unit that does possess the associated WRM assemblage. **NOTE:** Documented evidence of real world deployment satisfies these requirements.

5.9.4. All EMEDS commanders, deputy commanders, CMOs, MDOs, and MIOs will apply for Top Secret security clearances. Appropriate security training will be coordinated with the unit security manager.

5.9.5. UTC Formal Training. At a minimum, UTC formal training (those courses with a valid course number) must be accomplished every other AEF training cycle, unless otherwise directed. Personnel assigned to UTC that have attended formal training will remain on that UTC (or one similar) for a minimum of 24 months or until they PCS. The unit commander may waive the 24-month assignment requirement. The waiver will identify why the individual was removed from the position and when the 24-month period is completed. The waiver will be maintained in the Medical Readiness Office until the end of the 24-month period.

5.10. NBC Defense and NBC Defense Task Qualification Training (TQT).

5.10.1. NBC Defense and NBC Defense TQT will be conducted IAW AFI 10-2501, *Full Spectrum Threat Response Planning and Operations*.

5.10.2. NBC Defense TQT involves the performance of AFSC-related tasks in a nuclear, biological, or chemical environment. Minimum tasks to be performed will be identified by the SG Consultants/Career Field Managers in the RSVP/CFETP. MAJCOMs may identify additional specific tasks, standards and/or procedures for conducting this training within the command.

5.11. Combat Arms Training. AFI 36-2226, *Combat Arms Program*, and respective MAJCOM supplements govern combat arms training. Personnel identified in AFD 16-8, *Arming of Aircrew, Mobility, and Overseas Personnel*, will complete combat arms training as required. Failure to qualify does not remove an individual from deployment or PCS assignment overseas.

5.11.1. Additional guidance includes:

5.11.1.1. Personnel currently assigned overseas are trained according to the guidelines established by the unit's MAJCOM, or as directed by the theater Combatant Commander. Personnel assigned to certain PACAF locations (such as Hawaii and Alaska) are exempt from this training as specified through HQ PACAF.

5.11.1.2. All personnel assigned to a primary deployment position must complete firearms training.

5.11.2. Weapons and qualification requirements are as follows:

5.11.2.1. Minimum weapons requirements are identified in the Combat Arms Requirements for Deploying AFMS Unit Type Codes section of this instruction (**Attachment 5**). However, the theater Combatant Commander may levy additional requirements, which is generally specified in the operation's EXORD.

5.11.2.2. At least one person assigned to each UTC must qualify for each required weapon, as outlined in **Attachment 5**. Units will coordinate with their local Combat Arms personnel for additional weapons qualifications requirements for personnel on alternate deployment UTC positions. Failure to qualify does not automatically remove an individual from deployment status. All medical personnel who qualify may be issued a weapon.

5.11.3. Document weapons training on AF Form 522, **USAF Ground Weapons Training Data**, as prescribed in AFI 36-2226, *Combat Arms Program*. AFRC units are required to document training in WBITS.

5.11.4. For fraged UTCs, units are responsible for providing weapons for their own personnel, as outlined in **Attachment 5** and IAW AFD 16-8, *Arming of Aircrew, Mobility, and Overseas Personnel*. Weapons acquisition is not required if a base agency agrees to support the medical unit weapons requirement, as documented in a MOU/MOA.

5.12. Air Reserve Component (ARC) Training. Refer to AFMAN 36-8001, *Reserve Personnel Participation and Training Procedures*.

5.12.1. ARC units scheduled to initiate and complete their AT with an AC medical unit must provide that unit with their annual training plan 90 days prior to AT commencement. The plan must clearly delineate the AFSC-specific sustainment training requested. The actual training provided must be negotiated well in advance and be mutually agreed upon.

- 5.12.2. The host AC medical unit is responsible for providing agreed upon training to the ARC unit.
- 5.12.2.1. Effected host AC medical unit personnel will provide ARC medical personnel with AFSC-specific (RSVP) sustainment training as outlined in the annual training plan.
- 5.12.2.2. Upon completion of AT, the host AC medical unit will provide the ARC unit members with a signed letter, memo, or signed computer generated report to certify that the negotiated training was actually accomplished and documented. The documentation should include the dates of training, subjects covered and personnel in attendance. ARC members who complete annual training are expected to provide the signed document to their unit training manager so that the appropriate training folders and other training tracking systems such as WBITS and CCQAS are updated in a timely fashion.
- 5.12.3. IMA Training Program Management.
- 5.12.3.1. Headquarters Air Reserve Personnel Center Command Surgeon (ARPC/SG) will:
- 5.12.3.1.1. Coordinate and implement HQ USAF/SG medical readiness training objectives and policies as they apply to medical IMA reservists.
- 5.12.3.1.2. Provide regulatory policy on medical readiness training programs.
- 5.12.3.1.3. Assist AC medical units who encounter problems scheduling IMA reservists for MURT.
- 5.12.3.2. The unit of attachment commander will:
- 5.12.3.2.1. Ensure that IMA reservists receive required medical readiness training.
- 5.12.3.2.2. Ensure IMA Reservists receive information on training requirements, the training schedule, and other required information pertaining to MURT. Provide this information to the IMA when a tasking is established in planning documents.
- 5.12.3.2.3. Assign an AF reserve liaison officer/NCO or civilian manager.
- 5.12.3.2.4. Provide recommendations related to this instruction to HQ USAF/SGX.
- 5.12.3.3. The unit reserve liaison officer/NCO will:
- 5.12.3.3.1. Ensure IMA reservists receive a minimum of 60 days notice of scheduled MURT.
- 5.12.3.3.2. In coordination with the MRO, monitor the program to ensure MURT is completed and appropriately documented.
- 5.12.3.3.3. MURT documentation will be maintained for the current and previous AEF cycle in order to validate MURT currency.
- 5.12.3.3.4. Notify HQ ARPC/SG of any IMA reservist who fails to comply with these training requirements.
- 5.12.3.4. The unit MRO will:
- 5.12.3.4.1. Obtain a list of attached IMAs at least annually from the unit AF reserve liaison officer.
- 5.12.3.4.2. Ensure all pertinent training is tracked.
- 5.12.3.4.3. Forward the NBC training statistics annually for all attached IMAs to ARPC/SGE.

5.12.3.4.4. Assist the AF reserve liaison officer/NCO in completing all IMA MURT documentation.

5.12.3.5. The IMA reservist will:

5.12.3.5.1. Request the annual master MURT schedule from the unit of attachment.

5.12.3.5.2. Complete scheduled training as required, or arrange for alternate training agreeable to the unit of attachment.

5.12.3.5.3. Request orders using the Web Orders Tracking System (WOTS) if attendance will be in AT or Special Tour status. HQ ARPC/SG must receive the request at least 30 days in advance of scheduled training.

5.12.3.6. IMA Exercises and Training:

5.12.3.6.1. All medical IMA reservists assigned to Category B authorized positions must complete MURT on a JIT basis prior to deployment IAW paragraph [5.1.1.4](#).

5.12.3.6.2. Medical reservists in non-pay participating individual ready status are not required to complete MURT unless deployed, then on a JIT basis.

5.12.3.7. Methods of Attendance. Medical IMA reservists can complete the training requirements included in this chapter in one of the following capacities:

5.12.3.7.1. Annual Tour (AT).

5.12.3.7.2. Inactive Duty Training (IDT). IDT status can include either a pay or non-pay (retirement points only) status.

5.12.3.7.3. Special Tour-Reserve Personnel Appropriation (RPA) mandays. Request orders using the WOTS if attendance will be in Annual Training or Special Tour status. HQ ARPC/SG must receive the request at least 30 days in advance of scheduled training.

Chapter 6

ASSESSMENTS/EVALUATION AND MEDICAL REPORTING

6.1. Assessment Objective. Mission readiness is based upon how well a unit is organized, trained, and equipped. The assessment process centers on three vital steps: 1) compliance with all applicable provisions of this publication; 2) validation of data in MRDSS, ART, and SORTS; and 3) feedback from the commander, wing/base, Numbered Air Force (NAF), MAJCOM, AFIA, and Air Staff to plan for and correct identified deficiencies.

6.2. Medical Readiness (MR) Validators. MR validators are those processes that substantiate unit effectiveness in organizing, training and equipping. Major validators include but are not limited to: MRDSS, Operational Readiness Inspections, Operational Readiness Exercises, After Action Reports, SORTS, Joint Universal Lessons Learned System (JULLS), Audits, Exercises, Functional Management Reviews, Special Management Reviews, Situation Reports, MEDRED-Cs, NATO TacEval, AFIA/SG Sustained Performance Odyssey Surveys, Air Force Remedial Action Program (RAP), Aircrew Standards and Evaluation Visit (ASEV) and SAVs. MAJCOMs and GMAJCOMs will provide primary oversight to the verification and validation of their respective unit's readiness status.

6.3. Inspector General Exercises (IGX), Operational Readiness Inspections (ORI), Operational Readiness Exercises (ORE), and NATO Tactical Evaluations (TacEval). These are performance-based evaluations of unit capability to conduct missions in a simulated contingency scenario. Generally, UTCs identified in SORTS DOC statements (AF Form 723) are tasked to deploy, employ and in most instances redeploy. Medical units without a deployment mission may still be required to provide mission support to other contingency operations. MAJCOMs, NAFs, or other higher headquarters agencies direct ORIs and IGXs. OREs are wing directed. NATO schedules TacEvals. Units should refer to MAJCOM and Wing IG documents for inspectable criteria evaluated during ORIs and OREs. All AMC units will use the Mission Essential Task Lists (METL) to assess their UTC capabilities.

6.4. Exercise Objective. Specified exercises and evaluations of unit readiness plans ensure that units can provide the required medical response for wartime, humanitarian assistance, homeland security/defense, and disaster response contingencies. Periodic exercises train medical personnel, enable them to practice documented procedures and verify medical unit readiness and also enhance cooperation with civilian hospitals and agencies.

6.5. Exercise Requirements. Medical and AE exercises will be realistic and contingency based. Medical personnel will participate in non-medical exercises required IAW AFI 32-4001, *Disaster Preparedness Planning and Operations*, DoDI 1322.24, *Military Medical Readiness Skills Training*, and other deployment guidance, i.e., AFI 10-402, *Mobilization Planning* and AFI 10-403, *Deployment Planning*, to fulfill medical exercise requirements whenever possible. Establish and assess exercise objectives using evaluators trained IAW unit/wing exercise evaluation policies and procedures. Medical exercise evaluation team representatives will participate in wing/base exercise planning to ensure medical training requirements are inserted into exercise scenarios. Scenarios should promote both AFSC and non-AFSC-specific training. Exercise scenarios involving the simulated movement of medical resources to CONUS or OCONUS locations will incorporate pre-deployment, deployment, employment, re-deployment, and post deployment phases. All operational phases do not have to occur in one exercise. When planning required exer-

cises, units should integrate with wing activities as defined objectives and scenarios may fulfill requirements for multiple types of exercises, i.e., the Enemy Attack Exercise may incorporate a mass casualty scenario, which meets one requirement for the MCRP exercise. Lack of wing exercises does not preclude medical exercise requirements. The sections below describe the minimum medical exercise requirements. See [Attachment 7](#).

6.5.1. AFMS Involvement In A Major Field Training Exercise. DoDI 1322.24, *Medical Readiness Training*, establishes a requirement for all services to participate in an annual Joint Service exercise involving all echelons of care, to include AE and other ancillary support. AFMS participation will be determined by higher headquarters and appropriate units tasked IAW requirements identified during Joint exercise planning.

6.5.2. Required documentation shall include:

6.5.2.1. Critique Procedures. Team chiefs, medical EET members, and key players will conduct a post-exercise or incident critique (often known as a “hot wash”) immediately following the exercise when practical. The MR Office will use this critique to provide cross-feed among participants, identify problems not annotated by the base EET, identify training deficiencies, and areas for improvement. Include issues discussed during the critique session in the post-exercise/incident summary.

6.5.2.2. Post-Exercise or Incident Summary. A Post-Exercise or Incident Summary Report is required for unit or base-level exercises and are submitted to the unit’s MRSF/EMC for review. This comprehensive summary report focuses on unit involvement in an exercise or actual incident, and serves to document effectiveness of planning guidance, training programs, and operational responses. Following the event, units will use the summary to provide a forum for verbal and written inputs from team chiefs, EET members, and other observers. The MR Office consolidates inputs in the comprehensive summary report and uses it to brief the MRSF. This report should include the following information, as applicable:

6.5.2.2.1. Participants

6.5.2.2.2. Scenario

6.5.2.2.3. Number and types of casualties

6.5.2.2.4. Objectives

6.5.2.2.5. Achievement of objectives

6.5.2.2.6. Identification of deficiencies

6.5.2.2.7. Observations

6.5.2.2.8. Recommended corrective actions for MRSF/EMC review

6.5.2.2.9. Recommended changes to base and medical unit plans and checklists for MRSF/EMC review

6.5.3. Summary Report Review. Post-exercise or incident summary reports will be reviewed by the MRSF and attached to the minutes. Identified areas of concern are discussed by the MRSF and assigned OPRs to develop corrective action plans with estimated completion dates. Open items for corrective action are tracked through the MRSF/EMC until resolved, tested and closed. Unit commanders, through the MRSF or EMC, will elevate corrective actions that go beyond unit capabilities.

The MRSF will review and approve any recommended changes in local plans or any specific corrective actions.

6.6. Readiness Exercises.

6.6.1. MCRP/EMP exercise: (Not applicable to AFRC, or to active and reserve AE units)

6.6.1.1. Medical participation in wing/base exercises will be scenario dependent. Specific exercises may not require the participation of all personnel assigned to the medical unit at once. Determination of the extent of resources required to respond shall be made at the MCC or its equivalent.

6.6.1.2. All MCRP annexes shall be exercised at least annually. When possible, exercises should be coordinated and executed to assess mutual support arrangements.

6.6.1.2.1. Units can choose to exercise portions of the wartime mission separately, for example, blood donor center mission, as determined by the medical unit commander. Scenarios must provide practical application of didactic training and application of AFSC-specific training requirements.

6.6.2. Mass Casualty Exercise. Medical units will participate in a Mass Casualty Exercise in accordance with the Summary of Readiness Exercises. See [Attachment 7](#). Medical unit participation will be consistent with the specific medical capabilities and responsibilities as specified in wing plans. Demonstrated capability will be the primary focus of exercise participation.

6.6.3. Recall Exercises. Unit commanders will develop recall procedures. Recall plans should describe the methods and procedures the unit uses to locate and call back personnel to their duty station from their local residence or other non-duty locations. Recall exercises demonstrate the ability of the medical unit to provide contingency support and shall be conducted in accordance with the wing/base exercise schedule. Personnel subject to recall will be dependent upon the event scenario. Additional recall exercises may be conducted at the medical unit commander's discretion.

6.6.4. NDMS Exercise. Air Force NDMS FCCs must conduct an annual exercise with civilian hospitals that participate in the NDMS program. Planners will ensure that exercise scenarios closely resemble wartime conditions or domestic disaster response situations. After-action reports will be forwarded to MAJCOM/SGX.

6.6.5. Deployment Processing or Exercise. Units with a deployment mission fulfill deployment program requirements in accordance with AFI 10-403, *Deployment Planning and Execution*, and applicable base deployment program procedures.

6.6.6. Pre-positioned WRM Exercise. Pre-positioned assets require patient movement item (PMI) reports along with the inventory reports.

6.7. Integration of Medical/Aeromedical Evacuation Operations into Air Base Operations.

6.7.1. Intra-theater and inter-theater interfacing. Exercise scenarios should include the intra-theater and inter-theater AE interface. Participants should be briefed on the exercise scenario, theater CONOPS, rules of engagement, and supporting base plans. The goal of the training should result in seamless patient movement through the medical infrastructure.

6.7.2. Conduct of AE operations. The primary focus should be on understanding the medical/AE CONOPS, evolution of medical/AE operational capabilities, patient preparation for evacuation, real-

istic and safe flight line operations, establishment of logistical support, establishment of communications, the integration of PMI, and development of base operational support (to include weapons support).

6.8. Deployed Medical Reporting. HQ USAF and respective MAJCOMs have assigned operational reporting requirements for each medical unit. HQ USAF and MAJCOMs use these reports to make operational decisions on medical support of forces during emergency operations to include operational readiness status, unit availability, and patient care activities.

6.8.1. The unit commander will ensure the MEDRED-C (RCS: HAF-SGX(AR)8602) is submitted IAW procedures outlined in AFMAN 10-206, *Operational Reporting*. Liberal use of the REMARKS section is encouraged. This is one method of ensuring the MAJCOM receives valuable data regarding unit operations in the AOR.

6.8.2. In a deployed environment, casualty reporting as outlined in AFI 36-3002, *Casualty Services*, and AFI 10-215, *Personnel Support for Contingency Operations* will be accomplished by the Personnel Support for Contingency Operations (PERSCO) team or the attached military personnel flight (MPF). Close coordination must be maintained between the mortuary affairs officer, medical service personnel, and the PERSCO team.

6.8.3. Disease and Non-Battle Injury Data (DNBI) data will be compiled and reported by the personnel filling the public health and medical administration roles. The AFFOR Surgeon will determine the report format, frequency, and distribution. Computerized data collection and analysis can be done with the Medical Surveillance Theater Program or Theater Medical Information Program (TMIP) software and/or Global Expeditionary Medical System (GEMS). Reportable events are reported IAW AFI 48-101, *Aerospace Medical Operations*.

6.9. After-Action Reports RCS: HAF-SGX(AR)7901. After Action Reports (AAR) are required for MAJCOM-level or higher exercises and are submitted to the MAJCOM for review and distribution IAW paragraph 6.9.2. After action reports will contain sufficient detail and analysis to offer the reader an accurate account of the events to include, but not limited to, dates, persons involved, outcomes, and appropriate follow-up actions. **NOTE:** Prior to drafting AAR, verify classification level with the classification authority for the exercise/deployment/operation.

6.9.1. Medical treatment facilities and units, including ARC, must submit an after-action report to their respective MAJCOM/SG IAW AFI 10-204, *Readiness Exercises and After-Action Reporting Program* after support of a contingency operation or participation in a higher headquarters/JCS sponsored exercise, or as directed by the contingency AOR JTF or higher headquarters. Contingencies include the following:

6.9.1.1. National emergency/NDMS activation

6.9.1.2. Natural disaster

6.9.1.3. Armed conflict

6.9.1.4. Deployments

6.9.1.5. Humanitarian assistance

6.9.1.6. Any other response directed by HQ USAF, JCS, or the National Command Authorities.

6.9.2. Units will use the report format identified in AFI 10-204, unless otherwise directed by higher authority, i.e., JCS directed use of JULLS. MAJCOM OPRs should also provide information copies of the report to the following organizations:

6.9.2.1. AFMIC/MA-OPS, Fort Detrick, Frederick, MD 21702-5004. E-Mail:

<mailto:afmicops@afmic.detrick.army.mil>, SIPRNET: <mailto:afmicops@afmic.dia.smil.mil>

6.9.2.2. HQ USAF/SGML (AFMLO), Fort Detrick, Frederick, MD 21702-5006. (No generic e-mail or SIPRNET address available, send hard copy only)

6.9.2.3. HQ USAF/SGX, 1360 Air Force Pentagon, Washington DC 20330-9223. SIPRNET: <mailto:gregory.williams@af.pentagon.smil.mil>

GEORGE P. TAYLOR, JR., Lt General, USAF, MC, CFS
Surgeon General

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

- DoDD 6000.12, *Health Services Operations and Readiness*, 29 April 1996
- DoDD 6490.5, *Combat Stress Control (CSC) Programs*, 23 February 1999
- DoDI 1322.24, *Medical Readiness Training*, 12 July 2002
- DoDI 6490.3, *Implementation and Application of Joint Medical Surveillance for Deployments*, 7 August 1997
- NGR 500-1, *Military Support to Civil Authorities (MSCA)*, 1 February 1996
- AFPD 16-8, *Arming of Aircrew, Mobility, and Oversea Personnel*, 18 May 1993
- AFPD 41-1, *Health Care Programs and Resources*, 15 April 1994
- AFI 10-201, *Status of Resources and Training System*, 8 January 2002
- AFI 10-204, *Readiness Exercises and After-Action Reporting Program*, 12 July 2002
- AFI 10-208, *Continuity of Operations (COOP) Program*, 1 September 2000
- AFI 10-212, *Air Base Operability*, 29 April 1994
- AFI 10-215, *Personnel Support for Contingency Operations (PERSCO)*, 15 November 2002
- AFI 10-229, *Responding to Severe Weather Events*, 1 August 1998
- AFI 10-244, *Reporting Status of Aerospace Expeditionary Forces*, 19 February 2002
- AFI 10-245, *Air Force Antiterrorism (AT) Standards*, 21 June 2002
- AFI 10-301, *Responsibilities of Air Reserve Component (ARC) Forces*, 1 August 1995
- AFI 10-402, *Mobilization Planning*, 1 January 1997
- AFI 10-403, *Deployment Planning and Execution*, 9 March 2001
- AFI 10-802, *Military Support to Civil Authorities*, 19 April 2002
- AFI 10-2501, *Full Spectrum Threat Response (FSTR) Planning and Operations*, 24 December 2002
- AFI 32-4001, *Disaster Preparedness Planning and Operations*, 1 May 1998
- AFI 36-2226, *Combat Arms Program*, 15 May 2000
- AFI 36-2238, *Self-Aid and Buddy Care Training*, 1 September 1996
- AFI 36-3002, *Casualty Services*, 26 Aug 1994
- AFI 44-105, *Air Force Blood Program*, 1 October 1997
- AFI 48-101, *Aerospace Medical Operations*, 11 July 1994
- AFI 51-401, *Training and Reporting to Ensure Compliance with the Law of Armed Conflict*, 19 July 1994
- AFMAN 10-100, *Airman's Manual*, 1 August 1999

AFMAN 10-206, *Operational Reporting*, 14 May 2002
AFMAN 10-401V2, *Planning Formats and Guidance*, 1 May 1998.
AFMAN 23-110, *USAF Supply Manual*, 1 January 2003
AFMAN 32-4005, *Personnel Protection and Attack Actions*, 30 October 2001
AFMAN 36-8001, *Reserve Personnel Participation and Training Procedures*, 1 January 2000
AFCAT 21-209V1, *Ground Munitions*, 3 October 2002
AFH 10-416, *Personnel Readiness and Mobilization*, 22 December 1994
AFH 10-222v4, *Environmental Guide for Contingency Operations*, 1 August 1997
AFPAM 10-219V1, *Contingency and Disaster Planning*, 1 December 1995
AFPAM 10-219V5, *Bare Base Conceptual Planning Guide*, 1 June 1996
AFVA 10-2511, *USAF Standardized Attack Warning Signals for NBCC Medium and High Threat Areas*, 24 December 2002
AFVA 10-2512, *Mission-Oriented Protective Postures (MOPP)*, 24 December 2002
AFVA 32-4010, *USAF Standardized Alarm Signals*, 1 November 1997
AFRCI 10-204, *Air Force Reserve Exercise and Deployment Program*, 15 March 1999

Abbreviations and Acronyms

AAR —After Action Report
AC —Active Component
ACC —Air Combat Command
AE —Aeromedical Evacuation
AECOT —Aeromedical Evacuation Contingency Operations Training
AEF —Aerospace Expeditionary Force
AETC —Air Education and Training Command
AFB —Air Force Base
AFCAT —Air Force Catalog
AFFOR —Air Force Forces
AFI —Air Force Instruction
AFIA —Air Force Inspection Agency
AFMAN —Air Force Manual
AFMC —Air Force Materiel Command
AFMIC —Armed Forces Medical Intelligence Center
AFMLO —Air Force Medical Logistics Office

AFMOA —Air Force Medical Operations Agency
AFMS —Air Force Medical Service
AFPD —Air Force Policy Directive
AFPC —Air Force Personnel Center
AFRC —Air Force Reserve Command
AFRRI —Armed Forces Radiobiology Research Institute
AFSC —Air Force Specialty Code
AFSOC —Air Force Special Operations Command
AFSPC —Air Force Space Command
AFTH —Air Force Theater Hospital
AFWUS —Air Force Worldwide UTC Availability System
AMC —Air Mobility Command
ANG —Air National Guard
ANGRC —Air National Guard Readiness Center
AOR —Area of Responsibility
ARC —Air Reserve Component (includes Air National Guard and Air Force Reserve)
ARPC —Air Reserve Personnel Center
ART —AEF UTC Reporting Tool
AS —Allowance Standard
ASEV —Aircrew Standardization Evaluation Visit
ASTS —Aeromedical Staging Squadron
AT —Annual Training
ATC —Air Transportable Clinic
BEE —Bioenvironmental Engineer
BEMRT —Basic Expeditionary Medical Readiness Training
BICEPS —Brevity, Immediacy, Centrality, Expectancy, Proximity, Simplicity
BMT —Basic Military Training
BSC —Biomedical Sciences Corps
BSP —Base Support Plan
BW —Biological Warfare
C3ISR —Command, Control, Communications, Intelligence, Surveillance, and Reconnaissance
C4 —Combat Casualty Care Course

C4A —Combat Casualty Care Course for Administrators (Obsolete name, see JOMMC)

CAT —Crisis Action Team

CBRNE —Chemical, Biological Radiological, Nuclear, and High-yield Explosive

CBT —Computer Based Training

CBWDT —Chemical-Biological Warfare Defense Training

CCATT —Critical Care Air Transport Team

CCQAS —Centralized Credentials Quality Assurance System

CE —Civil Engineering

CEX —Civil Engineering Readiness Flight (Disaster Preparedness)

CME —Continuing Medical Education

CMO —Casualty Management Officer

CONOPS —Concept of Operations

CONUS —Continental United States

COOP —Continuity of Operations

COT —Commissioned Officer Training

CRT —Crisis Response Team

CRTC —Combat Readiness Training Center

CSC —Combat Stress Control

CSS —Contingency Support Staff

CW —Chemical Warfare

CWPC —Contingency War Planner's Course

DC —Dental corps

DNBI —Disease and Non-Battle Injury

DOC —Designed Operational Capability

DoD —Department of Defense

DoDI —Department of Defense Instruction

DP —Disaster Preparedness

DSN —Defense Switched Network

DRU —Direct Reporting Unit

DU —Depleted Uranium

EET —Exercise Evaluation Team

EMC —Executive Management Committee

EMEDS —Expeditionary Medical Support
EMP —Emergency Management Plan
EMRC —Expeditionary Medical Readiness Course (formerly known as BMRC)
EOC —Emergency Operations Center
EOR —Explosive Ordnance Reconnaissance
EUMD —Extended Unit Manning Document
EXORD —Execute Order
F-MURT —Field Medical Unit Readiness Training
FCC —Federal Coordinating Center
FEMA —Federal Emergency Management Agency
FSTR —Full Spectrum Threat Response
GCCS —Global Command and Control System
GEMS —Global Expeditionary Medical System
GMAJCOM —Gaining Major Command
GSU —Geographically Separated Unit
HAF —Headquarters Air Force
HAZMAT —Hazardous Material
HAZWOPER —Hazardous Waste Operations and Emergency Response
HSI —Health Services Inspection
HTA —High Threat Area
ICMOP —Integrated CONUS Medical Operations Plan
ICS —Incident Command System
IDMT —Independent Duty Medical Technician
IDT —Inactive Duty Training
IFE —In-Flight Emergency
IGX —Inspector General Exercises
IM/IT —Information Management/Information Technology
IMA —Individual Mobilization Augmentee
ISSA —Inter-Service Support Agreement
JCS —Joint Chiefs of Staff
JFCOM —Joint Forces Command
JIT —Just-In-Time

JMPC —Joint Medical Planner's Course (includes JMPC Basic and JMPC Advanced)

JOMMC —Joint Operations Medical Managers Course (Formerly known as C4A)

JOPEs —Joint Operations Planning and Execution System

JRTC —Joint Readiness Training Center

JTF —Joint Task Force

JULLS —Joint Universal Lessons Learned System

LOAC —Law of Armed Conflict

LTA —Low Threat Area

MAJCOM —Major Command

MC —Medical corps

MCC —Medical Control Center

MCRP —Medical Contingency Response Plan

MDNCO —Medical Defense Non-Commissioned Officer

MDO —Medical Defense Officer

MEDRED-C —Medical Report for Emergencies, Disasters, and Contingencies

METL —Mission Essential Task List

MIO —Medical Intelligence Officer

MISCAP —Mission Capability

MOA —Memorandum of Agreement

MOOTW —Military Operations Other Than War

MOU —Memorandum of Understanding

MPAT —Military Patient Administration Team

MR —Medical Readiness

MRDSS —Medical Readiness Decision Support System

MRIC —Medical Readiness Indoctrination Course

MRL —Medical Resource Letter

MRM —Medical Readiness Manager

MRNCO —Medical Readiness Non-Commissioned Officer

MRO —Medical Readiness Officer

MRPC —Medical Readiness Planners Course

MRSF —Medical Readiness Staff Function

MSC —Medical Service Corps

MSCA —Military Support to Civil Authorities
MTA —Medium Threat Area
MTF —Medical Treatment Facility
MURT —Medical Unit Readiness Training
NAF —Numbered Air Force
NATO —North Atlantic Treaty Organization
NBC —Nuclear, Biological, and Chemical
NBCC —Nuclear, Biological, Chemical, and Conventional
NDMS —National Disaster Medical System
NGO —Non-Government Organizations
NICI —National InterAgency Civil-Military Institute
NREMT —Nationally Registered Emergency Medical Technician
OCONUS —Outside the Continental United States
OCR—Office of Collateral Responsibility
OPLAN —Operation Plan
OPR —Office of Primary Responsibility
ORE—Operational Readiness Exercise
ORI —Operational Readiness Inspection
PACAF —Pacific Air Forces
PERSCO —Personnel Support for Contingency Operations
PHA —Preventive Health Assessment
PHO —Public Health Officer
PIC —Personal Information Card
PIM —Pre-trained Individual Manpower
PMI —Patient Movement Item
POM —Program Objective Memorandum
RAP —Remedial Action Program
RCOT —Reserve Commissioned Officer Training
RCS —Report Control Symbol
RMRFT —Reserve Medical Readiness Field Training
RSG —Regional Support Group
RSVP —Readiness Skills Verification Program

RTOC —Readiness Training Oversight Committee
SABC —Self-Aid and Buddy Care
SAV —Staff Assistance Visit
SIPRNET —Secret Internet Protocol Router Network
SME —Squadron Medical Element
SOF —Special Operations Forces
SORTS —Status of Resources and Training System
SPEARR —Small Portable Expeditionary Aeromedical Rapid Response
SRC —Survival Recovery Center
SSS —Staff Summary Sheet
TACC —Tanker Airlift Control Center
TacEval—Tactical Evaluations
TAES —Theater Aeromedical Evacuation System
TIC —Toxic Industrial Chemical
TIM —Toxic Industrial Material
TMIP —Theater Medical Information Program
TQT —Task Qualification Training
TRG —Training Group
USAFA —United States Air Force Academy
USAFE —United States Air Forces in Europe
USAFSAM —US Air Force School of Aerospace Medicine
USAMRICD—United States Army Medical Research Institute of Chemical Defense
USAMRIID —United States Army Medical Research Institute of Infectious Diseases
USTRANSCOM —United States Transportation Command
UTC —Unit Type Code
VA —Veterans Affairs
WAR-MED PSO —Wartime Medical Planning System Office
WBITS —Web Based Integrated Training System
WMD —Weapons of Mass Destruction
WOTS —Web Orders Tracking System
WRM —War Reserve Materiel

Terms

Aerospace Expeditionary Force (AEF) Cycle—The AEF construct establishes 10 AEFs, each serving 3-month deployment /on-call periods, over a 15-month cycle. The 15-month cycle includes a 10-month training period, a 2-month preparation period, a 3-month employment period, and a reconstitution period after redeployment to home base.

AEF Training Cycle—A period related to the 15-month AEF cycle. An individual's training requirements are based on the AEF they are assigned to. Each person must complete all training required based on the AEF training cycle NLT 60 days prior to their on-call period. Training required in multiples of the AEF training cycle, may be accomplished any time within the period as long as the individual does not exceed the total months of the AEF multiple before the end of their on-call period, e.g., an "every other AEF training cycle" event goes non-current after 30 months. For example, if an individual attends the EMEDS course during AEF cycle 2 he is not due for training until AEF cycle 4, unless he attended training so early in cycle 2 that he will not remain current through his deployment/on-call period. (See current AEF guidance for more details.)

Annual Training—A training period related to the calendar year. Training required on an annual basis must be accomplished every calendar year, e.g., an individual who attends an annual training event on 1 Jan 2006 is current until 31 Dec 2007.

BICEPS—An acronym for the management of Combat Stress Reactions: Brevity (usually less than 72 hours); Immediacy (as soon as symptoms are evident); Centrality of management (in a centralized Combat Stress Control (CSC) unit separate from, but proximal to, a medical unit); Expectancy (CSC unit personnel expectation that casualties will recover); Proximity (of treatment at or as near the front as possible); and Simplicity (the use of simple measures such as rest, food, hygiene and reassurance).

Clinician—See Provider.

Core requirements—Those essential training requirements without which an individual/unit would significantly degrade their ability to accomplish the AFMS mission. These requirements cannot be completed JIT. See [Attachment 3](#).

Disease Prevention—Encompasses the anticipation, prediction, identification, prevention, and control of preventable diseases, illnesses, and injuries caused by exposure to biological, chemical, physical or psychological threats or stressors found at home station and during deployments.

Disaster Response—Includes response to all types of natural and man-made emergency events: acts of nature; chemical, biological, radiological, nuclear, and/or high-yield explosives (CBRNE); hazardous materials incidents; infrastructure failure; etc.

First Responder—Those units/personnel who are first on the scene when medical care is required. These individuals provide initial life saving/life sustaining care to casualties prior to the transport of the patient to the next level of care. These situations include, but are not limited to In-Flight-Emergencies (IFEs), mass casualty situations, HAZMAT response, and other emergency responses. In some cases, triage teams may be classified as first responders.

Just-In-Time Training—Training that augments core requirements and occurs in conjunction with activities in support of wartime, humanitarian assistance and disaster response missions. Training is normally time sensitive and usually limited to that period of time that immediately precedes the activity, deployment or function. See [Attachment 3](#).

Medical Personnel—Personnel who support the AFMS mission and hold a 4XXXX AFSC. They may be assigned to medical or non-medical units.

Medical Unit Readiness Training (MURT)—Formerly known as “CMRT”. Courses, hands-on training, and exercises designed to develop, enhance and maintain military medical skills. MURT includes didactic and field training, and disaster response training (consistent with local requirements) required to ensure healthcare personnel and units are capable of performing operational missions.

MINIMIZE—A condition wherein normal message and telephone traffic is drastically reduced in order that messages connected with an actual or simulated emergency shall not be delayed.

Non-Clinician —See Non-Provider.

Non-Provider—Those individuals who are responsible for clinically managing casualties or providing direct casualty care during operational missions. See [Attachment 8](#).

Provider—Those individuals who have direct patient care responsibilities, who by virtue of their scope of practice, may be called on to clinically manage or assist casualties during a contingency, be it wartime, humanitarian assistance or disaster response. This includes those designated as “first responders” (ED and Flight Medicine Staff). For the purposes of this instruction, the terms clinician and provider will pertain to all physicians, nurses, physician assistants, and only those dentists and 4N0s used in a first response capacity. See [Attachment 8](#).

Sustainment Training—Training required to maintain or enhance the proficiency of individual readiness, clinical, and unit/platform skills.

Training Cycle—That period of time, as defined by each service component, in which all mandatory medical readiness training must be completed. The Air Force training cycle coincides with the 15-month AEF cycle.

Wound and Casualty Management—Wound management refers to those medical skills that are needed to care for trauma and disease non-battle injury patient conditions. Casualty management refers to those skills that are needed to triage and regulate casualties, to include medical land and air evacuation, and staging.

Yearly Training—A 12-month training period, i.e., Yearly training must be accomplished every 12 months and is non-current after 12 months have passed since the training date. For example, an individual who attends a yearly training event on 1 Apr 2006 is current through 31 Mar 2007.

Attachment 2

FORMAT FOR THE MEDICAL CONTINGENCY RESPONSE PLAN (MCRP)

A2.1. Basic Plan.

A2.1.1. References. List references and dates in seven subsections as follows:

A2.1.1.1. Air Force Policy and Guidance, e.g., AFPDs, AFIs, AFPAMs, AFMANs, etc.

A2.1.1.2. MAJCOM Policy and Guidance

A2.1.1.3. Wing Publications

A2.1.1.4. Unit Plans

A2.1.1.5. Maps, Charts, and Grid Maps (the base and surrounding area, as applicable)

A2.1.1.6. MOUs/MOAs

A2.1.1.7. Other references.

A2.1.2. Contributing Organizations. Include all units and organizations (military and civilian), which can support the medical facility. Describe the support provided by these entities and means of activating support agreements, if applicable. Any organization referenced in the plan should coordinate prior to publication. You can employ collocated ARC medical units only when they are performing unit training duty. ARC aeromedical evacuation units can provide support if it doesn't interfere with their unit flight obligations. Identify the number of personnel by AFSC and UTCs available. Ensure MOUs/MOAs are fully coordinated in writing and maintained in the medical readiness office. **NOTE:** It is important to understand that ANG medical and aeromedical unit personnel may already be tasked by the Incident Command System (ICS) or State Emergency Operations Center (EOC).

A2.1.3. Execution. Include at least the following paragraphs:

A2.1.3.1. Describe the conditions under which the MCRP will be executed, who directs the execution, and who executes the plan.

A2.1.3.2. Special instructions. State which parts of the plan are required reading.

A2.1.3.3. A descriptive statement for each major team and a corresponding reference annex. The descriptive statement should tell who is responsible for preparing and maintaining each annex. Indicate responsibilities for sub-teams as an appendix to the appropriate annex.

A2.1.4. Exercising the Plan. Develop a plan and specific guidance to exercise the MCRP. At a minimum, the MCRP will be exercised IAW paragraph 6.6.1. Include the MCRP exercise into the unit's annual training plan.

A2.2. Annexes. Each annex provides definitive information as to how, where, when, and who performs a particular function. Team compositions (peacetime disaster teams and Unit Type Codes) must indicate Air Force Specialty Code (AFSC) supporting their missions. Support each annex with checklists, designed to serve as a quick reference, chronological list of actions required in any given situation. Team chiefs prepare and maintain the checklists. You need not include checklists in the MCRP, but they must be readily available to each team chief, medical control center, and emergency treatment area. List supporting checklists (by subject or title) within the applicable annex. If not published in a unit training plan, include

an abbreviated list of training requirements and where a more comprehensive listing can be found (i.e., team training binder, AFSC-specific training database, AFI 41-106 training matrix, etc.). Include the following annexes. **NOTE:** Depending on local requirements, additional annexes not listed in this attachment may be necessary. Annotate and describe those annexes not applicable:

A2.2.1. Annex A. General Instructions. Include information applicable to all medical personnel, regardless of team assignment. Discuss the following:

A2.2.1.1. Recall procedures. Recalls (UTC, unit-wide, COMM-out) will be conducted IAW paragraph 6.6.3., and the procedure annotated in this annex.

A2.2.1.2. Space allocation.

A2.2.1.3. Triage categories and color-coding system. The Triage Officer examines all casualties and categorizes them according to a color-coded system. When using color-coding systems to represent triage categories, coordinate with local emergency response agencies to prevent confusion during actual emergencies or joint military/civilian exercises. The following CATEGORIES and colors are generally used for standardization:

A2.2.1.3.1. MINIMAL – **Green**

A2.2.1.3.2. IMMEDIATE – **Red**

A2.2.1.3.3. DELAYED – **Yellow**

A2.2.1.3.4. EXPECTANT – **Blue/Black**

NOTE: Civilian medical organizations do not recognize EXPECTANT as a peacetime triage category.

A2.2.1.4. A description and diagram of the patient flow within the facility (peacetime and wartime).

A2.2.1.5. Command, Control, Communications, Intelligence, Surveillance, and Reconnaissance (C3ISR). Indicate the location of the MCC and describe command and control components, communication systems, and ISR systems as applicable. List actions required to restore communications if they break down.

A2.2.1.6. Outline base mission support with clear delineation between peacetime and wartime procedures. Do not duplicate guidance contained in the Base Support Plan, but ensure vital information is readily available to applicable personnel. Consider guidance in AFI 10-802, *Military Support to Civil Authorities*.

A2.2.1.7. At a minimum, address the following: Generation mission support (medical/dental/mental health patient records screening, ensure currency of DD Form 2770, **Abbreviated Medical Record**, immunizations, BW/CW antidote instructions (issuance and proper use of), medical intelligence instructions); Battle Staff support; Disaster Control Group support.

A2.2.2. Annex B. Medical Facility Commander/Medical Control Center (MCC). Address at least those responsibilities listed in **Chapter 1** and briefly outline the chain of command to ensure continuity if the commander is unavailable during peacetime and wartime scenarios. Outline contingency operations procedures, responsibilities, and communications resources. Clearly delineate activities during peacetime and wartime contingencies. Additionally address medical reporting procedures utilizing examples.

A2.2.3. Annex C. Patient Dispersion. Address anticipated patient population in wartime and peacetime, projected changes in availability of hospital services during contingencies and the impact on patient dispersion. If routine care will not be curtailed, describe prioritization of care. Also describe aeromedical evacuation policies and guidelines, as applicable for patient dispersion. Include a description of aeromedical staging activities and communications between the Aeromedical Staging Facility, Mobile Aeromedical Staging Facility, and MTF, as applicable. Ensure MOUs/MOAs support patient dispersion.

A2.2.4. Annex D. Casualty Management (if appropriate). Describe casualty management for each respective team/work center, to include casualty flow within the facility. Facility usage, WRM inventory, maintenance and set-up should be addressed in Annex G, Medical Logistics. Include the following appendices and tabs. Annotate and describe those appendices and tabs not applicable:

A2.2.4.1. Appendix 1 - Aerospace Medicine

A2.2.4.1.1. Tab 1 - Field Treatment Team

A2.2.4.2. Appendix 2 - Clinical Teams

A2.2.4.2.1. Tab 1 - Minimal Team

A2.2.4.2.2. Tab 2 - Delayed Team

A2.2.4.2.3. Tab 3 - Immediate Team

A2.2.4.2.4. Tab 4 - Radiology Team

A2.2.4.2.5. Tab 5 - Laboratory Team

A2.2.4.2.6. Tab 6 - Pharmacy Team

A2.2.4.2.7. Tab 7 - Surgery Team

A2.2.4.2.8. Tab 8 - Nursing Services

A2.2.4.2.9. Tab 9 - Mental Health

A2.2.5. Annex E. Public Health Team. Outline support to the base and MTF in providing:

A2.2.5.1. Communicable and vector-borne disease surveillance, prevention, control, and reporting

A2.2.5.2. Field hygiene and sanitation surveillance

A2.2.5.3. Site selection consultation

A2.2.5.4. Food safety

A2.2.5.5. Medical intelligence and health threat assessment, to include NBC warfare and terrorism intelligence

A2.2.5.6. Deployment health threat education

A2.2.5.7. Pre and post deployment health screening management

A2.2.5.8. Biological agent disease surveillance and control

A2.2.5.9. Food safety and decontamination in a CBRNE environment

A2.2.5.10. Public health response in natural disasters

A2.2.5.11. Foodborne illness outbreak investigation

A2.2.5.12. Food security vulnerability assessment

A2.2.5.13. Deployment processing

A2.2.6. Annex F. Bioenvironmental Engineering (BEE) Team. Outline support to the base and MTF in providing:

A2.2.6.1. Evaluations or assessments of environmental and occupational health hazards and recommended actions for control of these hazards.

A2.2.6.2. Monitoring of base water supply to ensure potability, safety, and survivability.

A2.2.6.3. Monitoring, evaluation, and direction for control of chemical, biological, and radiological hazards.

A2.2.6.4. Assistance in selecting base and unit shelters.

A2.2.6.5. Service as a member of the Wing NBC Cell.

A2.2.6.6. Provide NBC detection guidance to the Public Health Team, as needed.

A2.2.6.7. Assistance to the CE Readiness Flight in developing an NBC detector deployment plan and conducting NBC detection.

A2.2.6.8. Health-based risk assessment advice to medical and line commanders on NBC and HAZMAT exposures.

A2.2.7. Annex G. Medical Logistics Team. Wartime planning shall include the identification of WRM management and maintenance requirements (to include BW/CW antidotes to applicable deploying forces), description of generation mission support, and defining procedures for emergency requisition of equipment and/or supplies. Peacetime planning shall outline logistics support such as procedures for emergency requisition, facility management, biomedical equipment repair/maintenance program and the following Appendices:

A2.2.7.1. Appendix 1. Address WRM inventory, set-up and maintenance, space allocation and manpower requirements.

A2.2.8. Annex H. Manpower Team. Indicate the team responsibilities in supporting the overall medical response. Address, as a minimum, patient movement, facility evacuation support, facility security, and procedures for requesting additional manpower support. This team can include medical unit personnel not directly involved in patient care, collocated ARC medical personnel present for duty, volunteer personnel, base personnel, outpatients awaiting discharge or transportation, and any other personnel available.

A2.2.9. Annex I. Crisis Response Team (CRT). Use this optional annex in addition to or in place of the "Mental Health Team," which is normally an appendix to Annex D. The primary responsibility of the CRT is to provide mental health services to victims and families on site and within the MTF during and post-disaster. Discuss team composition (for example, mental health officers, technicians, chaplains, public affairs officer) and responsibilities.

A2.2.10. Annex J. Facilities Management Team. Describe facility management activities in ensuring: maintenance and repair support; availability of required utilities; facility security; and maintenance or

repair of communications assets. Facility security will be staffed by the manpower team (see Annex H).

A2.2.10.1. Appendix 1. Develop fire evacuation/protection plan and list associated references.

A2.2.11. Annex K. Nutritional Medicine Team. Consider this function (particularly overseas), even though food service may not be a formally authorized function.

A2.2.12. Annex L. Patient Administration Team. Outline responsibilities relevant to patient administration functions during peacetime and wartime contingencies. Do not replicate day-to-day operational functions addressed by other directives. Focus should be on activities directly related to contingency operations.

A2.2.13. Annex M. Civilian Disturbances. Discuss medical operations during a civil disturbance.

A2.2.14. Annex N. Terrorist and Weapons of Mass Destruction (WMD) Threats. Plan medical operations and procedures for response to a terrorist attack on the base and/or the MTF. Threats include chemical, biological, radiological, nuclear, and/or high-yield explosive (CBRNE). Ensure Annex N supports FSTR Plan 10-2 (previously titled Disaster Preparedness OPLAN 32-1), to ensure wing requirements are met (or similar plan). The [unit] commander and staff have a need to know applicable classified threat information – base the Annex N on local and theater (as appropriate) threat assessments. As a minimum, commanders must use the information in the most current version of the Worldwide Chemical-Biological Threat to USAF Air Bases: 1995 – 2005 (S/NF), to develop the baseline threat. The unit NBC MDO is the OPR and the NBC MCO and MIO are the office of collateral responsibility (OCR) for Annex N.

A2.2.14.1. The Annex N will be based on local threat, vulnerabilities, wing and medical mission and limiting factors, personnel and MOA/MOUs. The intent is to plan and present a credible CBRNE defense and medical response capability given existing and available resources. The plan will address, at a minimum, procedures and processes to:

A2.2.14.1.1. Recognize, sample, detect, and identify CBRNE agents and diagnose casualties

A2.2.14.1.2. Handle, identify, and/or transport clinical and/or environmental samples for suspected biological agents. Include execution of the CDC laboratory response network and/or home station execution of the rapid advanced pathogen identification system (RAPIDS).

A2.2.14.1.3. Protect the unit and personnel from CBRNE effects

A2.2.14.1.4. Conduct disease surveillance to identify covert biological warfare (BW) agent use and/or endemic disease outbreaks

A2.2.14.1.5. Triage CBRNE casualties

A2.2.14.1.6. Decontaminate casualties that present at the MTF

A2.2.14.1.7. Treat CBRNE casualties, including restriction of movement and/or quarantine of contagious patients as appropriate

A2.2.14.1.8. Obtain and disseminate at appropriate level local and theater applicable CBRNE vulnerability assessments and intelligence

A2.2.14.1.9. Identify local limiting factors affecting ability to execute Annex N

A2.2.14.1.10. Reference and link to FSTR Plan 10-2 and other applicable deliberate plans

A2.2.14.2. The USAF WMD 1st Responder Pilot Program AFMS WMD Equipment List (available at <https://www.afms.mil/sgx/>) identifies medical WMD first response materiel applicable to many CBRNE events.

A2.2.14.2.1. These lists are guidelines and are based on planning assumptions of 300 NBC casualties and/or 100 explosive trauma casualties – non-pilot program bases may use the list for planning and programming.

A2.2.14.2.2. Pilot program bases are funded in FY02-05; other bases should program (in PE 28038f through MAJCOM) based on local threats, mission capabilities and wing requirements. Non-pilot program bases may use local funding to meet materiel and training gaps.

A2.2.14.3. If decontamination of incident casualties or first responders is required, it is a line responsibility to plan and equip to do so at the scene with designated non-medical personnel (ref AF/IL MSG DTG 231500Z APR 99, Weapons of Mass Destruction (WMD) Threat Response For US Air Force Installations, paragraph 4A(1)(D)). Every effort must be made to control and decontaminate at the scene. Medical treatment facilities which will treat incident casualties should plan, equip and train to decontaminate those who flee the scene and self-present at the MTF. See paragraph 1.7.9.1.

A2.2.14.4. The Annex N should identify processes and procedures for early recognition of covert biological agent use through disease surveillance. The Public Health Team (Annex E) has primary responsibility for this program. Units in the United States and territories must establish contacts with their local Public Health agency and civilian Emergency Management Coordinator in advance to provide estimates of degree to which local civilian support may be necessary for their beneficiaries. If assets from the National Pharmaceutical Stockpile (NPS) will be necessary to cover AF personnel in the event of a suspected or confirmed bioterrorism attack, units will coordinate request and distribution of these assets through the local public health authority. Information on the NPS is available at <http://www.bt.cdc.gov/Planning/index.asp>. If pharmaceuticals are required, up-channel the request via OPREP PINNACLE to the air staff and National Military Command Center and separately via the cognizant State health authority. Overseas installations report via OPREP PINNACLE. Overseas installations should maintain a full compliment of BW/CW countermeasures for all military in their WRM stocks per AFMAN 23-110 Volume 5, Chapter 15.

A2.2.15. Annex O. Transportation. Address requirements for medical transportation, materiel handling, and personnel support. Primary emphasis on wartime requirements is on movement, marshaling and staging of all medical resources to fulfill mission requirements, sheltering of vehicles (as applicable), and reference to appropriate base support plans. Peacetime considerations are relocation of supplies, equipment, and personnel to the alternate medical facility, as well as patient transport considerations.

A2.2.16. Annex P. Alternate Facility. Outline procedures for rapid transition from the medical facility to an alternate facility. Establish the level of care provided at the alternate facility. This annex must include the following (if another medical facility is planned for use, MOUs/MOAs must support the alternate facility):

A2.2.16.1. Length of time the facility will be used.

A2.2.16.2. Scope of service available at the alternate facility.

A2.2.16.3. A floor plan outlining space allotment for the various patient care activities.

A2.2.16.4. Food service agreements.

A2.2.16.5. Plan for movement of patients, equipment and supplies, including linen.

A2.2.16.6. Reference to local support agreements and implementation policy. Do not include the actual agreements in the MCRP, but indicate their location in the medical facility.

A2.2.16.7. All communication requirements and arrangements to meet requirements.

A2.2.16.8. Hazardous materiel procedures.

A2.2.17. Annex Q. Shelter Operations. According to installation shelter program guidelines, medical units will identify shelters for protecting or housing personnel. (See AFMAN 32-4005, Personnel Protection and Attack Actions.) Outline procedures for movement to the shelter. Indicate the type or extent of medical care that will be available in the shelter. Planning is based on the types of disasters most likely to occur in the particular area. Keep the formal shelter plan in the MCC and in the designated shelter. Delineate which activities are applicable to peacetime or wartime, only.

A2.2.18. Annex R. NDMS Peacetime Operations. MTFs designated as NDMS FCCs prepare this annex. The MCRP can reference separately developed NDMS operations or patient reception plans that describe NDMS operations and are used instead of this annex. MTFs not designated as FCCs can use this annex to describe potential involvement with NDMS operations, if applicable.

A2.2.19. Annex S. Deployment. Describe the unit's plan for mobilizing forces and force reception. Refer to Annex A and G for additional deployment processing guidance.

A2.2.20. Annex T. Disaster Response and Recovery. Use this annex to describe response and recovery procedures for "worst case" scenarios, such as a catastrophic natural disaster directly affecting your installation and facility. Address scenarios in which a disaster renders the base and medical facility partially or totally inoperable. Work with base CE Readiness Flight staff in developing this annex. Discuss protective measures (personnel and resources), phases of response, and recovery procedures. Include comprehensive procedures for evacuation or dispersion of patients, medical personnel, and resources. Recovery procedures should address at least the following:

A2.2.20.1. Reconstitution plans for medical personnel and medical resources.

A2.2.20.2. Re-establishing a medical capability.

A2.2.20.3. Establishing an insect and rodent control capability.

A2.2.20.4. Health care for active duty and non-active duty beneficiaries.

A2.2.21. Annex U. Blood Program. Describe procedures, personnel requirements, and facilities necessary to provide blood and blood derivatives for casualty treatment, if applicable. Planning should be consistent with AFI 44-105, Air Force Blood Program, and address situations that require activation of the blood program. Specify provisions for activating the blood donor center, blood transshipment center, or other assigned blood program missions to include procedures for operation and resupply. Indicate agreements with local agencies for obtaining necessary supplies.

A2.2.22. Annex V. Aeromedical Evacuation. Use this annex to describe the AE interface with base response activities, as applicable.

A2.2.23. Annex W. TRICARE. Use this annex to address the role of TRICARE during peacetime and wartime contingency operations.

A2.2.24. Annex X. Facility Expansion. Include facility expansion procedures (if applicable) to include manpower and staffing requirements and utilization. The Chief Nurse will be responsible for the development of this annex.

A2.2.24.1. Appendix 1. Describe facility expansion procedures and floor plan, as applicable.

A2.2.25. **Attachment 1**. Distribution. See paragraph **3.3.1**.

Attachment 3

MEDICAL UNIT READINESS TRAINING (MURT) MATRIX

Table A3.1. MURT Training Requirements.

(1)	Training Requirement	(2)	Frequency	(3)	Duration (Hrs)	Reference	Definition	Remarks
CORE REQUIREMENTS								
(16 hours)								
D	USAF Medical Service Mission/ Doctrine Briefing	C	Initial/As directed by MAJCOM	1		DoDI 1322.24, AFI 41-106	Includes AEF CONOPS (to include cycle information) and AEF medical support (EMEDS), Health Service Support in support of MOOTW/ SOF/Contingency Operations, AFMS Wartime Doctrine. Homeland Defense/WMD awareness. Echelons/stages of care and joint interoperability also included.	
D	Wound Care and Casualty Management (Formerly Wound Mgt)/SABC	C	Every other AEF training cycle	4		AFI 41-106, AFI 36-2238	The clinical aspects of medical management of casualties and disease non-battle injuries. Training includes, at a minimum, gunshot, vascular injuries, burn, neurological, orthopedic, maxillofacial, hypo/hyper thermal stress and injuries, hypovolemic shock, eye injuries, and use of blood products, as these injuries relate to the full spectrum of contingency operations. Basic principles of triage will also be included.	Clinical AFSC are listed in Attachment 8 and all AFSCs not listed require SABC. NREMT satisfies the SABC requirement. Technical training students receive SABC in conjunction with 3-level AFSC awarding courses.
D	Combat Stress Control	C	Every AEF training cycle	0.5		DoDD 6490.5	Familiarization with BICEPS principles of CSC management, as well as leadership, communication with troops, unit morale and cohesion and individual psychosocial stressors, before, during and after deployment. The amount, content, and type of training will be appropriate to the rank and responsibility of the Service member.	
D	Medical Effects of NBC Warfare	C	Every other AEF training cycle	2		AFI 10-2501, AFI 41-106	Medical effects of nuclear, biological and chemical warfare, and the medical management of these casualties. Satellite broadcasts of chem, bio and radiation courses will fill this requirement.	Required for all personnel with a clinical AFSC listed in Attachment 8 .
D	Geneva Convention/ Law of Armed Conflict	C	Annual	1		AFPD 51-4, AFI 41-106, AFI 51-401	Those elements as prescribed by AF/JAG. Requirement mandated by JAG for all personnel.	

(1)	Training Requirement	(2)	Frequency	(3) Duration (Hrs)	Reference	Definition	Remarks
D	Unit Mission Brief	C	Upon unit assignment and every other AEF training cycle	0.5	DoDI 1322.24, AFI 41-106	Detailed explanation of the unit's role during mobilization in support of War winning, Humanitarian, and Disaster Response operations. At a minimum, CONOPS, deployment sequence, and medical unit commander's intent must be included.	
D/F	Casualty Movement	C	Every other AEF training cycle	1	AFI 41-106	Basic principles triage should be reviewed. Techniques and procedures used to move casualties from one point to another. Should include basic litter carries, casualty loading, and casualty evacuation as appropriate to unit mission. A review of the movement of casualties through the echelons of care will also be included.	
D/O	AFSC-specific Readiness Skills Verification Program (RSVP) (Formerly Warskill Competencies)	C	As specified within RSVP	AFSC-specific	AFI 41-106	IAW AFI 41-106.	Credit may be given for civilian experience. Best Practice suggests this be accomplished during AT (AFSC tng), i.e., Top Star, Med Star, AECOT, tng at MTF, Indian reservation.
D	MCRP/EMP Training	C	Annual	Team specific	AFI 41-106	Requirements determined by MCRP/EMP annexes and Base Support Plans (i.e., driven by local requirements). See Attachment 2 for MCRP annexes.	Not applicable to RC and AE
DEPLOYMENT REQUIREMENTS							
(6.5 hours)							
O	Combat Arms Training	D	Biennial for AC and Triennial for ARC	4	AFI 36-2226, AFI 41-106, AFD 16-8	For qualifications, frequency of training, and numbers required by UTC, this element is prescribed IAW AFIs.	Dual qualification for enlisted couriers and aircrew

(1)	Training Requirement	(2)	Frequency	(3) Duration (Hrs)	Reference	Definition	Remarks
O	NBCC Defense (Formerly CBWDT Refresher)	D	Not to exceed (NTE) 15 months	4	AFI 10-2501, AFI 41-106, AFMAN 10-100	Instruction in the proper wear and use of the ground crew ensemble and mask during the various MOPP conditions. Includes understanding of alarms signals and use of personal chemical detection kits.	Initial within 60 days for military/emergency essential civilians “subject to deploy” or “identified to deploy” to a NBCC medium or high threat area. Coordination with local CEX/DP necessary. See reference CE AFIs for additional guidance.
O	NBCC Defense Task Qualification Training (TQT) (Formerly GROUND TQT) (4)	D	Not to exceed (NTE) 15 months	Determine d locally, 2	AFI 10-2501, AFI 41-106	Minimum tasks to be performed will be identified by the SG Consultants/Career Field Managers in the RSVP/CFETP. Topics may include loading and unloading casualties, litter carries, operating communication equipment, performing SABC, accomplishing reports, unexploded ordnance (UXO) procedures, and auto injector use.	May be accomplished concurrently with NBCC defense training. Includes donning and doffing.
O	UTC Training	D	Every AEF training cycle	Based on equipment availability	AFI 41-106	Training will include discussion of UTC CONOPS and AS review; hands-on experience with equipment is required for those units co-located with equipment sets. (See para 5.9.1.) Discussion on interoperability with other UTCs included. Applies to in-place wartime missions.	All FFCC* UTCs must attend initial formal training course as part of UTC training and will be SORTS reportable.
D	Deployment Process	D	Every AEF training cycle	1	AFI 10-403	Review of mobility folders, covering wills, Power Of Attorney, immunizations, personal mobility bag requirements, processing line expectations, and other wing unique requirements. Deployment exercise requirements are IAW AFI 10-403.	Each UTC or mobility position is required to process annually. May count deployment processing.
O	Explosive Ordnance Reconnaissance (EOR)	D	Initial and refresher as determined by MAJCOM	Determine d locally, 0.5	AFI 10-2501, AFI 10-403, AFMAN 10-100	Instruction should include basic recognition of standard EOR, and the proper documentation and reporting of EOR.	Suggested to be performed in conjunction with NBCC defense training.
FIELD REQUIREMENTS(5)							
(5.5 hours)							
F	Shelter Assembly	F	Every AEF training cycle	1	DoDI 1322.24, AFI 41-106	Safe, ergonomic approach to shelter assembly training will be consistent with those shelters appropriate to that unit’s mission.	

(1)	Training Requirement	(2)	Frequency	(3)	Duration (Hrs)	Reference	Definition	Remarks
F	Field Sanitation and Hygiene	F	Every AEF training cycle	1	DODI 1322.24, AFI 10-219v5, AFI 41-106, AFH 10-222v4	Personal hygiene, food and water handling, waste disposal (human and medical), and other medical responsibilities to educating force. Field sanitation and hygiene is an integral process of disease prevention.		
D	Disease Prevention	F	Every AEF training cycle	0.5	DoDI 6490.3, DoDI 1322.24, AFI 41-106	Operational measures and identification on: countering endemic disease, prevention of non-battle injuries, mental health, countering disease vectors (field/urban) environments, countering health threats in the environment, and force health surveillance.	Should be taught in conjunction with Field Sanitation and Hygiene.	
D	Threat and Future Battlefield Environment	F	Every AEF training cycle	0.5	DoDI 1322.24, AFI 41-106	Overview of foreign and domestic sources of imminent danger to US Forces stationed CONUS and OCONUS. Discussion of future battlefield settings where new weaponry may be used effecting the nature of injuries (i.e., laser weapons, particle beams, bio-terrorism, WMD, etc.). Future impact of Force Health Protection measures (developing vaccines, use of PIC Cards). Use most current intelligence production information available to meet the mission intelligence needs.		
D	Depleted Uranium (DU)	F	Initial	0.5	AFI 41-106, AFMAN 32-4005	Training should concentrate on diagnosis and treatment of casualties wounded or contaminated by DU munitions.	Applies to all physicians, nurses, nurse practitioners, dentists, physician assistants, medical technicians, and aeromedical technicians assigned to UTCs	
F	Low-Light & Black-Out Operations (Formerly Night Ops)	F	Every other AEF training cycle	2	AFI 41-106	Conduct medical operations during non-daylight hours. Casualty reception and treatment at night primary focus. Include effects of individual night vision blindness.		
JUST-IN-TIME								
(2 hours)								

(1)	Training Requirement	(2)	Frequency	(3)	Duration (Hrs)	Reference	Definition	Remarks
D	Command, Control, Communications, Intelligence, Surveillance, and Reconnaissance (C3ISR) (Formerly C4I)	J	Initial & JIT	0.5	DoDI 1322.24, AFI 41-106	Those activities that use information and business management systems to facilitate day-to-day operations in support of operational missions. This includes the use of radio communications, IM/IT (Information Management/Information Technology), TMIP (Theater Medical Information Program) and other technology insertions (GEMS).		
D	Site Selection	J	JIT	0.5	DoDI 1322.24, AFI 41-106	Guidance to evaluate a bed down site for deployed forces, emphasis is on site topography, vegetation, water sources, vector breeding sites, climate, evacuation routes, field sanitation requirements, and facility location.		
D	Medical Intelligence	J	JIT	0.5	AFI 41-106	Brief the medical threats/countermeasures at deployed locations to include endemic diseases, environmental hazards, hazardous insects, plants and animals, food and water precautions, field sanitation and hygiene considerations and WMD countermeasures.		
D	Interactions with Civilian and Federal Agencies (include NGO – Non-Government Organizations)	J	JIT	0.5	AFI 36-2250, AFI 41-106	Coordination between civilian support agencies such as hospitals, contracting, logistic supply lines, Red Cross, FEMA, and other disaster relief agencies.	Only applicable for units who have agreements with civilian/NGO organizations	
OTHER								
Medical Management of Biological Warfare Casualties							Initial Only for Clinicians/Providers (see definition of Provider)	

(1) Primary method of instruction: D = Didactic Element, F = Field Element, O = Other Exercise Element

(2) Content category: C = Core Requirement (applies to all AFMS personnel), D = Deployment Requirements (applies to all deployable personnel), F = Field Training (applies to those assigned to deployable UTCs), J=Just-In-Time based on an actual deployment location)

(3) Duration – Times are in hours and are guidelines for planning purposes not mandated time periods

(4) MAJCOMs should add additional items to meet MAJCOM mission needs

(5) Formal Field Training for ARC units is every four AEF training cycles (For ANG units, training is based on ANG/SG training guidance.)

MURT EQUIVALENCY MATRIX¹

Table A4.1. MURT Equivalency Matrix.

	AECOT	JRTC	EMRC/ BEMRT	MRIC	CRTC	EMEDS	C4	JOMMC	CCATT	FN	ConOps	RMRFT	ASTS
CORE REQUIREMENTS													
USAF Medical Service Mission and Doctrine Briefing/Unit Mission briefing/CONOPS	X	X	X	X	X			X		X		X	X
Wound Care			X	X	X	X	X					X	
Casualty Management	X	X	X	X	X	X	X			X		X	X
Combat Stress Control		X	X	X	X		X					X	
Medical Effects of NBC Warfare			X	X	X	X				X	X	X	X
Geneva Convention/Law of Armed Conflict		X	X	X	X			X		X		X	X
Casualty Movement	X	X	X	X	X	X	X	X	X	X		X	X
AFSC-specific Training (RSVP)						X			X			X	
MCRP Exercise													
DEPLOYMENT REQUIREMENTS													
Combat Arms Program					X								
Explosive Ordnance Reconnaissance (EOR)		X	X	X	X							X	
NBCC Defense ²			X	X	X		X				X	X	X
NBCC Defense TQT ²		X	X	X	X							X	
Deployment Process	X	X										X	X
FIELD REQUIREMENTS													
Shelter Assembly	X	X	X	X	X	X	X					X	X

	AECOT	JRTC	EMRC/ BEMRT	MRIC	CRTC	EMEDS	C4	JOMMC	CCATT	FN	ConOps	RMRFT	ASTS
Field Sanitation & Hygiene	X	X	X		X	X				X	X	X	
Threat & Future Battlefield Environment		X	X	X	X	X	X	X			X	X	
UTC Training	X	X				X			X				
Low-Light, & Blackout Ops	X	X	X	X	X	X	X					X	
Disease Prevention		X				X						X	
JUST-IN-TIME													
C3ISR	X	X	X	X	X	X	X	X				X	
Site Selection		X	X		X	X				X	X	X	X
Medical Intelligence	X	X	X	X	X	X		X			X	X	
Interactions with Civilian Activities Including NGOs		X	X		X						X		

Legend:

AECOT (Aeromedical Evacuation Contingency Operations Training), Sheppard AFB, TX

JRTC (Joint Readiness Training Center), Ft Polk, LA

EMRC (Expeditionary Medical Readiness Course), Sheppard AFB, TX

BEMRT (Basic Expeditionary Medical Readiness Training), Brooks AFB, TX

MRIC (Medical Readiness Indoctrination Course), Maxwell AFB, AL

CRTC (Combat Readiness Training Center), Alpena, MI

C4 (Combat Casualty Care Course), Camp Bullis, TX

JOMMC (Joint Operations Medical Managers Course, formerly known as C4A), Ft Sam-Houston, TX

CCATT (Critical Care Air Transport Team Course), Brooks AFB, TX

FN (Flight Nurse Course), Brooks AFB, TX

ConOps (Contingency Public Health Operations Course), Brooks AFB, TX

RMRFT (Reserve Medical Readiness Field Training), Sheppard AFB, TX

ASTS (Aeromedical Staging Squadron Course), Sheppard AFB, TX

NOTES:

1. The blocks marked with an X indicate the requirements that are considered accomplished after successful completion of the entire course indicated.
2. NBC Defense and TQT refresher is provided as initial training.

Attachment 5

MINIMUM WEAPONS REQUIREMENTS FOR DEPLOYING AFMF UTCS

Table A5.1. Minimum Weapons Requirements for Deploying AFMS UTCS.

MEDICAL UTC	#OFF	#ENL	M-9	M-16	TOTAL REQUIRED
FFAAR	2	5	1	3	4
FFAAS	0	1	0	1	1
FFAAT	2	4	1	3	4
FFANC	3	6	2	4	6
FFBAT	1	1	1	1	2
FFBD1	0	12	0	6	6
FFBMM	0	3	0	0	0
FFBTP	1	11	1	7	8
FFBU1	0	6	0	3	3
FFBU2	0	1	0	1	1
FFBU3	1	0	1	0	1
FFC2A	9	20	3	8	11
FFCCE	2	1	3	0	3
FFCCT	2	1	3	0	3
FFCCU	6	8	0	0	0
FFCCV	13	13			
FFDAB	1	2	1	2	3
FFDAD	1	3	1	3	4
FFEB1	70	151	32	68	100
FFEB2	17	2	8	1	9
FFEC1	84	203	35	85	120
FFEC2	47	96	21	40	61
FFEC3	23	62	11	31	42
FFEC4	27	65	12	32	44
FFEC5	38	83	18	41	59
FFEND	1	1	0	0	0
FFENT	1	1	0	0	0
FFEP1	2	1	2	1	3
FFEP2	3	2	3	2	5
FFEP3	7	20	4	10	14

MEDICAL UTC	#OFF	#ENL	M-9	M-16	TOTAL REQUIRED
FFEP4	11	14	6	7	13
FFEP5	3	2	0	0	0
FFEP6	1	4	0	0	0
FFEPT	27	40	9	13	22
FFEST	13	9	5	3	8
FFEW1	7	18	3	6	9
FFEW2	7	13	3	5	8
FFEWT	14	31	5	11	16
FFEYE	1	1	0	0	0
FFF0C	2	4	1	2	3
FFGK1	18	12	5	10	15
FFGK2	13	16	8	11	19
FFGK3	14	30	10	20	30
FFGK4	5	24	3	15	18
FFGK5	13	36	9	24	33
FFGK6	7	4	4	3	7
FFGK7	7	4	4	3	7
FFGK8	2	2	4	4	4
FFGK9	5	14	2	7	9
FFGKE	67	147	34	74	108
FFGKF	32	98	15	45	60
FFGKH	30	43	15	25	40
FFGKL	4	20	2	10	12
FFGKM	6	13	3	6	9
FFGKN*	0	2	0	2	2
FFGKR	1	3	0	0	0
FFGKT	3	0	0	0	0
FFGKU	4	2	4	2	6
FFGKV	2	1	2	1	3
FFGL1	1	5	1	5	6
FFGL2	2	0	2	0	2
FFGL3	1	1	2	0	2
FFGL4	0	4	0	4	4

MEDICAL UTC	#OFF	#ENL	M-9	M-16	TOTAL REQUIRED
FFGLB	0	19	0	19	19
FFGLE	1	12	1	12	13
FFGRL*	3	1	3	1	4
FFGYM	4	2	2	1	3
FFGYN	2	3	2	2	2
FFHA1	5	2	4	2	6
FFHA2	8	7	4	4	8
FFHA4	1	2	0	1	1
FFHA5	2	0	1	0	0
FFLAB**	10	29	16	23	39
FFLBD	6	21	2	5	7
FFLCA	22	64	5	15	20
FFLEA	41	139	11	34	45
FFLG1	0	3	0	0	0
FFLGC	1	8	0	0	0
FFLGD	0	6	0	0	0
FFMAX	1	1	0	0	0
FFMFS	5	0	5	0	5
FFNEU	1	1	0	0	0
FFPDD	1	1	0	0	0
FFPED	10	9	0	0	0
FFPER	1	1	0	0	0
FFPME	1	9	1	4	5
FFPPT	1	1	0	1	1
FFPRM	10	12	10	11	22
FFQAC	4	4	0	0	0
FFQAD	3	5	0	0	0
FFQAE	1	6	0	0	0
FFQB9	10	15	25	0	25
FFQBB	0	2	0	2	2
FFQC1	2	0	0	0	0
FFQC3	4	1	4	1	5
FFQC4	2	1	3	0	3

MEDICAL UTC	#OFF	#ENL	M-9	M-16	TOTAL REQUIRED
FFQCE	20	30	50	0	50
FFQCK	2	3	5	0	5
FFQCQ	40	60	100	0	100
FFQCT	0	5	0	5	5
FFQCU	8	11	8	11	19
FFQCV	3	3	0	6	6
FFQCX	2	3	2	3	5
FFQCY	8	24	8	24	32
FFQDA	2	3	5	0	5
FFQDB	10	15	25	0	25
FFQDC	40	60	100	0	100
FFQDD	20	30	50	0	50
FFQEJ	0	1	0	1	1
FFQEK	1	2	3	2	3
FFQP1	0	2	0	0	0
FFQP2	0	3	0	0	0
FFQPA	0	1	0	1	1
FFRA1	2	5	7	0	7
FFRA2	6	14	20	0	20
FFRA3	2	8	10	0	10
FFRAD	1	2	0	1	1
FFSYS	1	6	0	2	2
FFTEL	1	2	1	1	2

NOTES:

1. Weapons training will be in accordance with established guidance contained in AAFP 16-8, *Arming of Aircrew, Mobility, and Overseas Personnel*, AFI 31-207, *Arming and Use of Force by Air Force Personnel*, AFI 36-2226, *Combat Arms Program*, this instruction, and other applicable directives.
2. There must be a minimum of one qualified individual for each weapon required. The ammunition authorized for each weapon is based on the personnel-arming requirement. For medical personnel specified here, munitions authorizations for internal security, protection, and personal defense are found in AFCAT 21-209, *Ground Munitions*. AFCAT 21-209 also serves as the source for MURT ground munitions authorizations.

3. Handguns will be available for use by designated weapons couriers for each parent UTC with a weapons requirement. These handguns are reflected in the totals above.
4. Procure handguns (9mm) for officers and rifles (M-16) for enlisted personnel, unless otherwise indicated.
 - 4.1. * The IDMT (4N0X1) assigned to FFGRL/FFGKN, and deploying or supporting a TDY requirement as the single medical authority supporting deployed/other TDY personnel is authorized either M9, M-16 or both as the situation dictates.
 - 4.2. ** For the UTC, FFLAB, an additional six M-9's are required to support the six enlisted personnel dual tasked for ground and aircrew responsibilities.
5. With limited exceptions, the ratio of handguns to rifles reflects the UTC officer to enlisted man-power ratio.
6. Bases assigned fragmented portions of UTCs will ensure their tasked personnel are weapons trained and qualified as required by the UTC. If the arming requirement is 100 percent for that UTC, then all personnel assigned by both the lead unit and any fragged portions will be weapon qualified. If the arming requirement is less than 100 percent, then the applicable percentage of personnel assigned will be qualified, as required by the UTC. The lead unit for identified taskings will ensure personnel in fragged UTCs supporting them have weapons available to support identified requirements. *EXAMPLE:* If the UTC requires 50 percent of total personnel be weapons qualified, then both the lead unit and any bases assigned a portion of that UTC will ensure that 50 percent of the total number of their personnel assigned to the UTC will be weapon qualified. Both the lead unit and any fragged units will ensure the applicable training requirement is met.
7. CONUS units with generation missions/UTC taskings are exempt from weapons requirements.
8. Medical units on the Korean Peninsula will use the following guidance for determining weapons requirements:
 - 8.1. Weapons are required for at least 50% of medical authorizations. Personnel assigned to UTCs should be given priority and comply with weapons' training requirements. The MDG Commander will determine additional weapons' requirements above 50% of authorizations.
9. Annually, pilot units are responsible for determining and recommending weapons requirements for each assigned UTC to the MAJCOM MEFPK responsible for managing the UTC.

Attachment 6

SAMPLE FIELD TRAINING SCHEDULE FOR MEDICAL UNITS

Table A6.1. Sample Field Training Schedule.

STARTEX		
DAY ONE		
TIME	A-SHIFT	B-SHIFT
0530-0630	Deployment Processing	Deployment Processing
0630-0730	USAF Medical Service Mission/Doctrine Briefing	USAF Medical Service Mission/Doctrine Briefing
0730-0800	Site Selection	Site Selection
0800-0900	Transportation to MURT Field Site	Transportation to MURT Field Site
0900-1230	Field Gear Issue/Camp Set-Up	Field Gear Issue/Camp Set-Up
1230-1330	Lunch	Casualty Movement
1330-1430	Field Sanitation and Hygiene	Lunch
1430-1530	Casualty Movement	Field Sanitation and Hygiene
1530-1600	C3ISR	Interaction with NGO
1600-1700	Dinner	Dinner
1700-1730	Interaction with NGO	C3ISR
1730-2130	Wound Care & Casualty Management	Wound Care & Casualty Management
2130-2330	Low Light/Blackout Operations	Low Light/Blackout Operations
2330-0600	Off-duty	Off-duty
DAY TWO		
0600-0700	Breakfast	Breakfast
0700-0800	Medical Effects of NBC	Geneva Convention, and LOAC
0800-0900	Medical Effects of NBC	Shelter Assembly
0900-0930	Combat Stress Control	Disease Prevention
0930-1030	Shelter Assembly	Medical Effects of NBC
1030-1130	Geneva Convention, and LOAC	Medical Effects of NBC
1130-1230	Lunch	Lunch
1230-1300	Disease Prevention	Threat and Future Battlefield
1300-1330	Threat and Future Battlefield	Combat Stress Control
1330-1600	Mass Casualty Exercise	Mass Casualty Exercise
1600-1630	Exercise Debrief	Exercise Debrief
1630-1800	Site Tear-Down/Equipment Turn-In	Site Tear-Down/Equipment Turn-In
1800-1830	Return to Home Base	Return to Home Base
ENDEX		

Attachment 7

SUMMARY OF READINESS EXERCISES

Table A7.1. Summary of Readiness Exercises.

EXERCISE REQUIREMENT	FREQUENCY	AUDIENCE	REFERENCE	REMARKS
Mass Casualty	Annually	Scenario dependent	AFI 41-106, (AFI 10-2501	All medical personnel
Assemblage Set Up, Inventory, and Exercise	Every AEF training cycle for set-up/ inventory, and every other cycle for exercise	All personnel assigned to UTC with access to WRM equipment	DoDI 1322.24, AFI 41-106	Train to extent possible for equipment/ assemblage proficiency
Alternate Medical Treatment Facility	Every other AEF training cycle	Scenario dependent	AFI 41-106	Not applicable to ARC
Field Exercise/ Training	Every other AEF training cycle	Deployable personnel and as defined by MAJCOM/SG	DoDI 1322.24, AFI 41-106	ANG field exercises will be conducted on an every fourth cycle basis. AFRC field exercise will be conducted on an every other cycle.
Pre-Positioned WRM	As directed by MAJCOM	Applicable WRM assemblage	AFI 41-106	Consists of PMI and inventory reports. Not applicable to ANG.
NDMS	Annually	Scenario dependent	AFI 41-106	Exercise involvement driven by Federal Coordinating Centers
<i>(The following exercises are driven by guidance external to this instruction.)</i>				
Major Accidents - Munitions - Nuclear weapons - Off-base response - Air Show response - HAZMAT Team	Annually for each category applicable for medical unit	Scenario dependent	AFI 10-2501, FSTR Plan 10-2	For ARC Units: IAW Base/Wing exercise schedule and Commander's discretion.

EXERCISE REQUIREMENT	FREQUENCY	AUDIENCE	REFERENCE	REMARKS
Terrorist Use of WMD - Chemical, radiological, nuclear, or high-yield explosive incident - Biological attack incident	Biannually for each category	Scenario dependant	AFI 10-2501	Execute cross-functionally according to the local WMD threat: incorporate all local response elements. Alternate annually between the two categories of Terrorist Use of WMD exercises.
Enemy Attack	- Not to exceed 15 months for installations in a chem/bio LTA - Not to exceed 7.5 months for installations in a chem/bio MTA - Quarterly for installations in a chem/bio HTA	Scenario dependent	AFI 10-2501	Not applicable for ARC, but should be included in mass casualty exercises on a regular basis
Natural Disaster Response	Annually	Scenario dependent	AFI 10-229, AFI 10-2501	Natural disaster response typical to unit area. Not applicable for ARC, but should be included in mass casualty exercises on a regular basis.
Mobilization Exercise	Annually	All assigned to deployment status and deployment teams	AFI 10-402, AFI 10-403, AFPAM 10-219V1, AFPAM 10-417, AFH 10-416	Exercise entire range of deployment responsibilities
Recall	IAW Base/Wing exercise schedule and commander discretion	Scenario dependent	AFI 10-403	Evaluate capability to implement unit or UTC recall plan

Attachment 8

CLINICAL AFSC LISTING

Table A8.1. Listing of Clinical AFSCs.

AFSC	CORPS	DESCRIPTION
42B3	BSC	Physical Therapist
42E3	BSC	Optometrist
42F3	BSC	Podiatrist
42G3	BSC	Physician Assistant
42G3A	BSC	Physician Assistant, Ortho
42G3B	BSC	Physician Assistant, ENT
42G3C	BSC	Physician Assistant, Gen Surgery
42G3D	BSC	Physician Assistant, Perfusionist
42G3E	BSC	Physician Assistant, Emergency Room
42G3F	BSC	Physician Assistant, Oncology
42T3	BSC	Occupational Therapist
43B3A	BSC	Chiropractor
43Y3A	BSC	Health Physicist Med
44A3	MC	Chief Hospital/Clinic Services
44B3	MC	Preventive Medicine Specialist
44D3	MC	Pathologist
44D3A	MC	Pathologist, Hematology
44D3B	MC	Pathologist, Cytology
44D3C	MC	Pathologist, GYN
44D3D	MC	Pathologist, Forensic
44D3E	MC	Pathologist, Neuropathology
44E3	MC	Emergency Services Physician
44E3A	MC	Emergency Services Phys, Emergency Specialist
44F3	MC	Family Physician
44G3	MC	General Practice Physician
44H3	MC	Nuclear Medicine
44K3	MC	Pediatrician
44K3A	MC	Pediatrician, Adolescent
44K3B	MC	Pediatrician, Cardiology
44K3C	MC	Pediatrician, Developmental Ped
44K3D	MC	Pediatrician, Endocrinologist

AFSC	CORPS	DESCRIPTION
44K3E	MC	Pediatrician, Neonatologist
44K3F	MC	Pediatrician, Gastroenterologist
44K3G	MC	Pediatrician, Hematologist
44K3H	MC	Pediatrician, Neurologist
44K3J	MC	Pediatrician, Pulmonologist
44K3K	MC	Pediatrician, Infectious Disease
44K3L	MC	Pediatrician, Medical Genetics
44K3M	MC	Pediatrician, Nephrologist
44M3	MC	Internist
44M3A	MC	Internist, Oncologist
44M3B	MC	Internist, Cardiologist
44M3C	MC	Internist, Endocrinologist
44M3D	MC	Internist, Gastroenterologist
44M3E	MC	Internist, Hematologist
44M3F	MC	Internist, Rheumatologist
44M3G	MC	Internist, Pulmonary Diseases
44M3H	MC	Internist, Infectious Diseases
44M3J	MC	Internist, Nephrologist
44N3	MC	Neurologist
44P3	MC	Psychiatrist
44P3A	MC	Psychiatrist, Child Psych
44R3	MC	Diagnostic Radiology
44R3A	MC	Diagnostic Radiology, Neuroradiology
44R3B	MC	Diagnostic Radiology, Special Procedures
44S3	MC	Dermatologist
44S3A	MC	Dermatologist, Derm Surgery
44S3B	MC	Dermatologist, Derm Pathology
44T3	MC	Radiotherapist
44U3	MC	Occupational Medicine Specialist
44Y3	MC	Critical Care Medicine
44Y3A	MC	Critical Care Medicine, Pediatrics
44Z3	MC	Allergist
45A3	MC	Anesthesiology
45B3	MC	Orthopedic Surgeon
45B3A	MC	Orthopedic, Hand

AFSC	CORPS	DESCRIPTION
45B3B	MC	Orthopedic, Pediatrics
45B3C	MC	Orthopedic, Biomechanical
45B3D	MC	Orthopedic, Sports Medicine
45B3E	MC	Orthopedic, Spine Surgery
45B3F	MC	Orthopedic, Oncology
45B3G	MC	Orthopedic, Replace Arthroplasty
45E3	MC	Ophthalmologist
45E3A	MC	Ophthalmologist, Oculoplastics
45E3B	MC	Ophthalmologist, Cornea/External Disease
45E3C	MC	Ophthalmologist, Glaucoma
45E3D	MC	Ophthalmologist, Neuro-Ophthalmologist
45E3E	MC	Ophthalmologist, Pathology
45E3F	MC	Ophthalmologist, Strabismus/Ped
45E3G	MC	Ophthalmologist, Vitreous/Retina
45G3	MC	OB/GYN
45G3A	MC	OB/GYN, Endocrinologist
45G3B	MC	OB/GYN, Oncology
45G3C	MC	OB/GYN, Pathology
45G3D	MC	OB/GYN, Maternal-Fetal Medicine
45N3	MC	ENT
45P3	MC	Physical Medicine Physician
45S3	MC	Surgeon
45S3A	MC	Surgeon, Thoracic
45S3B	MC	Surgeon, Colon/Rectal
45S3C	MC	Surgeon, Cardiac
45S3D	MC	Surgeon, Pediatric
45S3E	MC	Surgeon, Peripheral Vascular
45S3F	MC	Surgeon, Neurological
45S3G	MC	Surgeon, Plastic
45S3H	MC	Surgeon, Oncologist
45S3J	MC	Surgeon, Multi-Organ Transplant
45U3	MC	Urologist
45U3A	MC	Urologist, Pediatrics
45U3B	MC	Urologist, Oncology
45U3C	MC	Urologist, Kidney or Pancreas Transplant

AFSC	CORPS	DESCRIPTION
46A3	NC	Nursing Administrator
46P3	NC	Mental Health Nurse
46P3A	NC	Mental Health Nurse Specialist
46S3	NC	Operating Room Nurse
46M3	NC	Nurse Anesthesia
46N3	NC	Clinical Nurse
46N3A	NC	Clinical Nurse, OB/GYN Nurse Practitioner
46N3B	NC	Clinical Nurse, Pediatric Nurse Practitioner
46N3C	NC	Clinical Nurse, Primary Care Nurse Practitioner
46N3D	NC	Clinical Nurse, Staff Development
46N3E	NC	Clinical Nurse, Critical Care
46N3F	NC	Clinical Nurse, Neonatal ICU
46N3G	NC	Clinical Nurse, Obstetrics
46N3H	NC	Clinical Nurse, Family Nurse Practitioner
46F3	NC	Flight Nurse
46G3	NC	Nurse Midwife
47G4	DC	Dental Staff Officer
47G3	DC	Dental Officer
47G3A	DC	Dental Officer, Comprehensive Dentist
47G3B	DC	Dental Officer, Advance Clinical Dentist
47G3C	DC	Dental Officer, General Clinical Dentist
47S3	DC	Oral Maxillofacial Surgeon
47H3	DC	Periodontist
47P3	DC	Prosthodontist
47B3	DC	Orthodontist
47D3	DC	Oral Pathologist
47E3	DC	Endodontist
47K3	DC	Pediatric Dentist
48A3	MC	Aerospace Medicine Physician, Spec
48G3	MC	Aerospace Medicine Physician (non-residency trained)
48R3	MC	Residency Trained Aerospace Medicine (RAM) Physician

AFSC	CORPS	DESCRIPTION
4H0X1	Enlisted	Cardiopulmonary Lab Technician
4J0X2	Enlisted	Physical Therapy Technician
4N0X1	Enlisted	Medical Service Technician
4N090	Enlisted	Medical Service Superintendent
4N0X1A	Enlisted	Allergy/Immunology Technician
4N0X1B	Enlisted	Neurology. Technician
4N1X1	Enlisted	OR, Technician
4N1X1B	Enlisted	OR, Technician, Urology
4N1X1C	Enlisted	OR, Technician, Ortho
4N1X1D	Enlisted	OR, Technician, ENT
4R0X1	Enlisted	Radiology Technician
4R0X2	Enlisted	Nuclear Medicine Technician
4P0X1	Enlisted	Pharmacy Technician
4V0X1A	Enlisted	Ophthalmology Technician
4Y0X1	Enlisted	Dental Technician