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THE SECRETARY OF THE AIR FORCE

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*Tactical Doctrine*

**HEALTH SERVICE SUPPORT COMMAND AND  
CONTROL IN EXPEDITIONARY OPERATIONS**

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**PURPOSE:** This Tactics, Techniques, and Procedures (TTP) publication describes a theory and philosophy of command and control (C2) for the Air Force Medical Service (AFMS) in a deployed environment. The intent is to describe how the AFMS can reach effective military decisions and implement effective military actions faster than an adversary in any conflict setting on any scale. In so doing, this publication provides a framework for all medics for the development and exercise of effective C2 **when deployed in support of military operations**. This publication represents a firm commitment by the AFMS to a bold, even fundamental shift in the way it will view and deal with the dynamic challenges of C2, focusing on the direct relationship between the AFMS and its Line of the Air Force (LAF) commanders.

**APPLICATION:** This publication applies to all Air Force military and civilian personnel (including Air Force Reserve Command [AFRC] and Air National Guard [ANG] units and members when deployed in Title 10 status). The doctrine in this document is authoritative but not directive.

**SCOPE:** The AFMS must be able to rapidly respond to the full-spectrum of mission requirements within the Air and Space Expeditionary Force (AEF) construct. This document provides airmen information on the overarching principles, processes, procedures, and organizational framework through which the AFMS plans, directs, and executes the health service support mission in deployed conditions. *It does not address domestic response or in-garrison C2.* Although this TTP is written for Air and Space Expeditionary Task Forces (AETF) in deployed settings, it has applicability across the spectrum of military operations.

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## CHAPTER 1

### ORGANIZATIONS, ROLES, AND RESPONSIBILITIES

**1.1. Introduction.** To support the Expeditionary Air Force and global engagement requirements, senior Line of the Air Force (LAF) and medical leadership must ensure command and control (C2) infrastructures are in place, understood, and executable. Health Service Support (HSS) C2 should be flexible, versatile, and capable of ensuring commanders and HSS personnel receive the most current planning, pre-deployment, deployment, employment, and redeployment information as well as associated post-deployment activities to support the warfighter. HSS provides casualty care and management, force sustainment, force health protection, human performance enhancement, and medical threat assessment in the area of operations (AO) (See AFDD 2-4.2, *Health Services* for a further description of the Air Force Medical Service [AFMS].)

**1.1.1.** The following medical tenets apply to the guidance contained in this TTP:

**1.1.1.1. Sustainment of the Human Weapons System.** HSS provides a broad range of services to ensure that personnel are physically and mentally prepared and sustained for contingency operations.

**1.1.1.2. Evacuate and Replace.** HSS doctrine has evolved from a return to duty focus to an emphasis on evacuate and replace. The large theater medical infrastructure of contingency hospitals, fixed medical treatment facilities, and clinics has drawn down commensurate with overseas LAF forces. With this reduced medical footprint, the interface between HSS facilities, Patient Movement Requirement Centers (PMRC), and Service patient movement systems is even more critical.

**1.1.2. Headquarters Air Force Surgeon General (HQ AF/SG), and Major Command Surgeons (MAJCOM/SGs).** HQ AF/SG and MAJCOM/SGs play an important role in HSS tactical doctrine. Each executes the medical portion of Service Department responsibilities under Title 10, United States Code to “organize, train and equip” to meet Combatant Commander requirements. Each provides trained, technically proficient, well-equipped and highly organized medical personnel to meet the mission requirements employed and sustained by the theater/deployed AFFOR/SG staff. The HSS policies and protocols for a theater of operations are directed by the AFFOR/SG. There is no relationship to parent or previously hosted command MAJCOM/SG policies or protocols.

### **1.2. Command and Control.**

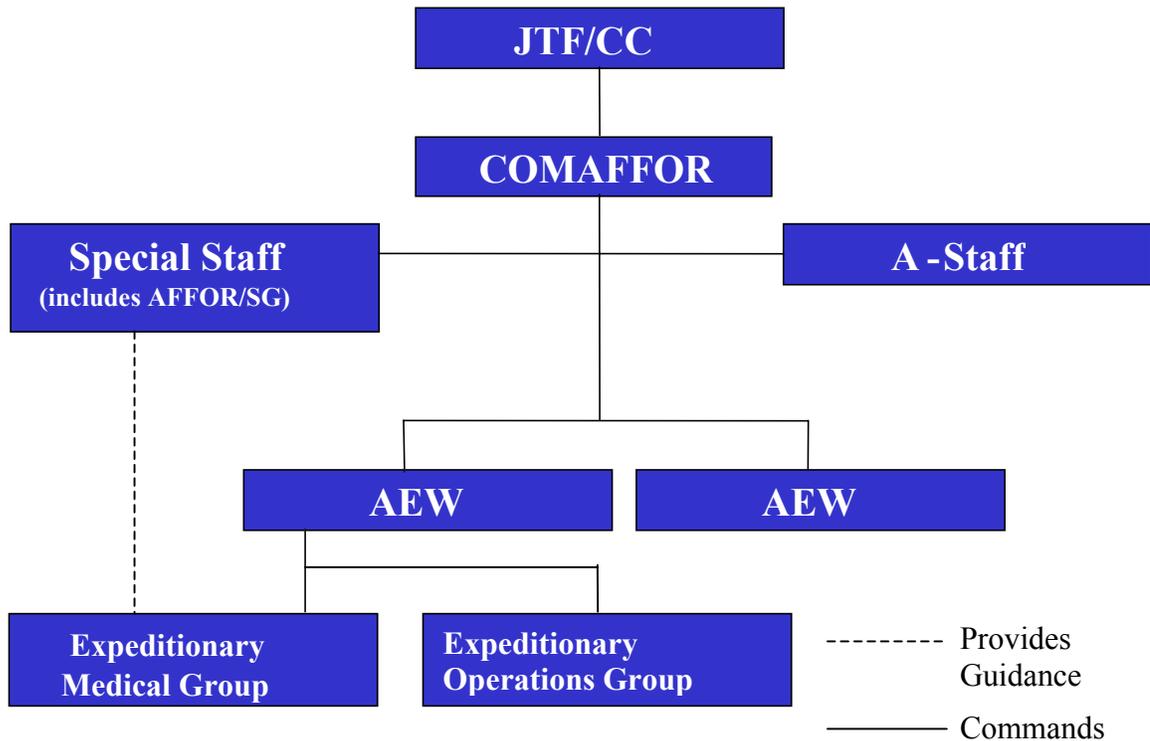
**1.2.1.** C2 is the exercise of authority and direction by a properly designated commander over assigned and attached forces in the accomplishment of the mission. C2 functions are performed through an arrangement of personnel, equipment, communications, facilities, and procedures employed by a commander in planning, directing, coordinating, and controlling forces and operations for mission accomplishment. (Reference AFDD 2-8, *Command and Control*.) Key terms associated with C2 are in the glossary.

1.2.2. It is crucial that airmen understand their chain of command. For the medic, appropriate C2 achieves the unity of effort and integration required to meet support requirements across the entire spectrum of HSS operations. HSS resources, including money, manpower and materiel, are scarce and must be planned, deployed, and employed for the maximum operational effect. Deploying personnel should receive a chain of command briefing prior to deployment.

1.2.3. **LAF Command and Control of the AFMS.** HSS C2 is vested through the LAF. From an independent duty medical technician (IDMT) serving in a remote site, to the commander of an Air Force Theater Hospital (AFTH), to the Air Force Forces Surgeon (AFFOR/SG), all report to and are accountable to the LAF personnel at their level of command for execution of the HSS mission.

**Air and Space Expeditionary Forces (AEF).** An AEF is an organizational structure composed of force packages of capabilities that provides combatant commanders with rapid and responsive air and space power. These force packages are tailored to meet specific needs across the spectrum of response options and will deploy within an Air and Space Expeditionary Task Force (AETF), as Air Expeditionary Wings (AEWs), Air Expeditionary Groups (AEGs) or Air Expeditionary Squadrons (AESs).  
 –AFDD 2, *Organization and Employment of Air and Space Power*

Figure 1.1. Notional Joint Task Force Structure



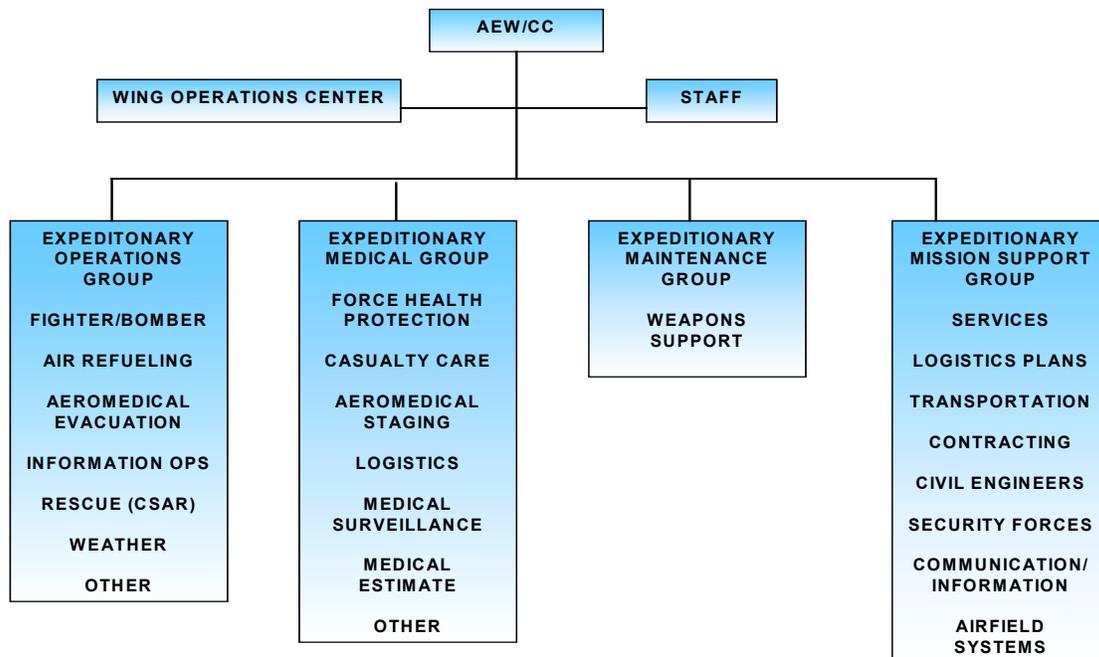
### 1.3. Joint Task Force Structure.

**1.3.1. Commander, Air Force Forces (COMAFFOR).** (See Figure 1) In any operation, a COMAFFOR is designated from the USAF and serves as the commander of USAF forces assigned and attached to the USAF component. USAF elements deployed in an expeditionary role are designated as an Air and Space Expeditionary Task Force (AETF). Normally, deployed forces come under the command of a Joint Force Commander (JFC) (See JP 3-0, *Doctrine for Joint Operations*).

**1.3.2. Special Staff: Air Force Forces Surgeon (AFFOR/SG).** The AFFOR/SG, a corps-neutral medical officer usually at the rank of colonel, is a member of the COMAFFOR special staff and is the director of USAF health service operations. The AFFOR/SG is responsible for overall health resources management and provides information on health surveillance and risk assessments, sustainment, and other force health protection issues. The AFFOR/SG does not exercise command authority or direct control over medical forces, but provides a policy, planning, coordination, and oversight function for the combatant commanders.

**1.4. Air and Space Expeditionary Wing.** An Air and Space Expeditionary Wing (AEW) is a deployed wing attached to an AETF by G-series orders. An AEW normally is composed of the wing command element and two or more expeditionary groups. (See Figure 1.2).

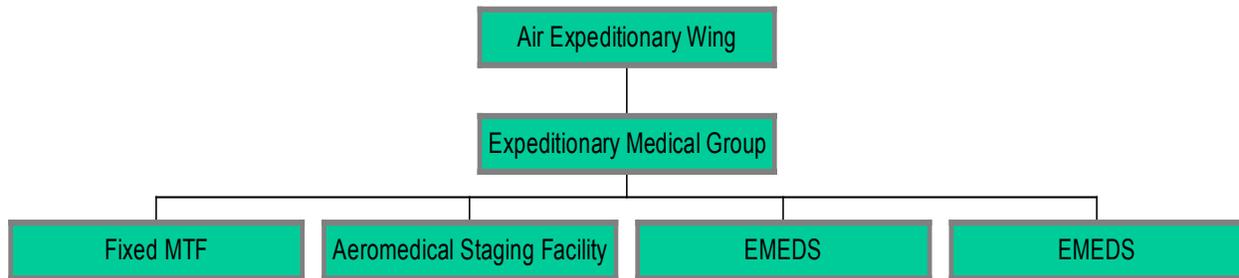
**Figure 1.2. Notional Air Expeditionary Wing Structure**



The AEW commander has administrative control (ADCON) of all assigned AEW assets, including medical support (except Air Reserve Component (ARC) personnel—See paragraph

1.9). C2 of HSS operations in joint and combined operations is defined in the warning/execution/operations order. The elements of medical support fall under the Expeditionary Medical Group (EMG). AE assets fall under the Expeditionary Operations Group (EOG), reference AE TTP 3-42.5 for further discussion. During deployments, understanding who controls forces is critical. EMG/CC controls the fixed Medical Treatment Facility (MTF), Contingency Aeromedical Staging Facility, and Expeditionary Medical Support (EMEDS)/AFTH. (See Figure 1.3).

**Figure 1.3. Expeditionary Medical Group in the AEW structure.**



## 1.5. Expeditionary Medical Group:

**1.5.1. Deployed Medical Commander (DMC).** The DMC is the commander of the deployed HSS assets, designated on G-series orders specifically for the deployment and is responsible to the AEW commander for HSS of the deployed population. The DMC functions similarly to a medical group commander (MDG/CC), and exercises professional oversight of all assigned or attached Air Force medical personnel, including squadron medical elements (SMEs) and independent duty medical technicians (IDMTs). The DMC communicates and coordinates with the AFFOR Surgeon on theater medical support issues and with other joint and combined medical units at his location. If an EMEDS or AFTH facility is deployed to an existing site with a MTF), the DMC and the MDG/CC establish the framework for cooperative efforts among AF medical personnel.

**1.5.2. Squadron Medical Elements (SMEs) or Independent Duty Medical Technicians (IDMTs) With and Without Deployed Medical Facility Support.** SMEs and IDMTs are under the C2 of LAF commanders; specifically, the commander of the unit to which they are assigned. However, while they report to their LAF commander, they are a part of and contribute a valuable resource to the overall medical capability of a base or operating location. As such, SME and IDMT personnel are under the professional guidance of the DMC (vice ADCON or tactical control [TACON]) when deployed along side an EMEDS or AFTH facility. In these instances, the DMC establishes the framework for cooperative efforts among Air Force medical personnel at the deployed location, ensuring a seamless and continuous medical support system for the warfighter. As the operations allow, the SMEs and IDMTs should be integrated into the day-to-day operation of the deployed medical facility, including sick-call coverage, mass immunizations, industrial/shop inspections, and other force health protection efforts. **If no EMEDS/AFTH component is present, the senior medical member (i.e., SME or IDMT) present is responsible for coordinating**

**health service support activities.** If SMEs or IDMTs are deployed to an existing site with an MTF, the MDG/CC exercises medical/dental professional oversight of the SMEs and/or IDMTs. In these instances, the MDG/CC establishes the framework for cooperative efforts among Air Force medical personnel and communicating with the AFFOR Surgeon and MAJCOM/SG staff. (See AFI 48-149, *Squadron Medical Elements* for further details).

Soon after arrival the US Army Command Surgeon for the Hungarian AOR called to inform us that we reported to him. 60 AEW stated we reported to them and the 86<sup>th</sup> in Ramstein AB asked us to report to them. We decided to report to the 60<sup>th</sup> but courtesy copied the other units. The 74 ACS was also located in Budapest but with no flight surgeon support. We volunteered to support their operations although they reported directly to 16 AF in Aviano AB.

A published medical chain of command for reporting should be established prior to deployment.

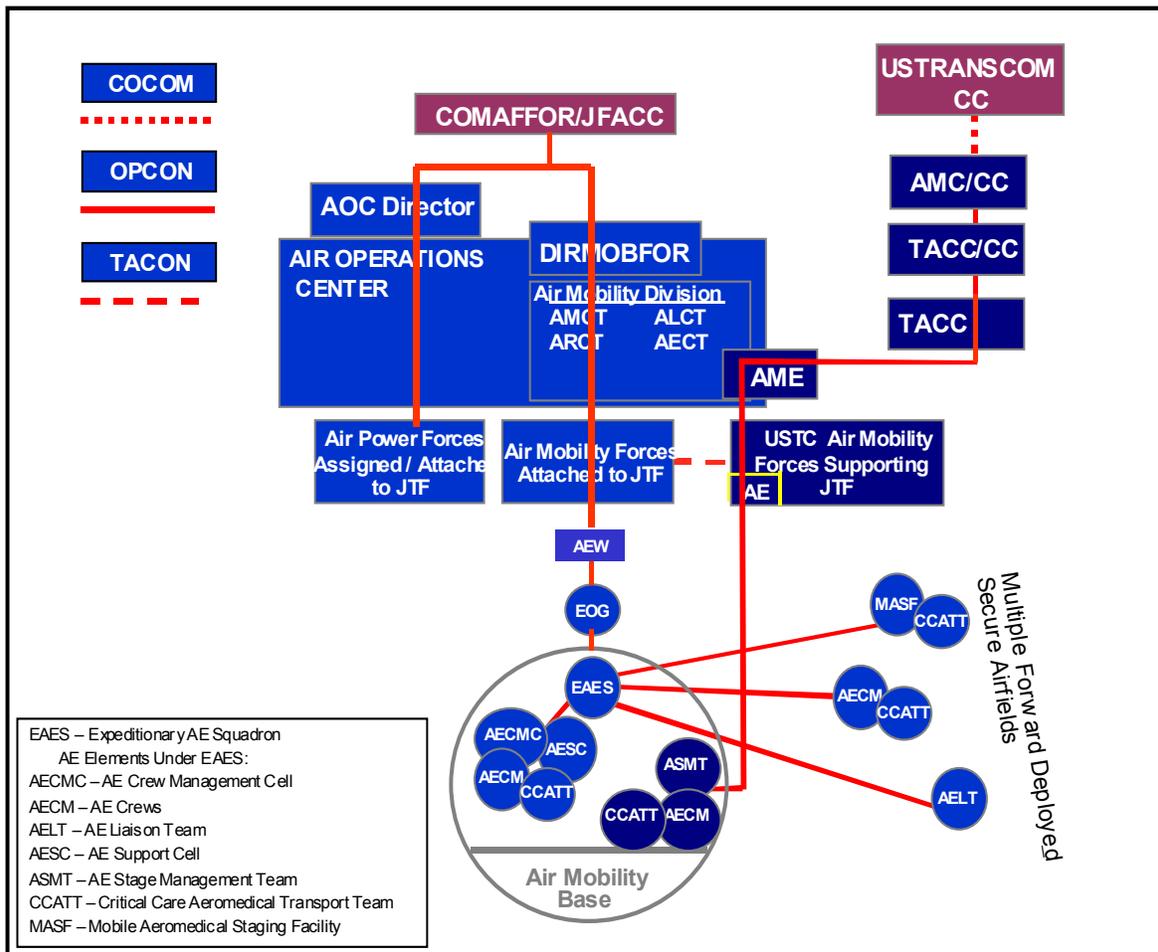
-Deployed Medical Commander in OEF

## 1.6. Aeromedical Evacuation.

**1.6.1.** AFTTP 3-42.5, *Aeromedical Evacuation* describes AE command and control in detail.

**1.6.2. Aeromedical Evacuation (AE) Command and Control.** C2 functions exercised over AE missions are consistent with those for all air mobility missions and are handled in accordance with the C2 structures described in JP 3-17, *Joint Doctrine and Joint Tactics, Techniques, and Procedures (JTTP) for Air Mobility Operations*; AFDD 2, *Organization and Employment of Air and Space Power*; AFDD 2-6, *Air Mobility Operations*; and Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42.5, *Aeromedical Evacuation*. The Tanker/Airlift Control Center, Air Mobility Operations Control Center (AMOCC) or theater AOC, provides C2 for air mobility assets used to accomplish AE missions within their respective areas of operation during mission execution. Decisions that affect patient medical care or destination medical facilities takes place with the advice and coordination of the Patient Movement Requirements Centers (PMRCs). When medical requirements warrant changes to a specific AE mission, those changes are coordinated through the AE cell within the appropriate airlift control center.

Figure 1.4. AE Contingency Structure.



### 1.6.3. Patient Movement Requirements Centers (PMRCs)—Global, Theater, and Joint.

The PMRC is a joint activity that coordinates patient movement for all modes of transportation, ground, water, or air. PMRCs should exist at the joint level, as an element of the joint movement center, to ensure coordination of joint Service capabilities. PMRCs are the single responsible agents in their respective theaters or area of responsibility (AOR) for patient movement management, projected patient movement requirements for Unified Command validation, regulating to appropriate medical facilities for treatment, coordination with component lift agencies for evacuation, and patient in-transit visibility. PMRCs have the authority to ensure patient movement and bed requirements are communicated to supporting agencies, healthcare facilities, and government agencies within their AOR. The PMRC may be joint, reporting to the joint task force surgeon; theater, reporting to the theater surgeon; or global, reporting to the US Transportation Command (USTRANSCOM) surgeon.

**1.7. AFMS Support in Military Operations Without a COMAFFOR.** Some military scenarios requiring medical support may involve AFMS personnel as the only AFFOR in an AOR. An example is a humanitarian relief operation, in which an Air Force medical team, in support of a JFC mission, provides medical support to a host nation's indigenous population. In

a situation of this nature, a medical commander is designated and the medical unit may be attached to the JFC who exercises command authority over the Air Force medics. Or, the medical unit may be in direct support of the JFC mission and command authority resides within the supporting commander's channels. (Reference JP 0-2, *Unified Action Armed Forces [UNAAF]*, for additional discussion of command authorities and relationships.) In these cases, the medical commander may be designated as the COMAFFOR. If a COMAFFOR is not designated, a deployed medical element should communicate operational issues with the theater SG staff responsible for the theater of operation. Medical commanders will have no command authority over LAF forces.

**1.8. Air Force Medical Support for Special Operations Forces (SOF).** Air Force Special Operations Command (AFSOC) is unique in that it is aligned under a functional unified command, US Special Operations Command (USSOCOM). AFSOC functions as both an Air Force MAJCOM and as the air component of USSOCOM. With this type of relationship, command and control is dependent on the structure assigned for the given operation or mission. Traditionally, when AFSOF are tasked to perform joint force special operations component commander missions, C2 should be through an established joint special operations air component commander. AFSOC operational medical personnel are under the C2 of the Air Force commanders. While they report to a LAF commander, they are part of, and contribute a valuable resource to, the overall medical capability of a base or operating location. In addition to providing medical support in a forward area, AFSOC medics perform casualty evacuation missions, assist with personnel recovery, and infiltration/exfiltration missions. When collocated with conventional medical assets or in a joint arena, the AFSOC DMC or senior member establishes the framework for a joint cooperative effort. AFSOC medical personnel may be under the professional oversight of a conventional medical commander (i.e., the DMC) or the senior medical officer on the base or operating location for clinical issues; or where applicable, the joint special operations task force surgeon. With the possibility of dual C2 and LAFs of communication at one operating location, it is essential medical roles and missions be communicated and an operating framework established.

**1.9. Air Reserve Component (ARC) Personnel.** Under full mobilization, full ADCON authority goes to the COMAFFOR. Under less than full mobilization, the COMAFFOR receives specified ADCON that includes Uniform Code of Military Justice (UCMJ) authority, force protection requirements, and other specific authorities written in G-series orders. The Air Reserve Component (ARC) retains all other ADCON authorities. The DMC may also receive specified ADCON (with UCMJ authority), written in G-series orders, for deployed ARC personnel.

## CHAPTER 2

## HEALTH SERVICE SUPPORT OPERATIONS

**2.1. Introduction.** The drive to the AEF has created an expeditionary mindset through the Air Force. Central to this mindset has been the need to meet mission requirements while responding more quickly, with more flexibility, and with a smaller logistics footprint and infrastructure. AEF has generated a planning environment where the Air Force may have only hours and days, rather than weeks or months, to project air and space power. HSS commanders and staff must understand each phase of the deployment process, to include an understanding of the levels of orders (e.g., Alert Order, Warning Order) and associated timelines. (Reference JP 5-0, *Doctrine for Planning Joint Operations* and AFSC PUB 1, *The Joint Staff Officer's Guide* for additional discussion on crisis action phases/planning/procedures and levels of orders.)

**2.2. Preparation.** Preparation begins with the earliest possible assignment of qualified personnel to tasked Unit Type Codes (UTC). Those assigned to *EMEDS UTCs should be given top* priority for attendance at the EMEDS Basic Course, Brooks AFB. This course should be complemented with multiple classified and unclassified sources, including:

**2.2.1.** LAF Intelligence reports/briefings, Judge Advocate General analysis, communication and logistical analysis.

**2.2.2.** Local medical intelligence officer (public health officer): disease threats and countermeasures, host nation medical capabilities, food and food sources, environmental conditions.

**2.2.3.** Local medical logistics office: allowance standard for assemblage; equipment familiarization; physical inventory of equipment UTCs.

**2.2.4.** Local medical readiness office: review AFI 41-106, *Medical Readiness Planning and Training* requirements.

**2.2.5.** MAJCOM Readiness offices: establish relationship for future communication, current modernization efforts for UTC, after action reports from previous deployments and exercises.

**2.2.6.** International Health Specialists consultation.

**2.2.7.** Manpower and Equipment Force Packaging (MEFPAK) Command for UTC (note: Air Combat Command (ACC) is MEFPAK for ground medical assemblages; Air Mobility Command (AMC) for AE and AE ground support UTCs; and Air Force Special Operations Command (AFSOC) for SOF Medical UTCs.)

**2.2.8.** On-line open resources: News sites for current and background information; CIA Fact Book – <http://www.cia.gov/>; [www.GlobalSecurity.org](http://www.GlobalSecurity.org) ; routine word searches for potential host nation information on common browsers such as [www.google.com](http://www.google.com).

**2.2.9.** Courses listed in Chapter 4 of this publication.

**2.3. Pre-deployment.** Upon receipt of an alert, prepare to deploy, warning order, or other notification from higher headquarters, the local medical readiness officer should conduct a pre-deployment conference and review of key documents and responsibilities with deploying UTC team chiefs.

**2.3.1. Documents.** Key documents include the unit Designed Operational Capability (DOC) statement and Status of Resources and Training System report; Medical Readiness Decision Support System, AEF Resourcing Tool, formal orders; time-phased force deployment data (TPFDD); medical intelligence reports; general intelligence reports; and force protection threats and responsibilities. The deploying medical commander should also accomplish the following actions:

**2.3.1.1.** Review appropriate medical doctrine and consider taking a CD-ROM or hard copy of applicable operational and tactical doctrine. AFMS doctrine can be found at <https://www.afms.mil/sg/index.htm>.

**2.3.1.2.** Verify deployability of UTC-assigned personnel. Identify and track shortfalls to resolution.

**2.3.1.3.** Establish mechanism for contacting supporting communications, intelligence, logistics, and security force units for input on services and capabilities relating to, or provided at, the deployed location. Obtain base support plan if available.

**2.3.1.4.** Confer with public health/medical intelligence officer for location-specific information on disease and environmental threats, countermeasures, host nation medical capabilities, approved sources for food and water, and other environmental factors.

**2.3.1.5.** Personally assess the deployability of equipment UTCs. Identify shortfalls, fill actions and work-arounds prior to deployment.

**2.3.1.6.** Compile references including applicable Air Force instructions and Concept of Operations (CONOPS) and prepare CD-ROM to carry on deployment. As a minimum, commanders should consider taking the Preventative Aerospace Medicine, Biological Augmentation Team, EMEDS, and Mobile Field Surgical Team CONOPS. Current CONOPS editions are available at <https://www.afms.mil/sgxr/conops.cfm>.

**2.3.1.7.** Review deployment order for command relationships, special instructions, and force health protection issues including public health, biological warfare/chemical warfare (BW/CW) threats, and immunization needs.

**2.3.1.8.** Contact local Logistics Readiness Squadron for transportation schedule. Note: personnel and equipment may not travel together.

**2.3.1.9.** Contact MAJCOM Readiness offices for relevant TPFDD analysis. The TPFDD presents a wealth of information on planned forces and capabilities at locations throughout the theater. Specific information to be extracted includes:

- 2.3.1.9.1. Origin of all medical UTCs deploying to the location of interest.
- 2.3.1.9.2. Medical capabilities at all theater locations.
- 2.3.1.9.3. Identification of lead LAF units and their deployed locations.
- 2.3.1.9.4. Population at risk by location.
- 2.3.1.9.5. Location of the PMRC.
- 2.3.1.9.6. Locations of AFFOR headquarters and AFFOR/SG, component surgeons and theater combatant commander's surgeon.
- 2.3.1.9.7. Medical resources already deployed or arriving prior to unit of interest.
- 2.3.1.9.8. After TPFDD analysis, contact other medical UTC team chiefs planned for the common destination.

**2.3.2. Pre-Deployment Orders.** The operation order (OPORD)/execute order identifies operational control (OPCON), tactical control (TACON), mission objectives, rules of engagement, force protection, handling of classified information, hazardous cargo, and other mission specific requirements for the deployment. *It must be thoroughly understood.*

**2.4. Deployment/In-Transit Phase.** The movement phase is critical for DMCs who must strive to maintain maximum control over deploying medical personnel and assemblages. Careful attention must be given to:

- 2.4.1. Designation of troop commanders.
- 2.4.2. Establishing accountability standards for deploying personnel (reporting for movement.)
- 2.4.3. Clarifying transition of "ownership" of the deploying UTCs from the supplying MAJCOM to the theater combatant commander.
- 2.4.4. Establishing procedures for individuals who become ill, incapacitated, or reassigned enroute.
- 2.4.5. In-transit visibility of movement of UTCs deploying from different origins and aerial ports of embarkation.
- 2.4.6. Appointment of designated couriers for controlling and securing hand-carried classified materials, weapons and ammunition, and controlled items (e.g., narcotics).
- 2.4.7. Timely and accurate Medical Report for Emergencies Disasters, and Contingencies (MEDRED-C) reporting.

**2.5. Employment.** To maintain appropriate C2 over deployed medical assets, the DMC must address the following areas: force beddown; base operating support, security and force protection; patient movement and patient movement items; logistics and resupply; procurement; blood products; and medical organizational structure and personnel management. Each of these areas is addressed in the OPORD. Upon arrival, the DMC must identify appropriate points of contact and establish procedures to do the following:

**2.5.1.** Track arriving personnel (through personnel support for contingency operations) and equipment (through logistics plans) UTCs.

**2.5.2.** Fill transportation/vehicle requirements (rentals, pre-positioned vehicles). Establish communications to include cellular phones, secure telephone equipment phones, Secure Internet Protocol Router Network (SIPRNET) and Non-Secure Internet Protocol Router Network (NIPRNET) links and computer networks.

**2.5.3.** Prepare and exercise mass casualty plans.

**2.5.4.** Obtain contracting support for local purchase as needed.

**2.5.5.** Prepare and provide for the installation casualty plans.

**2.5.6.** Generate medical reports (see Chapter 3).

**2.5.7.** Implement public health and bioenvironmental engineering services.

**2.5.8.** Meet specific aviation medical requirements.

**2.5.9.** Implement behavioral health services and critical incident stress management processes.

**2.5.10.** Host nation medical facilities and joint/combined medical units that meet acceptable standards of care serve as force multipliers. Local capabilities should be fully assessed to determine medical and surgical specialties and capacities available. Relationships may be forged through inter-facility education and mass casualty exercise opportunities in addition to formal memorandums of agreement.

**2.6. Redeployment.** The theater combatant commander authorizes the redeployment of medical resources. The DMC must receive approval from the local LAF commander and theater combatant command surgeon (via the AFFOR/SG) before redeployment of any medical personnel or materiel assets. The DMC must actively participate in redeployment planning, including preparing a time-phased reduction in medical services consistent with the deactivation of the deployed location and the threat scenario. If no EMEDS/AFTH component is present, the senior medical officer present will coordinate medical redeployment activities. Associated activities include:

- 2.6.1.** Careful and thorough reconstitution of deployed medical assets, to include inspection and preparation of equipment assets by the bio-medical equipment technician.
- 2.6.2.** Cargo and personnel transportation planning requirements.
- 2.6.3.** Transition planning, if required.
- 2.6.4.** Blood and biological waste disposition.
- 2.6.5.** Post-deployment medical surveillance requirements (health questionnaires).
- 2.6.7.** Termination and close-out of final reports.
- 2.6.8.** Destruction or storage/transportation of classified materials.
- 2.6.9.** Disposition of dated items not suitable for redeployment (pharmaceuticals, sterile supplies, etc.) and BW/CW antidotes.
- 2.6.10.** Personnel actions, including performance reports, letters of evaluation, and decorations.
- 2.6.11.** Preparation of debriefs and after-action reports in AFFOR/SG-specified format.

## CHAPTER 3

### COMMAND, CONTROL, COMMUNICATION AND INFORMATION SYSTEMS (C3I)

**3.1. Introduction.** Command, Control, Communication, and Information Systems (C3I) assets must be identified in the planning process and deployed to meet tactical and strategic C2 mission requirements. C3I must also link forward medical elements, through each level of command to final destination hospitals.

**3.2. Coordination with the Host AEW Infrastructure.** The HSS communication systems/equipment used must be interoperable to optimize joint area communications and frequency management operations. Communication planners must coordinate frequency requirements through appropriate frequency management channels (e.g.; installation, MAJCOM, and theater) to ensure all radiating equipment is spectrum certified and frequency supportable. Also, host-nation coordination must be initiated before a full-scale deployment. Non-programmable systems are usually not acceptable or recommended in a deployed theater of operation. Compatibility between intra-base radio systems is essential. Commanders should not assume compatibility since units come from multiple CONUS installations. Land-Mobile Radio systems integral to HSS tactical elements may or may not be compatible (especially with secure or private-LAF systems) with each other. It is essential that all HSS communications and computer systems can be sustained through maintenance capabilities provided by the deployed Expeditionary Communications Squadron or Flight. Recommend particular attention to communication and maintenance support in bare base locations where communication infrastructure is limited. Commanders should actively communicate with the AFFOR Surgeon to avoid taking equipment that cannot be maintained in theater.

**3.3. Organic HSS Communication & Information Systems.** Prior to deployment, the deploying medical commander should ensure any organic communication and computer systems are compatible with deployed forces' communication and computer systems by coordinating requirements and capabilities to higher headquarters planners. This is especially important when organic satellite communications are engaged to support telemedicine and other medical unique system requirements.

**3.4. Medical Reports and Communication.** All medical reports are submitted in accordance with AFMAN 10-206, *Operational Reporting* and specific Combatant Commander, JTF, and AFFOR guidance.

**3.4.1. Medical Report for Emergencies Disasters, and Contingencies (MEDRED-C).**

The MEDRED-C is a status report of HSS operations. This report is accomplished daily and communicated to the AFFOR surgeon, supported and supporting MAJCOM/SGs, and the HQ AF/SG. For sustained operations, the MEDRED-C may be required weekly with the concurrence of the AFFOR/SG. (See Attachment 2 for example of the MEDRED-C.) The MEDRED-C is an on-site assessment of the deployed medical unit ability to complete its mission. This report provides information on the operational readiness status, unit availability, and patient care activities of HSS units on alert for contingency operations, or which have come under the influence of an unusual occurrence (natural disaster or other emergencies). (See AFM 10-206, *Operational Reporting* for further information.)

**3.4.2. Situation Report (SITREP).** As a minimum, the MEDRED-C and deployed wing commander's SITREP must be accomplished. The SITREP is prepared in a narrative format, evaluating significant factors relating primarily to readiness, mobilization, personnel, and logistics. It supplies an overall mission review of a deployed UTC. The SITREP will often include the number of people supporting (Population at Risk), diseases by category being seen and numbers of individuals in each.

**3.4.3. USTRANSCOM Regulating Command and Control Evacuation System (TRAC2ES).** In transit visibility may be accomplished through standard mobility automated systems or the TRAC2ES. Patient Movement Requests are submitted to the PMRC by the service medical patient administration person in each facility and can be communicated through TRAC2ES.

**3.4.4. Additional reports.** Every deployment may require different deployment reports. These reports provide information that is used to make operational decisions on HSS and to perform medical intelligence analyses during contingency operations. Additional reporting may be established, based on mission, or specific theater requirements. Some of these reports may include: Joint Force Headquarters required Blood Status (BLOODSTAT) Reports, Logistics Status (LOGSTAT), Disease Reports, and Bed Status (BEDSTAT) Reports.

**3.4.4.1.** These reports are typically defined and prescribed in the theater or JTF-Surgeon's series of Letters of Instruction (LOIs), the Joint/Air Component OPODs (Annex K), and theater/JTF's Joint Communications-Electronics Operating Instruction. When time permits commanders and AFFOR staffs should fully indoctrinate and familiarize themselves with all of these documents and publications before deploying to the theater of operations. As the theater matures, fragmentation orders (FRAGO) and amendments to these documents will further clarify and refine instructions for communications and systems. In addition, theater maturation will drive a migration towards the implementation of CONUS in-garrison like communication systems practices and procedures. These include, but are not limited to Communications Security (COMSEC)/ Operations Security (OPSEC) Management, Work Group Manager (WGM) Certifications, Software Anti-Piracy Training and Education (SATE) Certification, and Local Area Network (LAN) Certifications.

**3.4.4.2.** It is important to remember, that in spite of higher headquarters reporting requirements, the HSS commander should always insure that the AEW Commander and staffs are aware of these requirements. If necessary, they should be coordinated with them prior to release of any significant operationally sensitive messages from the installation. This is especially important when submitting MEDRED-Cs as a result of significant medical or infrastructure impacting events (e.g. mass casualty incidents, or facility damage incidents) that may or may not impact other AEW resources.

**3.5. Secure/Non-Secure Communications.** HSS or casualty information becomes an OPSEC issue when linked to a particular military mission or operation. While HSS information itself is not normally classified, in the context of a mission, it should be protected as part of the

combatant commander's overall OPSEC program to deny information to the enemy. Observations made by HSS personnel may be integral to the overall intelligence gathering effort. The deployed HSS commander must be aware of the potentially valuable and sensitive nature of their operational observations and ensure that they are protected by applicable secure transmissions. In many cases classified storage and special space allowance requirements need to be taken into consideration when using secure communication devices. Storage for secure telephone keys and key tapes need to be planned for and employed. The location of these devices also needs to be considered in the facility floor plan and layout to insure sensitive information, when discussed, is protected. In many cases primary and secondary crash networks will eventually be placed on secure tactical phone systems that will require special protection.

## CHAPTER 4

### FORMAL TRAINING

**4.1. Introduction.** C2 training programs should be designed around realistic Force Health Protection scenarios that demand decision making within realistic timeframes to increase the training effect. This is achieved through dynamic curricula that anticipate the evolving environment. Training programs involving the full range of air and space power capabilities within a wide range of military operations provide a comprehensive training experience.

**4.2. Training Courses.** AFI 41-106, *Medical Readiness Planning and Training* directs specific basic training requirements for medical personnel. There are several additional training courses that enhance understanding of both LAF and HSS C2 principles and practices. The following curriculums are recommended:

**4.2.1. Joint Operational Medical Managers Course.** The Joint Operational Medical Managers Course is a course intended for commanders and executive staff members of deployable medical assemblages, but is a must for anyone holding a key senior staff position on the AFFOR SG staff. All AFFOR/SGs should be graduates of this weeklong course held twice a year through the Defense Medical Readiness Training Institute, Ft Sam Houston, San Antonio, TX.

**4.2.2. Joint Task Force Surgeon Seminar.** This course is hosted by the U.S. Joint Forces Command Surgeon, Norfolk, Virginia and held once a year. Only officers identified for AFFOR Surgeon and possible Joint Task Force Surgeon assignments should attend. This is a O-6 forum for theater medical command maturation. The ACC Surgeon solicits applications every year for this one-week course.

**4.2.3. Military Operations Other Than War Course.** The Military Operations Other Than War Course is hosted by the Expeditionary Warfare Training Center, Little Creek Naval Base, Virginia. It is designed to teach the planning and sustainment of military operations in lesser than wartime scenarios. It is a joint, multifunctional course. All AFFOR planners/staff members should attend this one-week course.

**4.2.4. Joint Medical Planner Course.** The Joint Medical Planner Course is hosted by the Office of the Joint Chiefs of Staff, Directorate of Medical Plans and held at Bethesda, Maryland. It is a three-week joint medical planner's forum for learning key deployment and employment planning. It is joint oriented and does not key on specific AFFOR SG processes. Along with Contingency Wartime Planning Course (CWPC), it is one of the core courses for all AFFOR SG staff members.

**4.2.5. Contingency Wartime Planning Course (CWPC).** The CWPC educates airmen in grades E-5 through O-5 in the art and science of contingency war planning. Provided through the Air University, should be the "first step" for all AFFOR/SG planners to understand the language and processes involved in both Deliberate and Crisis Action Planning (CAP). However, the CWPC is a two-week deployment course supporting in-garrison/predeployment CAP processes, and does not include in theater employment,

generation, force protection, sustainment and redeployment considerations. More information can be found at [http://www.au.af.mil/au/au\\_catalog\\_2002\\_03/au\\_cat\\_2002-03.pdf](http://www.au.af.mil/au/au_catalog_2002_03/au_cat_2002-03.pdf).

**4.2.6. Crisis Response Senior Seminar.** The Crisis Response Senior Seminar is offered by the Joint Special Operations University, Hurlburt Field, FL and is designed to educate colonels and above in the joint response aspects of DOD response to terrorism events. It combines the concepts of Crisis Management and Consequence Management as defined by Presidential Decision Directive 39. All potential AFFOR and JTF Surgeons should attend. A TOP SECRET clearance is required. See <http://www.hurlburt.af.mil/milonly/tenantunits/jsou/>.

**4.2.7. Emergency Preparedness Course.** The Emergency Preparedness Course supported through HQ USAF/XOH, at Mt Weather, VA and is a one-week course that teaches DOD response to disasters. While this focuses primarily the principles for a domestic response, it is applicable to overseas U.S. territories and possessions.

**4.2.8. EMEDS Basic Course,** provided at the USAF School of Air and Space Medicine, Brooks AFB, TX. A one-week course designed to familiarize personnel assigned to EMEDS UTCs with operational orientation.

**4.2.9.** Selective SOF C2 and area study courses provided by the Joint Special Operations University, at Hurlburt Field, Florida. See <http://www.hurlburt.af.mil/milonly/tenantunits/jsou/>.

**4.2.10. Aeromedical Evacuation Contingency Operations Training Course.** The Aeromedical Evacuation Contingency Operations Training Course is the premier USAF training course on AE operations for both clinical and operational element, as well as integration of crews into the theater AE system. This course is located at Sheppard AFB, TX.

**4.2.11. Tactical Aeromedical Training Course.** The Tactical Aeromedical Training Course provided through Air Mobility Command, is a theater AE tactics and procedures course that builds upon the training provided in Aeromedical Evacuation Contingency Operations Training and expands the tactical level of experience for the AE operations leader.

**4.2.12 Air Mobility Operations Course,** Air Mobility Warfare Center, McGuire AFB, NJ. The Air Mobility Operations Course is a LAF course which teaches the full-spectrum of airlift operations. This course for all functional areas within the airlift community. All senior AE officers should attend this course.

## Attachment 1

## GLOSSARY OF REFERENCES AND SUPPORT INFORMATION

*References*

JP-02, *Unified Action Armed Forces* [UNAAF]  
 JP 3-17, *Joint Doctrine and Joint Tactics, Techniques, and Procedures (JTTP) for Air Mobility Operations*  
 JP 5-0, *Doctrine for Planning Joint Operations*  
 AFDD 2, *Organization and Employment of Air and Space Power*  
 AFDD 2-8, *Command and Control*  
 AFDD 2-4.2, *Air Force Doctrine on Health Services*  
 AFDD 2-6, *Air Mobility Operation*  
 AFSC PUB 1, *The Joint Staff Officer's Guide*  
 AFTTP 3-42.5, *Aeromedical Evacuation*  
 AFM 10-206, *Operational Reporting*  
 AFI 41-106, *Medical Readiness Planning and Training*

*Abbreviations and Acronyms*

ACC	Air Combat Command
ADCON	Administrative Control
AE	Aeromedical Evacuation
AEF	Air and Space Expeditionary Force
AEG	Air Expeditionary Group
AES	Air Expeditionary Squadron
AETF	Air and Space Expeditionary Task Force
AEW	Air Expeditionary Wing
AFDD	Air Force Doctrine Document
AF/SG	Air Force Surgeon General
AFFOR	Air Force Forces
AFFOR/SG	Air Force Forces Surgeon
AFMS	Air Force Medical Service
AFRC	Air Force Reserve Command
AFSOC	Air Force Special Operations Command
AFSOF	Air Force Special Operations Force
AFTH	Air Force theater hospital
AMC	Air Mobility Command
AMOCC	Air Mobility Operations Control Center
ANG	Air National Guard
AO	area of operations
AOR	area of responsibility
ARC	Air Reserve Component
BMET	bio-medical equipment technician
BW/CW	biological warfare/chemical warfare
C2	command and control

C3I	command, control, communication and information systems
CAP	crisis action planning
COMAFFOR	commander, Air Force forces
COMSEC	communications security
CONOPS	concept of operations
DMC	deployed medical commanders
DOC	designed operational capability
EMEDS	expeditionary medical support
EMG	expeditionary medical group
EOG	expeditionary operations group
FRAGO	fragmentation order
HSS	health service support
IDMT	independent duty medical technician
JFC	joint force commander
JTF	joint task force
JTTP	Joint Tactics, Techniques, and Procedures
LAF	Line of the Air Force
LAN	local area network
LOI	letter of instruction
MAJCOM	major command
MAJCOM/SG	Major Command Surgeon
MDG	medical group
MEDRED-C	medical report for emergencies, disasters and contingencies
MEFPAK	manpower and equipment force package
MTF	medical treatment facility
NIPRNET	Non-Secure Internet Protocol Router Network
OPCON	operational control
OPORD	operations order
OPSEC	operations security
PMRC	patient movement requirements center
SATE	Software Anti-Piracy Training and Education
SIPRNET	Secure Internet Protocol Router Network
SITREP	situation report
SME	squadron medical element
SORTS	Status of Resources and Training System
TACON	tactical control
TPFDD	time-phased force deployment data
TRAC2ES	USTRANSCOM Regulating Command and Control Evacuation System
TTP	Tactics, Techniques and Procedures
UCMJ	Uniformed Code of Military Justice
USSOCOM	US Special Operations Command
USTRANSCOM	US Transportation Command
UTC	unit type code
WGM	work group manager

## *Glossary*

**advanced echelon (ADVON).** An initial deployment element of personnel and equipment within a specific unit type code (UTC). The ADVON portion of a UTC normally consists of the equipment and personnel required to establish an austere operational capability for a period of up to seven days.

**aeromedical evacuation (AE).** . The movement of patients under medical supervision to and between medical treatment facilities by air transportation (JP 1-02)

**Air Force Aeromedical Evacuation System.** Provides fixed-wing movement of patients requiring supervision by AE personnel to locations offering appropriate levels of medical care. The AE system can operate as far forward as fixed-wing aircraft are able to conduct air/land operations.

**air and space expeditionary force (AEF).** Composite organizations of air and space capabilities from which a tailored task force, composed of Air Expeditionary Wings, Groups and Squadrons; is created to provide forces to meet theater combatant commander requirements. An AEF is not a discreet warfighting unit. (AFI 10-400)

**air wing (AEW).** A wing or wing slice assigned or attached to a task force or an in-place NAF by MAJCOM G-series orders. An AEW is composed of the wing command element and some groups. The AEW commander reports to a COMAFFOR.

**command.** 1. The authority and responsibility for effectively using available resources and for planning the employment or organizing, directing, coordinating, and controlling military forces for the accomplishment of assigned missions. It also includes responsibility for health, welfare, morale, and discipline of assigned personnel. (JP 1-02)

**commander, Air Force forces (COMAFFOR).** Serves as the 'single-voice' Air Force commander to the joint force commander for health service support, and is responsible for all Air Force forces assigned or attached to the air component in joint or combined operations.

**control.** 1. Authority that may be less than full command exercised by a commander over part of the activities of subordinate or other organizations. (JP 1-02). [For the purposes of this document, the processes that happen before and during an operation. These involve dynamic balances between commanders directing operations and allowing subordinates freedom of action and is often two-way and involves influencing subordinates and monitoring results. Lastly, there are four basic C2 functions: planning, directing, coordinating, and controlling.] Words in brackets are added for clarity.

**distributed operations.** The process of conducting operations from independent or interdependent nodes in a teaming manner. Some operational planning or decision-making may occur from outside the joint area of operations. The goal of a distributed operation is to support the operational commander in the field; it is not a method of command from the rear. (AFDD 1.2) [The Transportable Blood Transshipment Center (TBTC) and the theater Aeromedical Evacuation Coordination Team (AECT) are examples of independent nodes that team to support

the theater medical system. While the relationships may vary according to the nature of the operation, the design of a distributed operation should enable a more survivable C2 network through distribution of tasks and information. In some instances, the commander may establish a formal supported/supporting relationship between distributed nodes. In other instances, distributed nodes may have a horizontal relationship.] Words in brackets are added for clarity.

**designed operational capability (DOC) statement.** The DOC statement prepared by the parent MAJCOM for each measured unit that outlines the DOC of the unit and contains unit identification, mission tasking narrative, mission specifics, and resources to be measured. It provides a unit commander a clear definition of their unit's wartime capability, based upon the authorized manpower and materiel strength of the unit.

**Expeditionary Air and Space Force.** The concept which defines how the Air Force will organize, train, equip, and sustain itself by creating a mindset and cultural state that embraces the unique characteristics of air and space power – range, speed, flexibility, precision – to meet the national security challenges of the 21<sup>st</sup> century. (AFI 10-400).

**expeditionary medical support (EMEDS)/Air Force theater hospital (AFTH).** The EMEDS/AFTH provides individual bed-down and theater-level medical services for deployed forces or select population groups within the entire spectrum of military operations. The EMEDS/AFTH supports theater combatant commander requirements by providing a modular and flexible theater hospitalization capability.

**Joint Strategic Capabilities Plan (JSCP).** The JSCP provides guidance to the JCS, combatant commanders, and the Services to accomplish tasks and mission based on current military capabilities, apportions resources to combatant commanders, based on military capabilities resulting from completed program and budget actions and intelligence assessments and is the principle vehicle by which the combatant commanders are tasked to develop OPLANs, CONPLANs and functional plans.

**joint task force (JTF).** A JTF is a force composed of two or more Military Departments established by the Secretary of Defense or commander of unified/sub-unified command or other JTF. The JTF's mission has a specific limited objective and the JTF is dissolved when its purpose has been served.

**JTF surgeon.** Appointed by the JTF commander and responsible for establishing, monitoring, or evaluating joint force health service support, including evacuation of the wounded, injured or sick. The JTF surgeon is responsible for coordinating and integrating health service support within the AO.

**Medical Operations Center (MOC) – Pentagon.** Assigned to the Air Force Contingency Operations Staff. Serves as the AF/SG functional area manager (FAM) for all medical UTC management activities. The MOC also serves as the focal point for all Joint Staff Actions for the CJCS and for medical planning reviews and advice to the JCS J-4, Medical Readiness Division.

**patient movement requirements centers (Global, Theater or Joint) (PMRC).** PMRCs are the single responsible agents in their respective theaters or AOR for collaborative patient movement planning, patient movement management, and patient in-transit visibility.

**reachback.** The process of obtaining forces, materiel, capability, or information support from Air Force organizations not forward stationed or forward deployed. (AFDD 2, AFDD 1-2) [Communications and information systems facilitate reachback by providing a seamless information flow of prioritized data to and from forward and rear locations. The reachback C2 is normally provided from a supporting/supported relationship. This relationship gives the forward-deployed Commander, Air Force Forces (COMAFFOR) the support necessary to conduct operations while maintaining a smaller deployed footprint. Effective reachback C2 enhances the operational capability and facilitates informed decision-making of the engaged COMAFFOR. Taking this concept to the tactical level, telemedicine is a prime example of reachback, e.g. providing specialty consultation from outside the AO versus deploying every potential medical capability.] Words in brackets are added for clarity.

**split operations.** Subset of distributed operations. It is usually used to describe those distributed operations conducted by a single C2 entity physically split between two or more geographic locations. A single commander must have oversight of all aspects of a split C2 operation. (AFDD 1-2) [For example, sections of the ATO may be developed from a rear area or backup operation center to reduce the deployed AOC footprint. In this case the AOC, the single C2 entity, is geographically separated and we refer to that as split operations. As a general rule, medical command and control does not include split operations.] Words in brackets are added for clarity.

**supported commander.** 1. The commander having primary responsibility for all aspects of a task assigned by the Joint Strategic Capabilities Plan or other joint operation planning authority. In the context of joint operation planning, this term refers to the commander who prepares operation plans or operation orders in response to requirements of the Chairman of the Joint Chiefs of Staff. 2. In the context of a support command relationship, the commander who receives assistance from another commander's force or capabilities, and who is responsible for ensuring that the supporting commander understands the assistance required. (JP1-02)

**supporting commander** 1. A commander who provides augmentation forces or other support to a supported commander or who develops a supporting plan. Includes the designated combatant commands and Defense agencies as appropriate. 2. In the context of a support command relationship, the commander who aids, protects, complements, or sustains another commander's force, and who is responsible for providing the assistance required by the supported commander. (JP 1-02)

## **TIMES (JP 1-02)**

**C-Day.** The unnamed day on which a deployment operation commences. The deployment may be movement of troops, cargo, weapons systems, or a combination of these elements.

**D-Day.** The unnamed day on which a particular operation (i.e., land assault, air strike, naval

bombardment, parachute assault, or amphibious assault) commences.

**N-Day.** In deliberate planning, N-Day signifies a negative C-Day or the number of days preceding C-day. In execution or time-sensitive planning, N-Day signifies the day a unit is notified for deployment or redeployment.

**R-Day.** The day on which redeployment of major combat forces takes place.

**H-Hour.** The specific time at which an operation or exercise commences.

**L-Hour.** The specific hour on C-Day at which a deployment operation commences.

**Q-Hour.** The hour mobility operations start in preparation for deployment.

**Attachment 2****MEDICAL REPORT FOR EMERGENCIES, DISASTERS AND CONTINGENCIES  
(MEDRED-C)**

**1. Subject and Purpose.** Provides information on USAF Medical Service units' operational readiness status, availability, and or patient care activities for units alerted for contingency operations (actual, exercise, or simulation). Reports apply to medical units influenced by unusual occurrences (e.g., natural disasters or other emergencies).

**2. References Material.** AFI 41-106, *Medical Readiness Planning and Training* (formerly AFR 160-25).

**3. Submitted By.** Medical units (including component medical commanders) with or without air transportable clinic equipment packages.

**4. Submitted To:**

ACTION ADDRESSEES:

Unit's Parent MAJCOM//SG/CAT//

Gaining MAJCOM// SG/CAT//

INFORMATION ADDRESSEES:

HQ USAF WASHINGTON DC//SGXR-MOC//

HQ WASHINGTON DC//MPRC//

AFOEC FT DETRICK //SG//

MAJCOM Alternate HQ

Other addressees as determined by parent and/or gaining MAJCOM contingency reporting

**5. When Submitted:**

5.1. Section A (Status Change)

5.1.1. Immediately, but not later than 2 hours after receiving an alert order, a declaration of change in DEFCON, or a subsequent change in alert status.

5.1.2. As necessary, to provide a status report on completed actions under a previously declared stage of alert.

5.1.3. As directed, by higher headquarters or as dictated by actions required by a particular stage of alert.

5.1.4. When a natural disaster or other emergency (e.g., tornado, terrorist bombing, civil disturbance, fire) affects a medical unit's normal operations.

5.2. Section B (Deployment). The unit's parent fixed facility submits the report after deployment of a mobility unit or asset. Units without mobility missions do not submit Section B.

5.3. Section C (Employment Status):

5.3.1. Once operational at employment location.

5.3.2. Daily as of 2359 local.

5.3.3. Upon a change of 25 percent in any element of the original report.

5.3.4. Update status when appropriate or as required. If the medical unit comes under the influence of an unusual occurrence such as a natural disaster, fire, or bomb explosion. Continue reporting daily until higher headquarters directs.

**6. How Submitted:**

- 6.1. Classify according to content. Mark unclassified reports "FOR OFFICIAL USE ONLY" and transmit Encrypt for Transmission Only (E F T O).
- 6.2. Transmit via AUTODIN.
- 6.3. Transmit during MINIMIZE.
- 6.4. Use the ESC C1 designator - Continue reporting, priority.

**7. Reporting Instructions.** Report each item as a separate line.**Section A--(Status Change Section)**

1. Line A1: Nature and effective date and time of status change.
2. Line A2: Number, name, and location of parent fixed facility and geographical location from which the alerted unit, flight, or element will deploy.
3. Line A3: Identity of facility alerted and/or unit type code (UTC) alerted for deployment.
4. Line A4: Planned employment location and estimated time of arrival (ETA).
5. Line A5: Identification of appropriate OPlan, disaster or Contingency Plan (CONPlan), or operation name.
6. Line A6: Narrative Remarks. Provide as complete a description of the situation and mission to be performed as possible.

**Example: Section A--Report**

(CLASSIFICATION)/JOPREP JIFFY/OPERATION (OR EXERCISE) NAME

SUBJ: MEDRED-C, SECTION A REPORT

A1. DEPLOYMENT ALERT EFFECTIVE 051500Z APR 92.

A2. 1FW HOSPITAL, LANGLEY AFB VA.

A3. 50-BED ATH, UTCS FFGKA, FFGK2, FFGK4, FFGK5, FFGK6, FFGK7.

A4. RAF MILDENHALL, UK, ETA: 081200Z APR 92.

A5. CINCUSAFE OPLAN 100-75, EAST ANGLIA EARTHQUAKE.

A6. MISSION TO PROVIDE MEDICAL ASSISTANCE TO CASUALTIES IN DISASTER AREA.

**Section B--(Deployment Section)**

1. Line B1: Number, name, and location of parent fixed facility and geographical location from which the alerted unit, flight, or element was deployed.
2. Line B2: Identify of unit and UTCs deployed.
3. Line B3: Planned employment location of deploying unit and ETA.
4. Line B4: Identification of OPlan, CONPlan, disaster plan, or operation name.
6. Line B6: Narrative Remarks. Make a general assessment of the situation including any deviation from information reported in previous messages or in the normal composition or size of deployed element. Identify anticipated limiting factors.

**Example: Section B--Report**

(CLASSIFICATION)/JOPREP JIFFY/OPERATION (OR EXERCISE) NAME

SUBJ: MEDRED-C, SECTION B REPORT

B1. 1FW HOSPITAL, LANGLEY AFB VA.

B2. 50-BED ATH (FFGKA, FFGK2, FFGK4, FFGK5).

B3. RAF MILDENHALL, UK, ETA: 081200Z APR 92.

B4. CINCUSAFE 100-75, EAST ANGLIA EARTHQUAKE.

B5. UNIT DEPLOYED 071300Z APR 92.

B6. UNIT TO SUPPORT EAST ANGLIA EARTHQUAKE VICTIMS. UNIT DEPLOYED SHORT

TWO AFSC 90250s AND ONE AFSC 9736. HAVE REQUESTED PERSONNEL TO COVER SHORTFALLS

THROUGH PERSONNEL CHANNELS.

### Section C--(Employment Status and Workload Section)

1. Line C1: Identity and type of unit.

2. Line C2: Report the exact employment location giving the name of the town, military site, state, country, etc.. If not known, indicate distance and direction from nearest town or city.

3. Line C3: Report the time (GMT) and the date the unit attained operational capability.

4. Line C4: Enter total number of physicians present for duty. Enter a slash (/) followed by the total of other medical personnel present for duty.

5. Line C5: Patient Workload Data - Since Last Report. Enter numbers and slashes, as indicated below based on the type of facility:

a. For Second Echelon Medical Treatment Units (2E), Squadron Medical Elements with or without Air Transportable Clinics (ATC), and Clinics (including Residual Medical Clinics): Number returned to duty (RTD), transferred, or expired since last report followed by a double slash (//) and cumulative totals for each category to date. Use a single slash (/) between each category: Example: Medical unit workload was 10 patients RTD/3 patients transferred/2 expired//20 RTD total/34 total transferred/5 total expired. The entry would appear as: *C5. 10/3/2//20/34/5.*

b. For Contingency Hospitals, CONUS Casualty Reception Hospitals (CRH), Air Transportable Hospitals (ATH), Convalescent Care Centers and CONUS Hospitals with expansion bed missions: Beds available, beds Occupied, number admitted, returned to duty, transferred, or expired since last report followed by a double slash (//) Patients Admitted, Returned to Duty, Transferred, and Expired to date. Use single slash (/) between each category. Example: Medical unit had 11 beds available/29 beds occupied/12 patients admitted/48 patients RTD/0 patients transferred/8 patients expired//35 total admissions to date/84 patients total RTD/20 total patients transfers/23total patients expired. The entry would appear as: *C5. 11/29/12/48/0/8//35/84/20/23. transferred-in//45 total transfers-out/215 total transfers-in.* The entry would appear as: *C5. 250/98/20/60//45/215.*

6. Line C6: Patient Evacuation Summary. For aeromedical staging units, medical facilities operating holding beds for aeromedical evacuation, and aeromedical evacuation control centers (AECC) only. All others will indicate N/A.

a. Evacuated within theater and evacuated to CONUS since last report. Each category is broken down into litter and ambulatory figures using a single slash (/). Use a semi-colon (;) to separate the categories of evacuated within theater from evacuated to CONUS and follow with a double slash (//). Following the (//) provide cumulative figures for each category to date. Example: Medical unit reports 100 litter/500 ambulatory patients evacuated within theater; 98 litter/600 ambulatory patients evacuated to CONUS//198 total litter/900 total ambulatory patients evacuated within theater; 500 total litter/1000 total ambulatory patients evacuated to CONUS. The entry would appear as: *C6A. 100/500; 98/600//198/900; 500/1000.*

b. Awaiting evacuation within theater and awaiting evacuation to CONUS since last report. Each category is broken down into litter and ambulatory figures using a single slash (/). Use a semi-

colon (;) to separate awaiting evacuation within theater from awaiting evacuation to CONUS. Example: Medical unit reports 230 patients awaiting evacuation within theater, (175litter/55 ambulatory); 145 patients awaiting evacuation to CONUS ( 120 litter/25 ambulatory). The entry would appear as: *C6B. 175/55; 120/25.*

7. Line C7: Medical Materiel Data. Report only War Reserve Materiel (WRM) stocks (by WRM alphabetical code) that have changed in materiel capability since previous submission of RCS: HAF-SG(SA)7131, WRM Medical Stock Status Report. Use project codes authorized by AFM 300-4, Volume III, ADE ME-178-1X. Follow each line entry by a numerical index from 0 to 100 to denote the percentage of materiel operationally ready.

8. Line C8: Facilities Status. Using a numerical index from 0 to 100, enter a percentage figure which represents usability of the facility. Consider loss of utilities, as well as physical plant.

9. Line C9: Narrative Remarks. Include:

- a. Commander's assessment of significant operational constraints.
- b. Limiting factors which adversely affect mission accomplishment.
- c. Include Date Time Group of messages/requests generated to effect emergency actions such as replacement of personnel, materiel resupply, and blood resupply.

10. Line C10: Use only to indicate a final report.

**Example: Section C--Report**

(CLASSIFICATION)/JOPREP JIFFY/OPERATION (OR EXERCISE) NAME

SUBJ: MEDRED-C, SECTION C REPORT

C1. 1FW LANGLEY AFB VA/50-BED ATH.

C2. RAF MILDENHALL, UK

C3. ATTAINED OPERATIONAL CAPABILITY 08/0800Z APR 92

C6. N/A

C7. B-78

C8. 100

C9. NARRATIVE REMARKS

C10. (Use only to indicate a final report.)

**8. Waivers.** Waiver authority to change format or combined MEDRED-C data is an overall (combined)

wing/group Situational Report (SITREP) is units MAJCOM. If waiver is granted for MEDRED-C

data to be combined in the wing/group SITREP, all addressees listed and .

**Source: (AFMAN 10-206, Ch 12, 14 May 2002)**

**Note: Source not altered to reflect current medical UTC configurations or AFSCs.**

## Attachment 3

## FORMAL EDUCATION MATRIX

SCHOOL	AFFOR/SG	AFFOR STAFF	EMEDS/AFTH COMMANDER	EMEDS/AFTH STAFF(FFEP2)	AE COMMANDERS	AE C2 OPERATIONS STAFFS
JOMMC	X	X	X	X	X	
JTFSS	X					
OOTW	X	X	X	X	X	
JMPC		X				X
CWPC		X				X
CRSS	X		X		X	
EPC	X	X	X	X		
EMEDS			X	X		
AECOT					X	X
TATC					X	X
AMOC					X	X

X-indicates courses that are recommended for the commanders and/or staffs

**JMOCC**-Joint Operational Medical Managers Course

**JTFSS**-Joint Task Force

**MOOTW**-Military Operations Other than War Course

**JMPC**-Joint Medical Planners Course

**CWPC**-Contingency Wartime Planning Course

**CRSS**-Crisis Response Senior Seminar

**EPC**-Emergency Preparedness Course

**EMEDS**-EMEDS Basic Course

**AECOT**-Aeromedical Evacuation Contingency Operations Training Course

**TATC**-Tactical Aeromedical Training Course

**AMOC**-Air Mobility Operations Course