

**BY ORDER OF
THE SECRETARY OF THE AIR FORCE**

**AIR FORCE TACTICS, TECHNIQUES, AND
PROCEDURES 3-42.5
1 NOVEMBER 2003**



Tactical Doctrine

AEROMEDICAL EVACUATION (AE)

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

OPR: HQ USAF/SGMD (Lt Col Fred P. Stone)
Supersedes AFTTP 3-42.5, 19 Jul 2001.

Certified by: HQ AFDC/CC
(Maj Gen David F. MacGhee)
Pages: 41
Distribution: F

SUMMARY OF REVISIONS: This Aeromedical Evacuation (AE) doctrine revision updates and clarifies information throughout the document including roles, responsibilities, and relationships at all levels. Chapter 2 clarifies and further delineates functions in the Tanker Airlift Control Center and theater Air Mobility Control Centers. Chapter 3 summarizes AE Military Support to Civil Authorities and incorporates Contract Approval Review Board certification requirements in accordance with Office of the Secretary of Defense policy. Chapter 4 expands on Special Mission Forces including Special Operations, marine expeditionary forces, and combat search and rescue. Coalition support, detainee missions, and inter-fly agreements have been defined. Unit type codes were updated and reflect changes in functions and interface points. The Allowance Standard Working Group has replaced the Equipment Review Working Group and, in Chapter 5, the Global AE Training Team and AE Steering Group have been replaced by the Global Aeromedical Evacuation Integration Team. Professional training includes the recommendation for trauma and/or Emergency Medical Technician training.

PURPOSE: The Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42 series of publications is the primary reference for combat support capability. This document, AFTTP 3-42.5, provides tactics, techniques, and procedures (TTP) for AE of patients across the range of military operations, from steady state/peacetime engagements through war-winning operations. Since AE is only one component of the larger Department of Defense (DOD) mobility airlift enterprise, the guidance is designed to assist planners in the successful integration of AE into airlift operations and interface successfully with ground medical operations.

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). The doctrine in this document is authoritative but not directive.

SCOPE: The Air Force AE system provides a critical patient movement capability that cuts across traditional Service lines. Since World War II, the preponderance of AE patients generated during wars and contingency operations have come from Army and Marine Corps ground

combat units. Therefore, it is important that the AE system integrates well with the medical components of all Services, not just those of the Air Force. Moreover, during the past decade, it has become increasingly important that the Air Force AE system continue to develop its capability to integrate with components of our Nation's allies.

TABLE OF CONTENTS

	Page
Chapter 1—AEROMEDICAL EVACUATION (AE)	
1.1 AE Mission	6
1.2 AE Concepts	6
1.3 Force Health Protection	6
Chapter 2—COMMAND, CONTROL, COMMUNICATIONS, AND COMPUTERS (C4)	
2.1 Introduction.....	7
2.2 Command and Control (C2).....	7
2.3 Airlift Control Agencies	8
2.4 Contingency AE Structure	8
2.5 Air and Space Expeditionary Forces.....	11
2.6 Medical Oversight.....	12
Chapter 3—OPERATIONS	
3.1 AE Across the Range of Military Operations	14
3.2 Steady-state/Peacetime Engagement and Crisis Response	14
3.3 Deterrence and Contingency Operations	16
3.4 War-winning Operations.....	16
3.5 CONUS Contingency AE	17
3.6 AE Interface With the Joint Community	17
3.7 AE Interface with the Patient Movement Process	17
3.8 Mission Coordination and Operational Considerations	18
3.9 Critical Care Air Transport Team	22
3.10 Special Considerations	22
Chapter 4—PLANNING AND SUPPORT CONSIDERATIONS	
4.1 Movement of Casualties	24
4.2 AE Planning Factors	24
4.3 Theater Evacuation Policy	24
4.4 Airframe Consideration	24
4.5 Airfield Capability	25
4.6 Potential Hostile or Terrorist Locations.....	25
4.7 Base Operating Support	25
4.8 Resupply	25
4.9 Biomedical Equipment Technician (BMET) Support	26
4.10 Communications	26
4.11 Ground Transportation.....	26
4.12 Determining Crew Support.....	26
4.13 AE Interface with Special Mission Forces.....	26
4.14 Detainee Missions.....	27
4.15 Inter-fly Agreements with MAJCOMs, Coalition Forces.....	27
4.16 Operations Phasing and Force Sequencing.....	27

4.17 AE Unit Type Code (UTC) Employment Concept.....28
4.18 AE UTC Selection and Utilization.....28
4.19 AE Mission Support Equipment31
4.20 AE Equipment and Supplies31
4.21 Patient Movement Items (PMI).....32

Chapter 5—TRAINING

5.1 Objective.....33
5.2 Responsibilities.....33
5.3 AE Aircrew Training/Qualification33
5.4 AE Contingency Operations Training (AECOT) and Training33
5.5 Operations Training.....34
5.6 Critical Care Air Transport Team (CCATT) Training34
5.7 Professional Education.....34
5.8 Currency Training.....34
5.9. Adopted Forms.....34

**Attachment 1—GLOSSARY OF REFERENCES AND SUPPORTING
INFORMATION.....**

36

**Attachment 2—PATIENT MOVEMENT PLANNING AND
EXECUTION ALGORITHM.....**

41

LIST OF FIGURES

	Page
Figure 2.1 Contingency AE Structure	9
Figure 3.1 Example of Options Available for AE Patient Movement	15
Figure 3.2 AE Interface With the Patient Movement Process	18

Chapter 1

AEROMEDICAL EVACUATION (AE)

1.1. AE Mission.

1.1.1. The Air Force AE system provides fixed-wing movement of patients requiring supervision by aeromedical evacuation crewmembers (AECMs) 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. The AE system is designed to be flexible to enable it to operate across the spectrum of potential scenarios, including but not limited to, humanitarian and disaster relief operations, small-scale contingencies (SSC), major theater wars (MTW), and military support to civilian authorities (MSCA). AE is currently integrating their unit type codes, processes, and procedures into mobility operations; designing elements that can be plugged in to provide additional capability, when and where needed, and interface with joint, coalition, and special operations that are versatile in nature.

1.1.2. The highly lethal potential of today's battlefield, the reduced medical footprint, and the "evacuate and replace" philosophy, have made the AE mission even more critical than in the past. Moreover, the evacuation of patients by air to facilities offering required levels of care must compete with other critical wartime airlift requirements.

1.2. AE Concepts. AE can significantly improve casualty recovery rates by providing timely and effective transportation of the sick and wounded to medical facilities offering appropriate levels of care. The AE system provides: (a) integrated control of casualty movement by air transport; (b) clinical and operational support personnel; (c) equipment for in-flight supportive care and ground support operations; (d) critical care air transport teams (CCATT) to monitor and manage specific patients requiring intensive care; (e) staging facilities on or in the vicinity of airheads and air bases for the administrative processing and care of casualties entering, en route through, or leaving the AE system; (f) command and control (C2) of all theater AE forces and AE operations; and (g) support to the communication network between airlift C2 agencies.

1.3. Force Health Protection: The concept of force health protection (FHP) represents the set of health programs that protect America's fighting forces. Casualty care and management support the warfighting commanders of all Services, coalition forces and civilians assigned to the military through the provision of essential care in theater, followed by rapid AE to definitive treatment without sacrificing quality of care.

Chapter 2

COMMAND AND CONTROL

2.1. Introduction.

2.1.1. C2 functions exercised over AE missions are consistent with those for all air mobility missions and are conducted in accordance with the C2 processes described in Joint Publication 3-17, *Joint Tactics, Techniques, and Procedures for Air Mobility Operations*; AFDD 2, *Organization and Employment of Aerospace Power*; and AFDD 2-6, *Air Mobility Operations*. In contingency operations, AE specific items will be outlined in the operation order (OPORD) in Annex C Appendix 30 and general patient movement guidance in Annex Q. AE assets should be integrated within the inherent mobility structure established to support airlift operations through the Air Mobility Division (AMD) to the wing and down to each element.

2.1.2. Patient evacuation from point of injury to initial treatment at a health care facility is the responsibility of each Service component. AE is not the only mechanism for movement of patients by air. Casualty evacuation (CASEVAC), a term used by all Services, refers to the movement of unregulated casualties aboard vehicles or aircraft. Medical evacuation (MEDEVAC), on the other hand, traditionally refers to US Army, Navy, Marine Corps, or Coast Guard patient movement using predesignated tactical or logistic aircraft temporarily equipped and staffed for en route care. MEDEVAC has generally implied the use of rotary-wing aircraft with medical attendants (MA). AF AE begins once a validated patient movement request (PMR) is passed to the AF component agency for execution.

2.1.3. Evacuation of patients between points within the theater is referred to as intratheater evacuation, while evacuation of patients between theaters is referred to as intertheater evacuation. In both cases, en route care is provided by trained AECMs, qualified flight nurses (FN) and AE technicians (AET), the AF AE support network, and may be augmented by CCATTs or medical attendants.

2.2. Operational C2.

2.2.1. Steady-state/Peacetime. Great strides have been made to standardize the AE system to ensure peacetime processes mirror wartime processes. This allows for the system to exercise its wartime infrastructure in peacetime and enhances wartime training. C2 of AE assets, to include tasking authority for AE and mobility forces, resides with the normal airlift and mobility C2 structure. Field and AE squadron (AES) operations will be conducted through operational wing C2 channels. The Tanker/Airlift Control Center (TACC) or Air Mobility Operations Control Center (AMOCC), or theater equivalent, provides C2 for tasking and execution for air mobility assets used to accomplish AE missions within their respective areas of operation. AE cells should be established within each of those organizations to provide the critical link between C2 of airlift operations and medical/joint interface. The theater validating flight surgeon(s) (VFS) and patient movement requirements center (PMRC) provide operational clinical oversight of a theater's AE operations.

2.2.2. Steady-State/Peacetime AE Structure. Combatant commanders are responsible for intratheater patient movement (PM) within their area of responsibility (AOR). The joint command validates theater requirements and passes AE requirements to the AF component for execution.

2.3. Airlift Control Agencies.

2.3.1. Tanker/Airlift Control Center (TACC). The TACC is responsible for tasking and controlling operational missions for all activities supporting USTRANSCOM's global air mobility mission. TACC serves as AMC's Air and Space Operations Center (AOC) for USTRANSCOM's air mobility mission and its functions include: current operations, C2, AE and aerial port operations, mission management, flight planning, deployment, diplomatic clearances, weather, and intelligence.

2.3.1.1 TACC AE Barrel. Barrels task resources to meet validated air mobility requirements, including airlift, tanker, and AE requirements. The TACC AE Barrel function tasks resources to meet requirements in their area of responsibility. Resources include AE crews, aircraft, and front-end crews. Barrel masters from AE, airlift, and tanker functions coordinate to task active duty resources. Access to AFRC and ANG forces is provided through a system of volunteerism. Requirements include appropriate alert postures as well as scheduled missions. Other airlift operations centers incorporate this function into the AE cell.

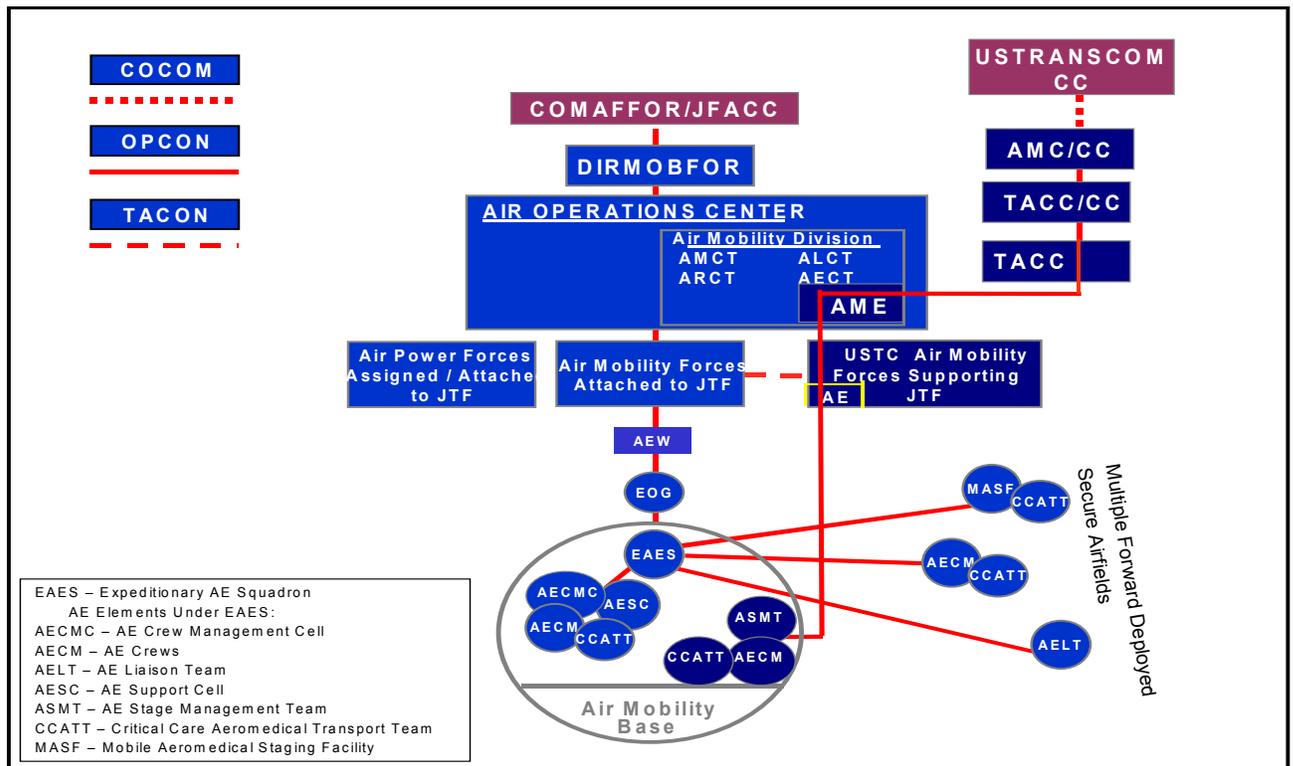
2.3.2. Air Mobility Operations Control Center (AMOCC). The AMOCC, or theater equivalent, is each theater's single C2 focal point for intratheater air mobility operations external to a joint task force (JTF). The AMOCC, or theater equivalent, provides centralized planning, tasking, scheduling, coordinating, and C2 for assigned and attached intratheater air mobility forces operating in the geographic combatant commander's AOR. The AMOCC integrates intertheater and intratheater air mobility operations to efficiently and effectively accomplish the theater air mobility mission and enhance the goal of seamless global mobility.

2.3.3. Aeromedical Evacuation Cell. The AE cell is the source of AE clinical and operational expertise and mission execution within the TACC/AMOCC. The AE Cell provides the critical link between C2 and operations and is the clinical interface with airlift operations and the PMRC. AE Cell personnel have extensive knowledge of flight physiology, airlift AE capability, and information technology such as, operational mission planning and tasking, scheduling, and mission monitoring of airlift and AE assets to support PM, as well as coordination with the Patient Movement Requirements Center (PMRC) for medical issues.

2.4. Contingency AE Structure (refer to AFDD 2-6, *Air Mobility Operations*). (See Figure 2.1.) Deployed expeditionary air and space forces are organized to ensure unity of command. Deployed AE forces will be organized within the constructs of the Air and Space Expeditionary Task Force (AETF) and will be tailored based on the size and scope of the operation. C2 of theater AE forces in contingency operations will be defined in the warning/execution/OPORD. AE assets may be under the operational control (OPCON) of the Joint Force Commander (JFC),

through the Joint Force Air Component Commander (JFACC) and, when not appointed as the JFACC, the Commander, Air Force Forces (COMAFFOR) for Administrative Control (ADCON). The AE commander is authorized to communicate directly with the joint forces surgeon (JFS), who is assigned to the staff of the JFC.

Figure 2.1. Contingency AE Structure.



2.4.1. Joint Force Commander (JFC). The JFC is responsible for PM in the AOR. JFCs below the geographic combatant commander level exercise OPCON over assigned and attached forces.

2.4.2. Joint Force Air Component Commander (JFACC). The JFACC derives authority from the JFC who exercises operational control, assigns missions, directs coordination among subordinate commanders, and redirects and organizes forces to ensure unity of the air component effort in the accomplishment of the overall mission. AE operations are an important part of the JFC's mission, and the JFACC plays a critical role in successful AE operations. The JFACC (as delegated by the JFC) exercises OPCON of assigned or attached forces.

2.4.2.1. An AE planner should be incorporated into A-5 of the COMAFFOR staff to outline, develop, and coordinate AE theater plans along airlift routes, including number and location of AE assets needed to support operational requirements. The planner should coordinate with the AFFOR SG to ensure visibility of theater medical

facilities/capabilities that may affect AE plans. The team may consist of AMC Director of Operations (DO) assets utilized in a reach-back status to support the operation and component until teams can be identified and trained.

2.4.3. COMAFFOR Special Staff. For contingency operations, the COMAFFOR special staff may include a senior AE expert as identified, in conjunction with the AE force provider, AMC DO, to support the COMAFFOR on the special staff. The AE expert will have extensive experience in the AE system, airlift operations and plans, and will have attended mandatory training as part of AMC DO pre-selection and training requirements. In some cases, the COMAFFOR special staff AE person may be selected from the AMC pool of trained candidates and conduct business in a “reach-back” status in order to support the contingency. Normally, this person will serve as the advanced echelon (ADVON) support staff to assist with the development of the initial AE force laydown, C2, establish AE policy, and coordinate the interface with airlift operations.

2.4.4. Director of Mobility Forces (DIRMOBFOR). The DIRMOBFOR is a senior mobility officer who is familiar with AOR or the joint operations area (JOA), and who possesses an extensive background in airlift operations. The DIRMOBFOR serves as the designated agent for all airlift issues in the AOR or JOA. The DIRMOBFOR also exercises coordinating authority among the airlift coordination cell, the AMD air mobility element (AME), the TACC, the joint movement center, and the air operations center (AOC) in order to expedite the resolution of airlift problems. Finally, the DIRMOBFOR, working with the JFACC/COMAFFOR, has a responsibility to ensure that AE assets are in-place, aligned in the airlift C2 structure, and that AE missions are planned and executed. Prior to a contingency the DIRMOBFOR is identified and an ADVON team is sent to evaluate theater requirements.

2.4.5. Deputy DIRMOBFOR. An AE officer with extensive AE experience and knowledge of plans and operations may serve as the Deputy DIRMOBFOR. This individual may deploy as part of an ADVON, or as a member of the AMD. Deputy DIRMOBFOR candidates with AE expertise will be selected by the AMC DO and trained in the AOC and leadership courses and may attend the theater validation course. This individual, when tasked, will fully integrate into the AMD and assist the DIRMOBFOR in all other duties as required.

2.4.6. AE Control Team (AECT). This team is located within the AMD of the AOC and is responsible to the AMD Chief, AOC Director, and DIRMOBFOR for current AE operational planning, tasking, and mission execution to the theater. Once a validated PMR is received, the AECT coordinates airlift and AE assets to meet AE requirements, tasks the appropriate airlift wings through the airlift control team (ALCT) and air tasking order (ATO), and passes mission information to the Patient Movement Requirements Center (PMRC). This team also coordinates airlift with AME/TACC/AMOCC to meet AE requirements. AECT members require an in-depth knowledge of AF instructions, aircraft configuration, and aircraft systems. The Joint Airlift Command and Control Course (JAC2C), the airlift planner’s course and/or an in-depth orientation of the TACC and/or AMOCC are highly recommended. A senior nurse on the AECT will be identified to coordinate AE/ECM requirements with the AE Command Squadron (AECS) Chief Nurse, i.e., team size and proficiency. CCATT requirements are coordinated through the theater-validating surgeon.

2.4.7. Air Mobility Element (AME). The AME is the deployed liaison element of the TACC to the theater AOC, and usually resides in the AMD. A description of the AMD and its functions can be found in AFI 13-1AOC, Operational Procedures-Aerospace Operations Center, Volume 3, Chapter 8. Intertheater airlift assets normally will not be attached to a theater AETF but will remain COCOM of USTRANSCOM and OPCON of AMC. These forces may be organized into a Mobility AETF or AEW. Coordination of airlift, patient movement items (PMI) and assets required to support AE will be requested through the AME in the AMD. The TACC/AME may coordinate the use of theater AE assets to support intertheater missions. Theater AE assets tasked to support TRANSCOM intertheater missions will fall under the direct control and TACON of TRANSCOM /TACC during execution and depositioning back to the theater when specified in the appropriate OPORD/DEPORD/EXORD. Otherwise, theater AE assets tasked to support intertheater missions remain under the OPCON/TACON of the theater air component and carryout these missions through a supporting/supported commander relationship.

2.5. Air and Space Expeditionary Forces.

2.5.1. Air and Space Expeditionary Wing (AEW). AE will deploy/employ in war as they exercise in peacetime. When the size and scope of the operation warrants establishing an AEW, AE forces will be aligned as part of the air and space expeditionary group (AEG) under the total AEW construct. AE standardization/evaluation will be integrated with similar Wing-level functions.

2.5.2. Air and Space Expeditionary Group (AEG). When the size and scope of the operation warrants a minimal footprint, a smaller AEG may be deployed instead of the larger AEW. AE elements will then be aligned as part of the air and space expeditionary squadron under the total AEG construct. Normally an individual squadron or element should not be deployed by itself. When the size and scope of the operation warrants the presentation of a single squadron, it should deploy with provisions for commensurate support and C2 elements and will appear similar to an AEG although some C2 elements may be positioned "over the horizon" rather than deployed forward.

2.5.3. Expeditionary Airlift Squadron (EAS). The Airlift Squadron is aligned under the Wing structure. Normally a mobility airlift squadron, AE, and airlift operations are integrated under the wing operations.

2.5.4. Expeditionary AE Squadron (EAES). The EAES is assigned to an AEW and operations group. The deployed unit type code (UTC) AECS integrates into AEW operations with the senior ranking officer designated as the EAES/CC on G-series orders.

2.5.4.1. AE personnel assigned to the expeditionary airlift wing such as mobile aeromedical staging facilities (MASF), AE crew management cells (AECMC), AE crews, CCATTs, communications, liaison teams, and AE elements within a defined AOR should be organized within an EAES. The AECS ensures all elements are prepared to conduct AE operations as tasked by the AOC.

2.5.4.1.1. Air Reserve Component (ARC) Personnel. Typically, the JFC, through the JFACC, exercises OPCON over ARC personnel that are assigned or attached to the joint force. ADCON of ARC personnel remains with the ARC, except under a full mobilization authorized by Congress and directed by the President.

2.5.4.2. The EAES will provide AE assets to support the wing operations center (WOC), and establish agreements with local medical treatment and base facilities for liquid oxygen (LOX), biomedical, logistic, and clinical training support as required. Requests for additional specialists to support AE operations in the wing or base structure should be forwarded up the wing chain of command. The AECS can arrange support requirements for follow-on AE forces, as required. In larger contingencies, there may be more than one EAES assigned to an AEW or AEG.

2.5.4.3. The EAES/CC will identify officers in charge (OICs) and non-commissioned OICs (NCOICs) of each UTC or geographic location to provide on-site direction of AE forces. The deployed AES/CC or designee, will work with the OICs/NCOICs to ensure AFSC and operational proficiency training is accomplished at each location. The AECS also ensures memorandums of understanding (MOU) are established with other deployed operations such as the medical facility. MOUs should be used to integrate the AES assigned biomedical equipment technician (BMET) within the local medical treatment facility (MTF) for equipment maintenance and repair. Equipment requiring repair beyond the deployed capability will be processed to the PMI hub for maintenance

2.5.4.4. Duties: The EAES/CC should designate a qualified senior nurse on the UTC as the Chief Nurse to maintain oversight of deployed nursing and proficiency issues. The Chief Nurse should have nurse executive (NE) or deputy NE experience. MAJCOM, Ops Group, or Unit standardization and evaluation experience is also recommended. Clinical training opportunities should also be identified and readiness skills verification (RSV) accomplished. AE life support requirements should be identified through C2 channels and MOUs signed to ensure these requirements are met. AE communications will be integrated into the WOC, when the situation permits. AE issues/problems should be elevated to the EAES/CC and up through the wing to the AMD and DIRMOBFOR and COMAFFOR staffs for resolution. CCATTs are an integral part of the AES and should be integrated into AE operations commensurate with rank and expertise. The senior CCATT officer should be designated as "CCATT Clinical Director" to work CCATT issues with the theater-validating surgeon. At least one person on the AECS should be a Flight Examiner/Instructor to act as an advisor to the EAES/CC on standardization/evaluation issues. This individual will also be responsible for maintaining the flight crew information file (FCIF) in conjunction with the wing/operations group.

2.6. Medical Oversight.

2.6.1. Joint Force Surgeon (JFS). Appointed by the JFC to serve as the theater or JTF special staff officer responsible for establishing, monitoring, or evaluating joint force health service support (JP 4-02). The JFS is responsible for coordinating and integrating health service support within the AOR as well as coordinating intratheater patient movement

support to the Joint Task Force Commander (JTF/CC). The JFS establishes patient movement policies and should coordinate with the USTRANSCOM, supported combatant command, and other Component Commands. The JFS should appoint a theater Medical Director who is responsible for the quality of patient movement clinical care provided within the AOR. The Medical Director appoints the theater VFS(s) who will support a joint patient movement requirements center mobilized to their AOR.

2.6.2. Air Force Forces (AFFOR) Surgeon. The AFFOR surgeon is the designated medical advisor to the COMAFFOR on all Air Force specific health services support resources, including health surveillance, risk assessment, and other FHP issues. The AFFOR Surgeon provides professional oversight for deployed Air Force medical units, writes a supporting concept of operations (CONOPs), and establishes clinical policies in coordination with AMC as lead command for AE, supported combatant command, and other Component Commands.

2.6.3. Theater Validating Flight Surgeon (VFS). The theater VFS works with the PMRC and complies with DOD and Service-specific medical licensing requirements. The VFS must have the appropriate knowledge base and experience sufficient to ensure proper medical care during transport as well as the ability to provide medical direction during transport for all patient types served by the patient movement system. The theater VFS must ensure compliance with applicable accepted practice standards for air and ground patient movement. Medical direction can be transferred from the theater VFS to a physician traveling with patients as a medical attendant or to a CCATT physician.

2.6.4. USTRANSCOM - AMC/Command Surgeon. The Command Surgeon, AMC is responsible for oversight of quality of care provided worldwide by the AE system.

Chapter 3

OPERATIONS

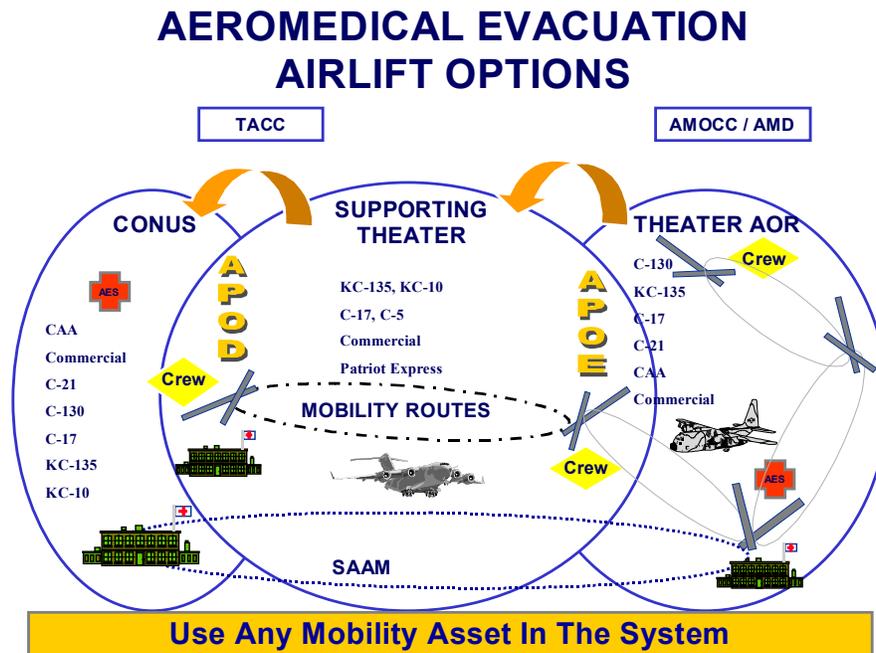
3.1. AE Across the Range of Military Operations.

3.1.1. Introduction. The nature of threats impacting the AE system varies considerably within the spectrum of operations. In most contingencies, or civil disaster response actions, airlift will be the preferred means of PM. Service or civilian modes of transportation may assist with the movement of casualties from a forward location or immediately after an emergent event.

3.1.2. HQ AMC is charged with the responsibility to operate the common-user Air Force fixed-wing AE system, to procure and execute commercial augmentation, and administer and execute the Civil Reserve Air Fleet (CRAF). AMC has been given the overall responsibility as the AE lead command for the Air Force. AMC manages and operates the intertheater and AE sub-systems, CRAF, and provides AE elements and planning assistance to the theater of operations, in intermediate supporting theaters, or in CONUS. USAFE and PACAF are responsible for their theater-assigned AE units and associated airlift units. During contingencies which exceed theater AE capabilities, AMC will provide mission-specific augmentation forces to support increased theater requirements and will expand or establish the intertheater capability to support movement between theaters of operation, or to CONUS, as required.

3.2. Steady-State/Peacetime Engagement and Crisis Response. To support peacetime AE and train for war, the AE system will align with operational airlift processes and routes and focus on validated patients requiring in-flight care. AE will be fully incorporated under DO/Wing operations. As part of the global mobility task force (GMTF), AE will have a presence during base establishment. Theater AMOCCs and the TACC will execute the AE mission by optimizing the use of available multi-mission aircraft; mixing cargo and AE on mobility missions, and integrating AE requirements into cargo channel routes. Airlift for urgent and priority patients will be tasked from alert AE crews, diversion of in-system select (ISS) aircraft, or contracting with a civilian air ambulance (CAA). To enhance responsiveness, AE crews and CCATTs should be strategically positioned based on airlift and key patient originating locations. (Figure 3.1)

Figure 3.1. Example of Options Available for AE Patient Movement.



3.2.1. In order to support peacetime requirements and train for war, the AE system will align with operational airlift processes and infrastructure and focus on validated patients requiring in-flight care. The system will shift from routine scheduled C-9A and C-141 missions to a frequency and requirements-based system using all passenger-capable mobility airlift platforms. Qualified AE crewmembers will be multi-platform trained on aircraft systems and procedures to provide optimal in-flight patient care.

3.2.2. Theaters will validate patient movement channel mission requirements through the existing theater unified command cargo/passenger annual validation process. Patients traveling as passengers in a Temporary Duty (TDY) status must be validated as clinically able to do so by the theater PMRC and granted duty pax priority. Associated costs with the use of seats on military lift by patients, attendants, and AE assets will be outlined in appropriate DOD Instructions (DODI) and joint publications.

3.2.3. Patients requiring in-flight medical care, but not supported by the organic AE system, may be moved via other Service assets or civilian air ambulance (CAA). Outpatients and eligible beneficiaries needing air transportation, but not requiring in-flight care, can be moved by commercial airline travel, contract airlift, duty passenger travel, or in a space available status in the DOD transportation system, as validated by the PMRC.

3.2.4. In the AE system, CAA should only be used when AE requirements cannot be filled with organic aircraft. In accordance with Office of the Secretary of Defense (OSD) policy, Contract Approval Review Board (CARB) approval is required on all commercial conveyances contracted by the military to move passengers, patients, or paratroopers. AMC contract airlift will be CARB certified. However, non-CARB certified CAA may be used in

emergencies to save life, limb, eyesight, or in the event that serious threat of significant deterioration in medical condition exists.

3.2.5. AE Military Support to Civil Authorities (MSCA).

3.2.5.1. Those activities and measures taken by DOD components to foster mutual assistance and support between DOD and any civil government agency in planning or preparing for, or in the application of resources for response to, the consequences of civil emergencies or attacks, including national security emergencies. (DODD 3025.15)

3.2.5.2. The Air Force AE system supports patient evacuations accomplished through the National Disaster Medical System. USTRANSCOM is the authority that validates the requirement to support civilian authorities with Director of Military Support DOMS, Federal Emergency Medical Agency (FEMA), and the NDMS. Once validated, AMC and TACC are the lead operational authority (LOA) for AE planning, coordinating, and, when directed, executing MSCA support. AMC/DO also provides trained AE coordinating officers and coordinating elements for MSCA from existing active and reserve component forces in execution of the Federal Response Plan (FRP) in the continental United States. AE assets required will depend on the size and scope dictated by the disaster or contingency and may be supported by in-place AE infrastructure or the deployment of AE assets to the disaster area.

3.2.5.2.1. ANG AE assets, being part of their state's Emergency Management Plan (EMP), may be mobilized and deployed/employed in a state activated status prior to federalization.

3.2.5.3. AMC plays a key role in response efforts by providing experienced AE personnel, planners, and support staff. With proper authorization, AE personnel may be used to support local efforts at command and control centers, staging at existing airports, and/or AE liaisons at medical treatment facilities preparing patients for in-flight care.

3.3. Deterrence and Contingency Operations. AE forces are incremental and can build from a small liaison team to a full theater AE system (TAES). The initial, expeditionary, AE assets can deploy far forward, are mobile, and support the various medical ground units from all services.

3.4. War-Winning Operations. During support of war-winning operations, AE employs its full capability, to include staging, AE aircrew members, specialty teams, and integrated communications. During wartime, AE includes the movement of military casualties from forward airfields to more capable facilities farther to the rear and, if required, on to definitive care facilities. The AE system may be tasked to transport injured/ill special operations forces, provide support for noncombatant evacuation operations (NEO), and/or evacuate injured/ill repatriated US or allied prisoners of war (POW). On certain occasions, the AE system may also be tasked to evacuate injured/ill enemy prisoners of war (EPW), detainees, and coalition forces. Finally, during war-winning operations AE includes transportation of patients to and redistribution within CONUS.

3.5. CONUS Contingency AE. AE missions returning patients from the theater will deliver the patients to CONUS. Staging facilities will be strategically placed to support defined airlift routes. Additional medical assets may be required to support patients at organic enroute hubs. Redistribution of casualties in CONUS may also involve a network of commercial airlift. For wartime operations, the CONUS patient redistribution system and AE requirements will be defined in the Integrated CONUS Medical Operations Plan (ICMOP) created by United States Joint Forces Command.

3.6. AE Interface With The Joint Community. A PMRC is responsible for identifying MTF capability, regulating patients to the closest capable facility, clinically validating, and coordinating with service components for patient evacuation. This process matches the patient to a MTF with the necessary capabilities and bed availability. PMRs are validated before being turned over to the Service component for execution. The airlift operations centers may request other destinations due to availability of airlift and routes to support AE. These decisions will be coordinated with the PMRC.

3.7. AE Interface with the Patient Movement Process (Figure 3.2)

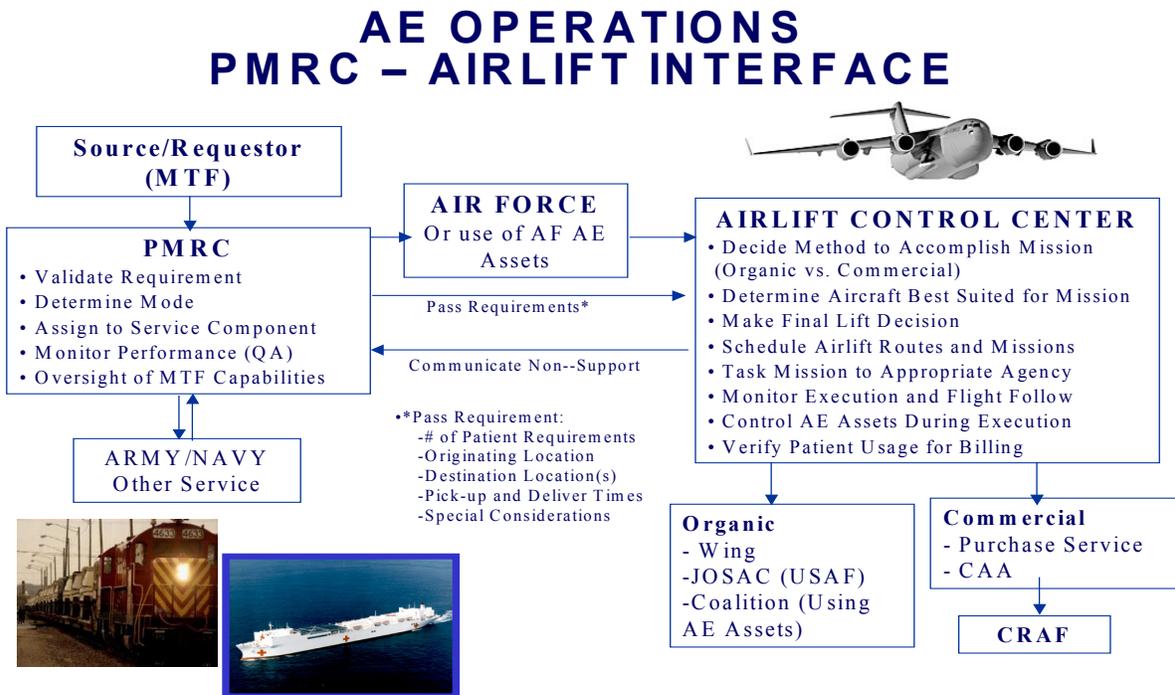
3.7.1. Patient Movement Request (PMR). The PM process begins when the health care unit sends a PMR to the servicing PMRC (attachment 2, Patient Movement Planning and Execution Algorithm). The PMRC evaluates the request for necessity, acuity, and eligibility. PMRs are submitted to the PMRC by the service medical patient administration person in each facility and will be communicated through TRAC2ES for patient in transit visibility (ITV). Operational tracking of AE missions will be through standard air mobility automated systems.

3.7.2. Patient Movement Requirements Centers (PMRCs)—Global, Theater, and Joint. The PMRC is a joint activity that is responsible for PM management and coordination. The PMRC validates patient movement requests, regulates patients to appropriate medical facilities for continued medical care, and determines the mode of transportation (air, sea, ground). PMRCs should exist at the joint level, as an element of the joint movement center, to ensure visibility of joint assets for PM lift options. PMRC staffing includes flight nurses (FN) as patient movement clinical coordinators (PMCC). One or more theater VFS are assigned or delegated by the theater Command Surgeon to work with the PMCC. Theater VFSs provide physician medical direction and clinical oversight of PM validation, transfer/en route care planning, and en route care, as needed, during AE. The PMCCs provide flight nursing and administrative expertise during validation and may be delegated validation authority by the VFS for routine patients using approved algorithms.

3.7.3. Patient Movement Clinical Coordinator (PMCC). A PMCC is a flight nurse (FN) assigned to a PMRC who provides clinical and flight nursing oversight for clinical validation of patient movement requests. The senior PMCC may establish training requirements for PMRC personnel, conducts case reviews, develops PMRC clinical practice guidelines for personnel (FN or enlisted medical technicians) performing clinical regulation/validation in the PMRC, and defines the scope of practice for clearing patients by PMCC's when an originating MTF flight surgeon is not available.

3.7.4. Patient Administration Director (Clerk/Officer) (PAD) or the Medical Regulating Officer (MRO) is responsible for contacting the PMRC with PM requirements and submitting patient movement data. This individual manages patient numbers and bed classifications, determines availability of facility-based resources to assist with the movement of patients, and coordinates the use of those assets. The PAD/MRO serves as the liaison between the referring physician and medical staff, the patient, and the PMRC and is responsible for inputting patient data for PM requests.

Figure 3.2. AE Interface With the Patient Movement Process.



3.8. Mission Coordination and Operational Considerations.

3.8.1. Management of AECMs. Management of AECMs is essential for efficient system operations. Crew management and tasking includes support to all aircrews, AE crewmembers, CCATTs, and other supporting medical augmentees. AE crew management will be integrated into mobility aircrew tasking orders, airlift stage management operations, and crew alert processes. AE crews will be alerted in the same processes other ACMs are alerted, i.e. aircraft commander (AC). It is the medical crew directors (MCD) responsibility to contact the command post, enroute, to find out the next mission's AC and provide the AC with required information to ensure an integrated crew response to the upcoming mission. AE equipment will be considered part of aircrew equipment.

3.8.2. AE Mission Priorities. PM priorities for AE missions will be derived from situational factors and/or individual patient clinical conditions.

3.8.3. DOD Definitions for Theater Evacuation Precedence: Times begin once a patient is validated and stabilized for movement (Intertheater pickup will add 12 additional hours). The timeframes are expected response time, but can be negotiated with the lift agency (refer to JTTP 4-02.2, *Patient Movement in Joint Operations*). In contingencies, follow Annex Q directives for specific joint operation priorities.

3.8.4. Mission Coordination. Once the mission has been identified, the AOC/AMOCC/TACC will task mobility wings for airlift, crews, and augmentation assets (equipment and/or specialized medical personnel support). The AE cell or AECT will pass mission information, including aircraft arrival and departure times, through the Wing as well as to the servicing PMRC and originating and destination health care facilities. The AE cell will coordinate ground transportation to/from the flight line. The AE cell or AECT will flight follow the mission and all operational aspects of AE.

3.8.5. Unregulated Casualties. When security or operational conditions exist that would require casualties to be moved immediately, patients may be moved without prior PMRC validation. However, a VFS or medical authority will be identified to clear the patients for the AE environment. In each case, the originating AE component will attempt to alert the AECT of the departure of AE missions with unregulated patients. The AECT will then notify the PMRC.

3.8.6. Patient Considerations and Preparation for AE. Proper clinical preparation for AE increases the likelihood of successful patient outcome. Originating physicians and staff, in consultation with local flight medicine personnel, should begin preparatory actions by outlining, to the PMRC the care plan the patient requires en route. Every effort should be made to identify age groups, (e.g. neonates) and clinical disease states that require or could require specialty care en route. Lastly, psychiatric patients must be carefully assessed for their potential for presenting an in-flight risk to flight safety because of their demonstrated behaviors.

3.8.7. Patient Stability. Patients validated for transportation by air must be stabilized (secure airway, controlled hemorrhage, treated shock, and immobilized fractures) as much as the situation and resources allow. Potential interventions (i.e., IV or Foley catheter) should be initiated prior to flight, when possible. Patients not clinically stable due to severity of wounds or medical condition, limited medical resources, or time constraints may require advanced clinical capability while awaiting transport at an airhead or during flight. At times, the patient's clinical instability may be the very reason that they are being moved from a lesser capable facility to another of greater capability. The AE system provides qualified flight nurses and AETs who are augmented by CCATTs or other MAs, based on patient stability and condition.

3.8.8. Patient Preparation. The physician should consider the care needed both in the air (such as availability of special equipment and cabin altitude) and at interim stops, and consult with a VFS as required. The physician has responsibility for patient classification, movement precedence, reporting, documentation, and preparation. The originating MTF will ensure patients are prepared for AE to include anti-hijacking security inspection.

3.8.9. Management of Patient Weapons. During contingency operations, weapons will be returned to the user Service or, in special situations (special mission forces activities) weapons will be cleared and transported in accordance with (IAW) aircraft regulations and Geneva Conventions. Explosive and hazardous items found with patients will also be returned to the patient's Service. AE forces should outline a procedure if ordinance is found on casualties entering the AE system. Removal of weapons and munitions require host force protection personnel intervention.

3.8.10. Patient Essentials. Patients will be transported with their medical records or evacuation battle tag, valuables, personal effects, and medically essential items IAW established regulations. Medical equipment and supplies required to support patients during evacuation are referred to as PMI and should be coordinated with the AE system in advance. The originating facility will be responsible for providing these items and should provide a 1-day minimum of supplies, except for PM from theater to CONUS and within CONUS where a 3-day minimum should be provided. While in theater, patients should also be transported with their chemical warfare/biological warfare (CW/BW) gear as applicable.

3.8.11. En Route Care.

3.8.11.1. En route care requires the use of state-of-the-art, lightweight, medical equipment to ensure the evacuation system is able to successfully transport a patient from the point of injury or illness to definitive care. Configuration and medical equipment interface with the aircraft is of utmost importance and is one of the competencies demonstrated by the AECM. En route care equipment and supplies will be standardized throughout the system and will comply with air-worthiness requirements. This will ensure rapid equipment exchanges and forward re-supply.

3.8.11.2. Documentation. The DD Form 602, *Patient Evacuation Tag*, or AF Form 3899, *Aeromedical Evacuation Patient Record*, should accompany each patient to ensure appropriate care is documented during transport and serves as the legal record of patient care while in the AE system. These documents are primarily used to direct and record en route care. A DD Form 601, *Patient Evacuation Manifest*, should be completed for each AE mission if an automated manifest is unavailable. See AFJH 41-313 *Aeromedical Evacuation Documentation*.

3.8.11.3. Clinical Considerations. Clinical considerations include standards of care, performance, and practice throughout the continuum of care as well as nursing guidelines. These are outlined in the *Air and Surface Transport Nursing: Principles and Practice* handbook available in all AE units.

3.8.11.4. Standards of Performance. The standards of performance are the expected levels of function of a care provider, based on education, level of experience, and criteria of current position and Air Force specialty code (AFSC) requirements. AE assets, at a minimum will be proficient in their AFSC defined readiness skills verification standards.

3.8.11.5. Standards of Practice. Standards of practice are the identified levels of accomplishment that focus on medical personnel and includes competence, experience,

and education. The primary goal of AE medical transport is to meet the perceived, actual, or potential health needs of the patient while maintaining the continuum of care. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards are applicable to patient care in AE. A qualified senior nurse will be identified at each AE element to ensure patient care teams are experienced and competent to provide for the type of patient care required. CCATTs co-located with the operations should be consulted to ensure their training needs are met. The senior nurse will also mix teams and shifts to ensure each patient care team meets standards of practice.

3.8.11.6. Nursing Care Guidelines. AECMs/CCATTs must ensure that every effort is made to provide continuity of care for each patient. The MCD and charge medical technician (CMT) will supervise, and assist the other AECMs while they perform patient care. The CCATT physician is clinically responsible for care given to CCATT-assigned patients. See *Air and Surface Transport Nursing: Principles and Practice* handbook

3.8.11.7. Physician Roles and Responsibilities. The following contains guidance and instructions for DOD and Department of Veterans Affairs (DVA) physicians and health care providers on the proper procedures to follow when validating and preparing patients for AE.

3.8.11.7.1. Referring Physician Responsibilities. The referring physician is jointly involved in preparing patients for AE with the nursing and administrative staff as well as the VFS. The referring physician, in partnership with the VFS, maintains responsibility for the patient until the patient is under the direct care of the receiving physician at the destination medical facility. Responsibility can be transferred to another physician when accompanying the patient. If any patient concerns arise during transfer, the AECT/AE cell will be notified for guidance or coordination. The AECT/AE cell may contact the PMRC or referring physician for further direction.

3.8.11.7.2. MTF Flight Surgeon (FS) Responsibilities. The flight surgeon (FS) is the local authority for determining whether patients are physiologically ready for air transport. If one is not available, the theater VFS should be available for consultation. The local FS is responsible for continually assessing an AE patient's clinical status to assure the status is unchanged, particularly just prior to departure or if further stabilization is required. The FS may also determine if the patient's category should change and adjust enroute clinical care as indicated to safely transport patient. The local FS provides flight medicine oversight of patients remaining over night at staging facilities unless the patient is transferred to other physicians for specialty or higher-level care.

3.8.11.7.3. Medical Attendant (MA) Responsibilities. The majority of AE missions do not require MAs. MAs should only be requested in unusual cases because it diminishes the originating facility's capability to care for others. AE crews demonstrate competency in routine and intermediate patient care and can adjust crew size and proficiency to support most patients. All MAs will be familiar with the patient and possess the level of skills appropriate to the patient's needs and are responsible for providing and coordinating patient care requirements with the

MCD/FN. A physician accompanying the patient is the clinical authority for that patient's care. Documentation of patient care and medication administration in flight is the responsibility of the MA. The MA will remain with and accompany the patient to the health care facility or may be relieved by another competent caregiver.

3.9. Critical Care Air Transport Team (CCATT).

3.9.1. A CCATT is a specialty care or critical care team authorized operational support status that can be added to the basic AE crew to provide a higher level of care to critically ill patients during AE staging and flight. When in flight, the CCATT physician is responsible for clinical decisions and care concerning the critically ill patient(s) and works under the operational direction of the MCD for mission management and the aircraft commander for operational management. In the event of potential threats to the aircraft or crew, during most contingency operations, casualties will be brought quickly to the flight line where they will be assessed on or near the aircraft.

3.9.2. While en route, the staging facilities should be notified of any unusual or critical care support requirements during remain overnight or extended periods on the ground. The staging facility should arrange for patient care coverage to ensure the CCATTs, MA, or AECMs are allocated rest/recovery periods between flights. If they are unable to meet the needs of the patient, the PMRC, TACC, and aircrew should be notified in advance.

3.9.3. Requests for CCAT teams come from the originating physician, PMRC VFS, or destination-accepting physician. CCATTs are tasked to augment theater evacuation requirements as directed by the AECT, AMOCC, or the TACC AE cell.

3.10. Special Considerations.

3.10.1. Do Not Resuscitate (DNR) Patients. When a patient is diagnosed as having a terminal condition, the medical records must clearly state the patient's condition. Almost any patient can be moved by AE if the proper care environment and specialized medical team is provided. AE personnel are not allowed to accept partial resuscitation orders. Terminally ill or severely traumatized patients, whose condition is so unstable that flight survival is unlikely, should not be moved. However, the tactical/resource situation in a contingency may require movement of such patients in spite of this recommendation. In these situations an AF Form 3838, Do Not Resuscitate (DNR) Certification For Aeromedical Evacuation, should be considered. In accordance with AFI 41-301, *Worldwide Aeromedical Evacuation*, AE patients must have an order that indicates either full resuscitation or DNR. This order is annotated on the patient's DD Form 602, *Patient Evacuation Tag*, must be signed no more than 72 hours prior to the originating flight and will cover the entire time in the AE system. During the aircrew brief, the MCD will review the DNR issues and procedures with the AC and aircrew to prepare for a possible death in-flight. Attending physicians should address DNR status of peacetime AE patients facing imminent death or classified as very seriously ill (VSI), recognizing that the stresses of flight may pose significant risk for precipitating death. The theater VFS will validate peacetime DNR patients for whom AE poses an unacceptable risk of death or injury.

3.10.2. Apparent Patient Death In-Flight. The MCD/FN will advise the AC of an apparent in-flight death and notify affected medical facilities of the situation. In order to maintain patient confidentiality, no specific personal information is transmitted. The patient will be referred to by patient cite number only. If the next stop is not the patient's destination and the aircraft is not in a critical phase of flight, the MCD may contact the AE C2 agencies to discuss options. If the aircraft is in a critical phase of flight or has landed, the MCD will contact the AE C2 agencies and make arrangements to have a physician meet the aircraft and pronounce the patient dead. The patient will then be off-loaded. If the next destination is the deceased deplaning point, the body will be off-loaded regardless of whether it is a military or civilian facility. Once the patient has been pronounced dead, continued airlift ceases except in unique situations and upon communication between the MCD/AC and C2 authorities. If airlift is continued, ensure a death certificate is included in the individual's record.

3.10.3. Contaminated Patient Considerations. Contaminated patients must be decontaminated before entering the AE system unless the combatant commander and USTRANSCOM/CC direct otherwise (AFDD 2-8.1). Decontamination/isolation and processing procedures must be in place to prevent spreading or further damage from chemical, biological, radiological, nuclear, and high yield explosive (CBRNE) threats and ensuring the appropriate protection for patients, aircrew, and aircraft. All procedures must be reviewed with the aircrew by the MCD or flight surgeon. Patients with disease conditions resulting from biological warfare should be decontaminated and have appropriate treatment initiated. Caregivers at the referring facility must ensure that patients with communicable diseases are prevented from spreading the disease through the use of protective equipment by the patient and/or the crew, as deemed necessary by the theater VFS. A presentation of a large number of patients needing decontamination can overwhelm the AE system and diminish mission capability. AF Manual (I) 44-156, *Treatment of Biological Warfare Agent Casualties*, gives detailed information for moving patients suffering from biological warfare exposure.

3.10.4. Medical Emergency in Flight. All in-flight occurrences will be reported to the airlift operations center through the AC. The AECT or AE cell will establish a phone patch with a theater medical authority if clinically applicable. Upon completion of the mission, the MCD will contact the AECT or AE Cell to coordinate follow-up actions and requirements. AFI 41-302 Chapter 5, *AE Patient Safety/Quality Program*, provides AMC policy on guidelines for implementation of AE event/near miss.

3.10.4.1. When medical emergencies occur during flight, providers must take reasonable and necessary action, within their knowledge and experience, to preserve life and health. FNs will immediately start interventions following the most current advanced cardiac life support (ACLS)/basic life support (BLS) guidelines.

3.10.4.2. The AC must be notified immediately regarding the gravity and nature of the situation. The AC and team will take appropriate actions, including landing at the nearest airfield that can both operationally support the airframe and provide medical support for the patient. In critical circumstances, the MCD may request the AC declare an in-flight medical emergency to expedite landing.

Chapter 4

PLANNING AND SUPPORT CONSIDERATIONS

4.1. Movement of Casualties. The movement of United States (US) casualties is accomplished by all available forms of transportation, including ships, ground vehicles, and rotary- and fixed-wing assets. Although evacuation of patients from levels one (front line operations/unit level care) and two (basic resuscitation and stabilization) is normally a Service responsibility, AE units may, depending upon the operational situation, evacuate casualties from forward airfields when requested to do so by the combatant commander (See AFDD 2-4.2, *Health Services* for a discussion on levels of care). AE planning requires the integration of Joint and Service specific capabilities into the theater or JFC's concept of operations. Health service support considerations include the tactical mission and situation, enemy and friendly capabilities, threat assessment, and the theater evacuation policy. AE planners are an integral part of the airlift planning team and should build appropriate AE support into the enroute structure. The AE planner should interface with medical planner to ensure appropriate medical capability along airlift routes

4.2. AE Planning Factors. Medical planners must take many factors into account to select the best or most appropriate means of executing each AE mission. Airlift routes -are identified in order to establish potential AE plans.

4.3. Theater Evacuation Policy. The theater evacuation policy states the maximum number of days (hospitalization and convalescence) a patient may be held within the theater for treatment. Patients who, in the opinion of appropriate medical authority, cannot be returned to duty (RTD) within the prescribed period are evacuated as soon as practical to the next appropriate level of care for further treatment. The evacuation policy is normally 7 days for the combat zone and a combined total of 15 days for the combat zone and the communications zone, in accordance with guidance from the Secretary of Defense in coordination with the geographic combatant commander and Chairman of the Joint Chiefs of Staff. Upon execution and during operations, the theater evacuation policy may be adjusted based on various factors including the number of definitive care beds available in, or deployable to, the theater. It is important to note, the evacuation policy does not imply that a patient must be held in the theater for the entire period identified in the theater evacuation policy.

4.4. Airframe Considerations. It is critical to identify the availability of various airlift platforms that are appropriate for the volume and clinical requirements of the patients to be moved. The AE Cell or AECT are resident experts in AF mobility airlift capabilities and system interface.

4.4.1. Organic Mobility Lift and In System Select (ISS). Organic aircraft are service airframe assets that have been obtained primarily through mission tasking or through en route diversion and mission reprioritization for AE use. Organic airlift is the major airframe component of expeditionary AE. Requirements can vary from obtaining a seat to moving ambulatory patients (or procuring a pallet position to move litter patients) to as much as procuring an entire aircraft to perform a single mission or routine channel mission. The airlift operations centers have visibility of airlift operating in the AOR and may divert a

mission, ISS, to support the patient request. The AE cell/AECT coordinates AE tasking to ensure all assets are available to support the ISS mission. All regrets will be turned back to PMRC to determine alternative lift options.

4.4.2. AE Civil Reserve Air Fleet (CRAF). The AE CRAF program provides airlift platforms, upon contract activation, from commercial airlines specifically to perform/support AE missions. CRAF AE equipment is supported through “ship sets” that provide components necessary to convert the Boeing 767-200/200ER/300/300ER aircraft to a configuration capable of performing AE missions.

4.5. Airfield Capability. The mobility enroute structure and proximity of medical facilities to the airfield determines AE laydown. Proposed onload, en route, and offload airfields must be able to support the operation. The AE Cell or AECT coordinates with airlift operators to determine operating restrictions such as quiet hours, no-light operations, approach restrictions, refueling restrictions, time to upload and download patients, etc. In addition, mission planners must consider flight line security, secured launch, and PHOENIX Raven requirements for designated airfield locations.

4.6. Potential Hostile or Terrorist Locations. The requirements for security forces to support aircraft during AE missions must be considered in the planning and airlift planning process. The PHOENIX Raven program provides these specially trained security forces personnel to protect AMC aircraft and will be included on all AE missions to locations designated “Ravens required.” AECMs will carry weapons, when appropriate and authorized, to protect themselves and their patients.

4.7. Base Operating Support. AE operations depend on integration with the Line of the Air Force (LAF) to provide base operating support. This support is needed for AE units attached to specific locations as well as en route transient support during patient evacuation through the system and must be coordinated with appropriate agencies prior to deployment. These requirements include, but are not limited to, transportation (including patient transportation), messing and other consumable materials, water, fuels, cryogenics, LOX and other gases (obtained from fuels or on a contract basis), billeting, latrines, showers, laundry, and security. Additional requirements include: alternate generator support (primary generator capability is included in allowance standards), fire protection, vehicle maintenance support, vehicle decontamination, maintenance and logistics, life support, contracting, supportive information/communications systems maintenance, waste management, and personnel decontamination. AE UTC mission capabilities statements (MISCAPS) must be reviewed to determine specific requirement especially in regard to communication and transportation support.

4.8. Resupply. Sustained AE operations are dependent upon a well-designed resupply system for the continued availability of consumable medical supplies and PMI at all en route support locations. Planning for onboard or transportable therapeutic oxygen and any associated resupply is essential to prevent mission delays. The AE planner should work with the medical planner to outline logistics hubs and personnel to support LOX refill and PMI, BMET support in the theater and enroute.

4.9. Biomedical Equipment Technician (BMET) Support. Equipment repair is essential in the theater for routine maintenance and minor repair. Deployed MTFs (and potentially civilian and coalition facilities) can support AE equipment repair and maintenance in steady state but not surge periods. Therefore the AE planner should insert AE BMET capability into potential hubs and align with local medical treatment facilities to ensure AE equipment is processed to meet mission requirements.

4.10. Communications. Planners must ensure AE communication capability is integrated with the mobility airlift and communication squadron network. Communication must be maintained with subordinate deployed AE elements that may not be on or near an AF wing.

4.11. Ground Transportation. Most AE units deploy with integral transportation capability for limited patient and crew transport at forward locations. AE planners should ensure proper aircraft support equipment is available at the airfield, i.e. support pallets and loading systems. The MTF is responsible for transport to the aircraft. Medical planners should determine the availability of other Service ambulances and vehicles and, if necessary, establish contracts or obtain host-nation support.

4.12. Determining Crew Support. It is imperative that planners ensure crew resources are allocated appropriately and a designated replacement schedule to replace crews departing the theater must be established. Consideration must be given to length of crew duty day, augmentation of basic crews, required crew rest period, as well as ensuring transportation and billeting arrangements. Aircrews and CCATTs should be positioned with MASF and AECM stage management sites to allow for rapid response.

4.13. AE Interface with Special Mission Forces.

4.13.1. Special Mission Operations and Rescue. Some special mission operations and expeditionary forward deployed operations, such as Special Operations (SOF), marine expeditionary forces, and combat search and rescue (CSAR) do not possess organic conventional AE capability and must identify requirements for, and obtain conventional AE support at forward airbases.

4.13.2. Casualties. Evacuation of casualties within the joint special mission arena can be a particularly complex issue since these forces often operate in small, widely dispersed teams, and in locations not easily accessible. Flexibility and sensitivity to the particular needs of the special mission community, both clinically and administratively, is important to consider in determining how to best support their AE requirements. This includes instances where casualty identification must be protected and not entered into the regulating system. The special mission forces are responsible for care and evacuation of casualties from the forward location to the secure airfield where AE forces may be prepositioned to support the operation. The special mission teams will conduct the evacuation of patients on their organic vehicles and should not require any AE/CCATT interface. At the secured airfield AE/CCATT assets will assume responsibility for the casualties, freeing special mission medical assets to return to forward locations. AE assets will provide the support required to AE patients to reach definitive care. To prevent personnel with critical specialties from being evacuated from

theater, Special Mission Forces personnel may require a separate evacuation policy to facilitate reconstitution.

4.13.3. Training to Support Forward Special Missions. Normally, the interface point with special operations is the MASF. MASF personnel have contingency operations training and in forward locations must be ready to perform AE missions, as well as provide limited holding for patients having been provided resuscitation and surgical intervention. A CCATT and/or additional crews may augment the MASF as required. AE missions originating at secure forward airfields may require AE operations in low light or blackout conditions. When supporting these forces, AECMs/CCATTs need to be trained in trauma training, low light/low noise, weapons, and survival in austere locations to meet special mission requirements. The planner should understand the need for limited resources and yet versatile, flexible capability to support special missions.

4.13.4. Special Ops Critical Care Air Transport Team (FFQC4). Specialized CCAT teams train with the AF Special Ops Forces (SOF) to meet their unique mission requirements. These teams provide care to casualties transiting the SOF casualty evacuation system and provide continued trauma and post-operative casualty management aboard organic SOF aircraft and other opportune evacuation platforms. SOF Medical Elements (SOFME) are on operational support flying status, have been trained in SOF aircraft and attend the AE Technician course. If the situation warrants, conventional CCATTs are authorized to fly with SOFMEs on organic SOF aircraft.

4.14. Detainee Missions. Detainee missions fall under the responsibility of security forces and are politically sensitive. Normally a CONOPs is written to outline roles and responsibilities. AE forces should receive training in advance of supporting these missions and must follow security forces guidelines at all times.

4.15. Inter-fly Agreements with MAJCOMs, Service, and Coalition AE Support. The Air Force employs fixed-wing aircraft for the movement of patients and utilizes AECMs to supervise medical treatment of those patients. Other services and coalition forces use various ground transport, and rotary and fixed-wing aircraft for PM. They also use their own medically trained crewmembers or MAs. US Air Force AE aircrew members may perform appropriate duties in non-US Air Force aircraft if it is in the interest of the US Government and approved by both the theater combatant commander and the controlling aircraft authority. In addition, coalition forces may also integrate with AE forces. The AE planner will identify the potential need. The operations center, in peacetime or wartime, normally works inter-fly agreements through the LAF. In peacetime, MAJCOMs may require inter-fly agreements to be processed before AE crews from one command can fly with others.

4.16. Operations Phasing and Force Sequencing. AE forces provide a rapid, flexible, incremental, mobile response. UTCs are selected to provide the required level of command, control, communications, patient care, and system support. This allows planners to select specific packages required to support steady state as well as contingency operations, or those used for developing MTW operation plans (OPLAN).

4.17. AE UTC Employment Concept. All AE UTCs are lighter and modular to optimize use of limited airlift during the initial phases of an operation, without sacrificing capability. Some of the equipment UTCs are man-portable to ensure AE can be employed in the very early stages of a contingency. The concept is to employ an immediate, versatile, and flexible AE presence to respond to the needs of the deployed forces. Personnel will need to be multifunctional and capable of performing additional duties. After the initial buildup, the planners can augment the deployed teams with more manpower and equipment (augmentation packages), as required, to support more intense or ongoing operations.

4.18. AE UTC Selection and Utilization. AE UTCs are developed based on the building block “plug-in/pull-out” principle, allowing planners to select specific UTCs capable of supporting the range of steady state, contingency or MTW OPLANs. The UTCs are divided into three major categories: command and control, patient care, and support, and are designed to meet highly mobile and austere conditions. As workload changes or is projected to change, UTC packages may be deployed or redeployed in small increments or combined with other UTCs to provide capability needed.

4.18.1. Command and Control UTCs: C2 UTCs, AECT and EAES, are outlined in Chapter 2 and integrated with airlift operations.

4.18.2. Patient Care UTCs.

4.18.2.1. Aeromedical Evacuation Crew Member (AECM). The AECMs perform in-flight patient care on any fixed-wing aircraft using medical equipment that meets airworthiness testing certification standards. Crewmembers are knowledgeable about the stresses of flight and effects of altitude on patients, basic trauma skills, and patient safety. AECMs are experts on the interface between aircraft systems and medical equipment to meet patient care requirements. Crews can also augment any ground UTC requiring additional clinical management or mission support capability. The basic AECM team may be tailored by the designated chief nurse to support the patient’s needs and requirements. During execution of the AE mission, AE crews and CCATTs are directed by air operations center in control of the airlift mission, i.e. AECT/AMOCC for theater or TACC for intertheater airlift.

4.18.2.1.1. Medical Crew Director (MCD). The MCD is a qualified flight nurse designated and trained as the AECM responsible for overall management of a particular AE mission and provide oversight of nursing care. The MCD utilizes all resources on-board and works closely with all attendants and team members, and the aircraft commander to ensure the safety of all patients, passengers, attendants and crew. When a significant change in patient medical status or concern regarding a patient’s capability to tolerate the airborne environment occurs the MCD should contact the AMD/TACC AE cell to coordinate with the PMRC. The PMRC on-call theater VFS is available to provide clinical guidance. If the PMRC cannot be contacted, the MCD is the senior medical authority for all patient care issues and should render care within his or her scope of practice, available clinical resources on-board, and current standards of care.

4.18.2.2. Critical Care Air Transport Team (CATT). CCATTs provide specialized care, in conjunction with AE crews, to evacuate critical patients requiring advanced care during transportation. Recognized as clinical experts, these teams are medically responsible for their patients and function under the in-flight direction of the MCD and AC. The CCATT physician is clinically responsible for care given to CCATT-assigned patients and may be asked to assist or advise on the care of the other patients. CCATTs may be staged at crew bed-down locations with fixed and/or mobile AE staging facilities. Teams positioned in staging facilities may augment the patient care capability of that facility. CCATTs may be assigned leadership functions within their assigned UTC and wing consistent with rank, training and experience. AE missions that require CCATT augmentation will be identified/validated by PMRC/AECT. The theater validating surgeon, in conjunction with the CCATT director, designated by the AES CC, normally coordinates individual CCATT mission requirements. The CCATT physician determines team requirements based on each mission and may pair and tailor as needed. The AECT monitors, tracks, and informs the PMRC on the use of CCATT resources.

4.18.2.3. Aeromedical Expeditionary Support Equipment Package. When AECMs and CCATTs are deployed to forward locations early in an operation or to support Global Mobility CONOPS, a Base Operating Support (BOS) equipment packages including tents, generators, and a vehicle (when tasked) may be used to support their BOS requirements.

4.18.2.4. Mobile Aeromedical Staging Facility (MASF). The MASF provides rapid response patient staging, limited holding and AE crew support capability to support SSCs, humanitarian and civil disaster response operations, and MTWs. The MASF is normally located at or near airheads capable of supporting mobility airlift. The MASF is designed to provide forward support with the smallest footprint. It is made up of three short crews, communications, liaison, and patient care teams. When crews are tasked from the MASF, they should be rapidly backfilled because the nurses and techs are also utilized for patient holding capability. The MASF includes a capability to receive patients, provide supportive patient care, and meet administrative requirements on the ground while awaiting AE. CCATTs should be assigned to every forward based MASF to enhance rapid evacuation. Additionally, the MASF equipment package contains sleeping tents to provide BOS for deployed personnel. The communications capability assigned to the MASF may be integrated into the tanker/airlift control element or operations cell. An individual may be identified to work with the aerial port element on the flight line to coordinate AE load planning, configuration, and operational support.

4.18.2.4.1. MASF Augmentation. The MASF may be augmented with additional personnel and equipment to increase patient staging capability as needed.

4.18.2.4.2. The Contingency Aeromedical Staging Facility (CASF). The CASF may be used at major inter-theater hubs to support the full spectrum of contingency operations and Air and Space Expeditionary Force (AEF) operations including humanitarian relief operations (HUMRO) and homeland defense missions. The CASF interfaces with the AE mission and falls under the command and control of the medical group commander.

4.18.3. Support UTCs.

4.18.3.1. AE Liaison Team (AELT). The Air Force AELT provides support between the forward user and the AE system in the form of operational and clinical interface. This interface may occur at locations that do not otherwise have AF personnel on them such as far forward/bare bases and shipboard. An AELT may be geographically separated from the other AF assets. The flight nurse on the team assists the medical unit in preparing AE patients for flight. The administrative officer is responsible for working with the airlift center and aerial port element to ensure the aircraft is properly configured and equipment pallets, patients, and AE support personnel are properly manifested on the AE mission. The communications personnel will be integrated into the airlift operations element supporting flight line operations or the WOC. Establishing a communication network with airlift operations is essential for rapid evacuation.

4.18.3.2. Crew Management Cell (CMC). The CMC provides direct supervision and crew management for assigned, attached, and transiting AE crews and CCATTs in conjunction with the TACC/AMOCC, AECT and base operations, as applicable. The CMC coordinates requirements to include launch and recovery, life support, billeting, food service, transportation and administration for AECMs/CCATTs. In addition, the CMC may assist AECMs and CCATTs with aircraft configuration. This UTC manages and tracks equipment for AECMs and CCATTs. The CMC can be deployed independently or in conjunction with other UTCs to meet mission requirements. This UTC is for use in the tactical environment.

4.18.3.3. AE Stage Management Team (ASMT). The ASMT is integrated into the AMCC and located at strategic airlift hubs or en route locations to support aircrews, equipment, and launch and recover operations. The ASMT manages assigned and transiting AECMs/CCATTs, aircraft configuration, and equipment to include CRAF support, patient loading interface, and re-supply of in-flight kits, medications, and patient liquid oxygen. Communications capability will be integral to the AMCC.

4.18.3.4. AE Support Cell (AESC). The AESC provides communications and air and space ground equipment (AGE) maintenance support to all UTCs assigned to the TAES. The AESC should be staged with equipment at key locations, normally with the AECS, within the AOR to support AE requirements. Communications networks will be integrated with airlift operations. The AESC may have BMET support to ensure routine inspection and simple maintenance of AE equipment can be conducted in the AOR or within the theater. At sites with MTFs, a MOU may be established with these AE BMETs augmenting MTF teams. Major equipment repairs should be conducted at PMI centers with equipment swapped out to ensure theater capability is not degraded.

4.18.3.5. PMI teams are composed of medical logistics teams and biomedical equipment repair teams. The logistics teams provide manpower for operational management of the PMI center. Duties consist of storage, reception, inventory control, issue, palletizing, shipping, and identification of equipment requirements. The equipment repair teams provide regional maintenance and repair capability for equipment in PMI centers and/or

cells. Duties include scheduling and completing scheduled preventative maintenance and calibration, repair and maintenance services, and updating the PMI information system.

4.19. AE Mission Support Equipment.

4.19.1. Patient Support Pallet (PSP). The PSP will provide litter capability on the tanker aircraft and expands litter capacity on some airlifters. The PSP is a modified 463L pallet with litter positions and seats and is centrally managed by AMC. It is designed to support steady-state theater operational requirements as well as PM on opportune airlift without integral litter capability. As a result, the PSP increases the number of MDS capable of performing AE missions. (See PSP CONOPs published by HQ AMC).

4.19.2. SPECTRUM. The SPECTRUM patient care module is routinely used on operational support aircraft to support urgent, single patient requirements (including infant isolette). The aircraft usually require modification to accept the SPECTRUM. The base of the SPECTRUM contains oxygen, electrical outlets and suction to support patient care.

4.19.3. Patient Loading System (PLS). The PLS is the preferred method for enplaning/deplaning patients in tanker and CRAF aircraft. However, the K-loader or equivalent may be used for patient loading if no PLS is available. While the PLS actually used in support of AE CRAF missions and operated by Aeromedical Staging Squadron personnel at strategic hubs, there is also a need for PLS to support tankers, and other opportune AE missions during day-to-day operations at forward locations.

4.20. AE Equipment and Supplies.

4.20.1. Sustained medical logistics support for AE operations is essential. Reachback and resupply operations ensure sustainment of theater AE forces. Maintenance and refilling of liquid oxygen containers requires qualified LOX personnel. LOX refilling agreements should be coordinated by the EAES commander with the respective supporting operations group. Other items of interest are the shipment of in-flight medical kits and interface with prime vendor suppliers to fulfill deferred procurement items. Planners should identify supply hubs requirements and request additional support AE operations, i.e. additional LOX support personnel at airlift hubs and logisticians at deployed locations. The initial point of entry into the logistics chain will be at the attached wing level. Medical supplies may be supported by the proximal MTF medical logistics function. In large operations or contingencies, an interface with single integrated logistics manager (SIMLM) system may be generated. Requirements for class 8 supplies will be processed through the established theater system. Reachback to CONUS or home unit is not advised.

4.20.2. Responsibilities.

4.20.2.1. AE Equipment: The in-flight and theater AE environment exposes medical equipment to unique stresses. Equipment should be able to withstand environmental extremes of temperature and humidity, aircraft vibration, altitude and rapid decompression of the aircraft, and electromagnetic interference to and from the aircraft. Interface with the aircraft should not pose any safety hazards to the patients or aircrew.

Equipment items are tested and certified as airworthy and compatible with Air Force mobility airlift.

4.20.2.2. As the lead command for AE, HQ AMC provides continuous review and oversight of the AE system, thus ensuring the AE force is appropriately supplied and equipped to perform the mission. AMC Director of Plans and Programs is responsible for integrating AE into mobility airlift and requirements for new equipment to support AE. AMC DO manages day-to-day oversight of AE equipment. The Allowance Standard Working Group (ASWG) consists of representatives from all AE components (active, guard, reserve) and includes aircrew members, nursing, administration, operations, communications, and logistics personnel. This group was chartered by AMC to be the AE equipment review authority. The ASWG reviews equipment package allowance standards, examines new equipment requirements, and coordinates with the Human System Center—Technical Planning Integrated Product Teams, Air Force Medical Logistics Office, and the Joint Readiness Clinical Advisory Board to facilitate standardization and compatibility with the joint community.

4.20.2.3. The Air Force Medical Development Laboratory (AFMEDL) at Brooks AFB, Texas, is responsible for the airworthiness evaluation process for new or proposed medical devices for AE and coordinating with AMC. All medical equipment utilized for AE must be certified by AFMEDL as safe for use in aircraft.

4.21. Patient Movement Items (PMI).

4.21.1. A major factor in the movement of patients through the levels of care is to ensure specific medical equipment and durable supplies designated as PMI are available. The PMI system supports in-transit patient care capability without removing equipment from patients. The system exchanges like-kind PMI without degrading medical capabilities, and provides prompt recycling of PMI. The system provides a seamless in-transit patient and/or equipment management process from initial entry into AE to the patient's final destination. PMI system UTCs deploy in support of the AE system and are collocated with AE at key interface points to provide initial AE operational capability, to sustain AE operations, and to minimize equipment turnaround time. Equipment will be managed, supplied, and resupplied through the PMI centers and joint transportation and logistics systems. It is the originating health care facility's responsibility to provide the PMI required to support the patient during evacuation. Services should plan, program, and secure equipment that is air certifiable to use in deployable platforms. In a contingency, the PMI cell may be collocated with the SIMLM, normally at a robust air and logistics hub.

4.21.2. While the PMI program is mandated by the Assistant Secretary of Defense (Health Affairs), the USAF/SG has oversight responsibility, and AMC/SG has program management responsibility.

4.21.3. MAJCOM and theater surgeons are executive managers of PMI within their areas; i.e., AMC/SG, PACAF/SG, USAFE/SG. Usually positioned at strategic AE hubs, PMI centers will store and maintain PMI while actively interfacing with AE operations.

Chapter 5

TRAINING

5.1. Objective. The overall objective of the AE training program is to develop and maintain a high state of mission readiness of AE personnel for rapid employment across the spectrum of operational requirements. AE personnel should be able to interface with airlift operations, prepare any mobility aircraft for patient evacuation, and provide appropriate en route and in-flight patient care intervention using certified AE equipment..

5.2. Responsibilities. HQ AMC is the lead command for AE as specified in AFPD 11-2, *Aircraft Rules and Procedures*, and AFPD 10-21, *Air Mobility Lead Command Roles and Responsibilities*. HQ AMC is responsible for standardizing aircrew flying training requirements in coordination with other user MAJCOMs. The AMC Director of Operations (HQ AMC/DO), is the lead command designee for training course requirements, training tasks, and coordinating the development and publication of AE training standards. The Global Aeromedical Evacuation Integration Team (GAIN) is the clearinghouse for clinical and operational issues that impact the global AE system. The GAIN interacts with appropriate agencies, such as AMC SG for CCATT and AE clinical guidelines, to develop, standardize, and evaluate programs and platforms in response to customer requirements.

5.3. AE Aircrew Training/Qualification.

5.3.1. The USAF School of Aerospace Medicine (USAFSAM) located at Brooks AFB, TX is responsible for the formal school syllabus for AE crewmembers, which includes training in altitude chamber, survival, clinical, AE equipment, and ground training. Currently, the primary method of AE aircrew qualification is to complete unit-qualification training in their unit-specific mission design series (MDS). All AECMs meet requirements listed in AFI 48-123, *Medical Examination and Standards*, and complete physiological training.

5.3.2. Qualification training may occur at the unit level until a formal AF school is established. Ground training covers aircraft systems, aircraft emergency equipment, life support, medical emergency equipment, and patient care procedures. Flight training consists of training flights that reemphasize ground-training areas in an operational environment. Students must experience a variety of mission scenarios during their training to include aircraft and medical emergencies as well as survival, evasion, resistance, and escape training.

5.3.3. All available mobility aircraft are considered for patient transport. The existing aircraft certification program is designed for qualified and current AECMs to train and orient on aircraft (which they are not qualified on) prior to performing an AE mission. Minimum requirements for certification include aircraft emergency procedures and equipment, ground and in-flight safety issues, compatibility of AE equipment with the aircraft, and a ground or flight training period. Certification has the same training objective as qualification, except it does not require a flight evaluation (refer to AFI 11-2AE Volume 1).

5.4. AE Contingency Operations Training (AECOT) and Formal Training Courses. AECOT is conducted at Sheppard AFB, Texas and provides initial and sustainment training at various sites, including the Air Mobility Warfare Center, for all AE UTCs as well as UTCs augmenting AE, such as CCATTs. The course emphasis is on readiness and preparation for wartime or contingency operations and teaches personnel the entire spectrum of AE ground operations. Training encompasses all phases of deployments to include predeployment, employment, post-employment, and post-deployment activities. Formal training courses may consist of patient care within the AE system, hazardous cargo certification, cargo processing, pallet building, vehicle loading, aircraft configuration, aircraft load planning, and aircraft loading.

5.5. Operations Training. Many courses are available for airlift operations training. The Air Mobility Operations Course offers personnel insight into mobility operations. The AOC and JAC2C courses are the basic training platform for airlift operations center personnel. The Airlift Planners course is also available. Stage Management courses for scheduling and managing aircrews will be required for the CMC and ASMT. Training sites providing practical, tactical training scenarios, load-out training, and joint C2 relationships are highly recommended. This cannot be overemphasized as AE personnel may deploy far forward. AMC is in the process of developing an AE flight qualification program and leadership courses.

5.6. Critical Care Air Transport Team (CCATT) Training. CCATT training requirements are determined by the manpower, equipment, and force packaging (MEFPAK) manager (AMC/SG) and the CCATT pilot unit. Training includes attendance at the CCATT formal course at Brooks AFB. Physicians are trained in advanced cardiac life support (ACLS) and advanced trauma life support (ATLS). Critical care nurses are trained in ACLS and Trauma Nurse Core Course (TNCC). Cardiopulmonary technicians are trained in ACLS. CCATTs training requirements are integrated into the AE system through membership in the GAIN. Attendance in AECOT is required.

5.7. Professional Education.

5.7.1. Flight nurses are licensed, registered nurses with a variety of clinical expertise. Trauma training and Emergency Medical Technician (EMT) training is highly recommended for all flight nurses in order to support our wartime mission. All nurses are responsible for clinical competency, based on the AFSC-specific (46F and 46N) series core competency list approved by the Director, AF Nursing Services.

5.7.2. Clinical training for FNs and AETs is governed by the Readiness Skills Verification Program and Career Field Education and Training Program (CFETP). In addition, all AETs are certified as both an emergency medical technician (EMT) and BLS provider.

5.8. Currency Training. To maintain currency, each AECM normally maintains requirements established IAW AFI 11-301, *Aircrew Life Support (ALS) Program*; AFI 11-202, Volume 1, *Aircrew Training*, Volume 2, *Aircrew Standardization/Evaluation Program*, and Volume 3, *General Flight Rules*; and AFI 11-2AE Volume 1, *Aeromedical Evacuation Aircrew Training*, and Volume 2, *Aeromedical Evacuation Aircrew Evaluation Criteria*. These include minimum number of flying hours, periodic written examinations and flight evaluations, maintenance of a

current flight physical, and periodic completion of physiological training, life support, ground egress, and medical equipment training.

5.9. Adopted Forms. AF 3838, *Do Not Resuscitate (DNR) Certification for Aeromedical Evacuation*; AF 3899, *Aeromedical Evacuation Patient Record*; DD 601, *Patient Evacuation Manifest*; DD 602, *Patient Evacuation Tag*.

DAVID F. MacGHEE, Major General, USAF
Commander, Air Force Doctrine Center

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

DOD Instruction 6000.11, Medical Regulating
JP 3-17, *Joint Doctrine and Joint Tactics, Techniques, and Procedures for Air Mobility Operations*
JP 4-02, *Doctrine for Health Service Support in Joint Operations*
JP 4-02.2, *Joint Tactics, Techniques, and Procedures for Patient Movement in Joint Operations*
AFDD 2, *Organization and Employment of Aerospace Power*
AFDD 2-1.8, *Counter Nuclear, Biological, and Chemical Operations*
AFDD 2-4.2, *Health Services*
AFDD 2-5, *Information Operations*
AFDD 2-6, *Air Mobility Operations*
AFPD 10-21, *Air Mobility Lead Command Roles and Responsibilities*
AFH 10-2502, *USAF Weapons of Mass Destruction (WMD) Threat Planning and Response Handbook [draft]*
AFPD 11-2, *Aircraft Rules and Procedures*
AFI 11-2AE, Vol 1, *Aeromedical Evacuation Aircrew Training*
AFI 11-2AE, Vol 2, *Aeromedical Evacuation Aircrew Evaluation Criteria*
AFI 11-202 Vol 1, *Aircrew Training*
AFI 11-202 Vol 2, *Aircrew Standardization/Evaluation Program*
AFI 11-202, Vol 3, *General Flight Rules*
AFI 11-301, *Aircrew Life Support (ALS) Program*
AFI 41-106, *Medical Readiness Planning and Training*
AFPD 41-3, *Worldwide Aeromedical Evacuation*
AFI 41-301, *Worldwide Aeromedical Evacuation System*
AFI 41-302, *Aeromedical Evacuation Operations and Management*
AFJI 41-306, *Physician's Roles and Responsibilities in Aeromedical Evacuation [Draft]*
AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care [Draft]*
AFI 41-309, *Aeromedical Evacuation Equipment Standards*
AFJH 41-313, *Aeromedical Evacuation Documentation [Draft]*
AFI 41-316, *Aeromedical Evacuation In-flight Kit Packaging Guide*
AFI 44-102, *Community Health Management*
AFI 44-109, *Mental Health and Military Law*
AFI 44-119, *Medical Service Quality Improvement and Risk Management*
AFMAN (I) 44-156, *Treatment of Biological Warfare Agent Casualties*
AFI 46-101, *Nursing Operations*
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Supporting Information

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Public Law 104.113, National Technology Transfer Act
Presidential Circular 119A

Abbreviations and Acronyms

AC	aircraft commander
ACLS	advanced cardiac life support
ADCON	administrative control
ADVON	advanced echelon
AE	aeromedical evacuation
AECOT	aeromedical evacuation contingency operations training
AECM	aeromedical evacuation crewmember
AECMC	AE crew management cell
AECS	AE command squadron
AECT	aeromedical evacuation control team
AEG	air and space expeditionary group
AELT	aeromedical evacuation liaison team
AES	aeromedical evacuation squadron
AESC	aeromedical evacuation support cell
AET	aeromedical evacuation technicians
AETF	air and space expeditionary task force
AEW	air and space expeditionary wing
AF	Air Force
AFDD	Air Force Doctrine Document
AFFOR	Air Force forces
AFI	Air Force Instruction
AFJH	Air Force Joint Handbook
AFJI	Air Force Joint Instructions
AFJMAN	Air Force Joint Manual
AFMEDL	Air Force Medical Development Laboratory
AFMLO	Air Force Medical Logistics Office
AFRC	Air Force Reserve Command
AFSC	Air Force Specialty Code
AFTTP	Air Force Tactics, Techniques, and Procedures
AGE	aerospace ground equipment

ALCT	airlift control team
ALS	aircrew life support
AMC	Air Mobility Command
AMCC	Air Mobility Control Center
AMD	air mobility division
AME	air mobility element
AMOCC	air mobility operations control center
ANG	Air National Guard
AOC	air operations center (JP 1-02), air and space operations center [USAF]
AOR	area of responsibility
ARC	Air Reserve Component
ASMT	AE stage management team
ASWG	allowance standard work group
ATLS	advanced trauma life support
ATO	air tasking order
BLS	basic life support
BMET	biomedical equipment technicians
BOS	base operating support
C2	command and control
CAA	civilian air ambulance
CARB	Contract Approval Review Board
CASEVAC	casualty evacuation
CASF	contingency aeromedical staging facility
CBRNE	chemical, biological, radiological, nuclear, and high yield explosive
CCATT	critical care air transport team
CFETP	Career Field Education and Training Program
CMT	charge medical technician
CMC	crew management cell
COMAFFOR	commander, Air Force forces
CONOPS	concept of operations
CONUS	Continental United States
CRAF	Civil Reserve Air Fleet
CW/BW	chemical warfare/biological warfare
DEPOD	deployment order
DIRMOBFOR	director of mobility forces
DNBI	disease and non-battle injury
DNR	do not resuscitate
DO	director of operations
DOD	Department of Defense
DODI	Department of Defense Instruction
DVA	Department of Veterans Affairs
DOMS	Director of Military Support
EAES	expeditionary AE squadron
EAS	expeditionary airlift squadron
EMEDS	Expeditionary Medical Support System

EMP	emergency medical plan
EMT	emergency medical technician
EPW	enemy prisoner of war
EXORD	execution order
FCIF	flight crew information file
FEMA	Federal Emergency Medical Agency
FHP	force health protection
FN	flight nurse
FRP	Federal response plan
FS	flight surgeon
GAIN	global AE integration team
GATES	Global Air Transport Execution System
GDSS	Global Decision Support System
GMTF	Global Mobility Task Force
GPMRC	Global Patient Movement Requirements Center
HUMRO	humanitarian relief operations
IAW	in accordance with
ICMOP	integrated CONUS medical operations plan
ISS	in-system select
ITV	in-transit visibility
IV	intravenous
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JAC2C	Joint Airlift Command and Control Course
JFACC	joint force air component commander, (JP 1-02), joint force air & space component commander [USAF]
JFC	joint force commander
JFS	joint force surgeon
JPMRC	joint patient movement requirements center
JTF	joint task force
JTF/CC	joint task force commander
LAF	Line of the Air Force
LOA	lead operational authority
LOX	liquid oxygen
MA	medical attendant
MAJCOM	major command
MASF	mobile aeromedical staging facility
MCD	medical crew director
MDS	mission design series
MEDEVAC	medical evacuation
MEFPAK	manpower, equipment, and force packaging
MIL-STD	military standard
MISCAPS	mission capabilities
MOU	memorandum of understanding
MRO	medical regulating officer
MSCA	military support to civil authorities
MTF	medical treatment facility
MTW	major theater war

NBC	nuclear, biological, and chemical
NCOIC	non-commissioned officer in charge
NDMS	national disaster medical system
NE	nurse executive
NEO	noncombatant evacuation operation
OIC	officer in charge
OPCON	operational control
OPLAN	operation plan
OPORD	operation order
OSD	Office of the Secretary of Defense
PACAF	Pacific Air Forces
PAD	patient administration director
PLS	patient loading system
PM	patient movement
PMCC	patient movement clinical coordinator
PMI	patient movement items
PMR	patient movement request
PMRC	patient movement requirements center
POW	prisoners of war
PSP	patient support pallet
RSV	readiness skill verification
RTD	return to duty
SIMLM	single integrated logistics manager
SOF	special operations forces
SOFME	SOF medical elements
SSC	small-scale contingency
TACC	Tanker/Airlift Control Center
TACON	tactical control
TAES	theater aeromedical evacuation system
TDY	temporary duty
TNCC	trauma nurse core course
TPMRC	theater patient movement requirements center
TRAC2ES	USTRANSCOM Regulating Command and Control Evacuation System
TTP	Tactics, Techniques, and Procedures
UTC	unit type code
US	United States
USAFE	United States Air Forces in Europe
USAFSAM	USAF School of Aerospace Medicine
USTRANSCOM	United States Transportation Command
VFS	validating flight surgeon
VSI	very seriously ill
WMD	weapons of mass destruction
WOC	wing operations center

Attachment 2

PATIENT MOVEMENT PLANNING AND EXECUTION ALGORITHM

