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# *C/KC-135 OPERATIONS PROCEDURES*

**COMPLIANCE WITH THIS PUBLICATION IS MANDATORY**

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This supplement provides additional guidance to AFI 11-2KC-135, Vol 3, and applies to Pacific Air Forces assigned aircrew. This supplement applies to PACAF or PACAF-gained Air National Guard (ANG) units. It does not apply to the Air Force Reserve Command (AFRC) units.

**AFI 11-2KC-135, Volume 3, 1 December 1999, is supplemented as follows:**

20.3.1.1. (Added) PACAF-Directed Aeromedical (AE) Missions. Waiver authority for active duty or ANG units flying PACAF-directed AE missions controlled by the PACAF AMOCC is PACAF/DO. PACAF/DOTV personnel are the authorized agent and maintain 24-hour watch through the AMOCC/AE Cell.

20.3.1.2. (Added) The AE Squadron Chief Nurse (AES/SGN) or acting Chief Nurse, is the waiver authority for non-flight certified medical equipment on AE aircraft originating in the Pacific Theater. The Medical Crew Director (MCD) will brief the aircraft commander (AC) on all waivers for all non-flight certified medical equipment prior to engine start.

20.5.1.1. (Added) PACAF AMOCC is the overall command and control authority in the Pacific for PACOM AE operations. When off station, ACs should coordinate with PACAF AMOCC for computer flight plans, diplomatic clearances, en route support, maintenance support, etc. The AMOCC/AE Cell is the focal point for AE mission changes and will coordinate those changes with the Theater Patient Movement Requirements Center (TPMRC), and applicable AE mission squadrons.

20.5.1.1.1. (Added) The MCD is responsible to pass an "End of Mission/Patient Status" report to the PACAF AMOCC at the end of each AE channel mission. If the AE channel mission continues over a period of days, the MCD will pass the report at the end of each travel day.

20.5.1.2. (Added) **Operational C2 Reporting:** Mission flight following and support will be provided by the appropriate agency as follows:

20.5.1.2.1. (Added) **Home Base launch:** WG Command Post providing C2 for that location.

20.5.1.2.2. (Added) **Off station launch from a USAF Air Base:** PACAF AMOCC, DSN 448-8888/449-4030, commercial (808) 448-8888/449-4030. Any local PACAF Command Post should be notified and coordinated with for any services required for mission accomplishment (i.e. Patient Loading System, AC units, etc)

20.5.1.2.3. (Added) **No C2 available:** Off-station launch from a base or airport without a command post: PACAF AMOCC, DSN 448-8888/449-4030, commercial: (808) 448-8888/449-4030.

20.5.4.1. (Added) **Medical Assistance:** The MCD is responsible for coordination with originating and en-route medical facilities regarding the physical condition of patients. Should a patient's condition change in-flight, the MCD will request that a flight surgeon or physician reevaluate the patient's ability to continue travel and notify the TPMRC. Matters affecting flight safety are the prerogative of the aircraft commander (AC).

20.5.6. (Added) **Aircraft Malfunction Reporting:** For any aircraft malfunction that will affect departure timing, immediately notify C2 facility as available. If aircraft malfunction ETIC is greater that 1 hour, ensure C2 facility passes aircraft status and ETIC to PACAF AMOCC for coordination with AE Cell/TPMRC. In addition, ensure C2 facility coordinates aircraft status/ETIC with local Medical Treatment Facility (MTF) providing AE patient care so patient movement to aircraft can be delayed if possible. If an aircraft malfunction ETIC will exceed 1 hour, patients are already at the aircraft, and aircraft cabin temperatures dictate patient movement to a more comfortable environment, the MCD should coordinate to have patients transported to an alternate patient holding facility (i.e. passenger terminal) or back to the local MTF as appropriate.

20.6.2.1. (Added) The aircraft commander and SQ/DO will make the determination whether an intelligence briefing is necessary for any routine/urgent AE mission based upon incidents or observations. Prior to flight, the aircraft commander or their designated representative will ensure that all aircrew members are briefed on intelligence data relevant to the mission. Ultimate responsibility rests with the aircraft commander to ensure this briefing is accomplished prior to departing home station. Anything out of the ordinary (i.e. contact with foreign national intelligence personnel or unusual military activity observed) shall be cause to debrief appropriate intelligence agencies. Debriefs should take place as soon as practical upon return to home station.

20.6.12. (Added) The AC will ensure a copy of patient/passenger load and weight and balance form is given to ground emergency personnel or responsible agent prior to engine start.

20.7.6.1. (Added) Patient meals will be box-lunch variety (cold), since the galley is rendered inoperable. Arrangements will be made by TPMRC with medical facility nutritional support centers to prepare specialty meals. AECM's will ensure a large cooler be carried an all AE flights and filled ½ way with ice to ensure proper meal storage temperatures.

20.8.3.1. (Added) **AE Mission Kits:** AE mission kits will be carried in accordance with HQ AMC guidance (as coordinated with HQ PACAF/DOTV).

20.8.3.2. (Added) The AE crew will check the kit prior to home stations departure. Non-standard missions may require additional items.

20.8.5.1. (Added) Within the constraints of patient care, the MCD or designated AECM will be on interphone (headset) during critical phases of flight (to included takeoff/landing) and should, to the maximum extent possible, be on aircraft interphone during all phases of flight.

20.8.7. (Added) **Weight and Balance:** The MCD will coordinate with the boom operator to ensure proper patient/passenger load data is available for weight and balance calculations. The MCD will also ensure the boom operator has a list of all equipment weights.

20.8.8. (Added) After departure, the MCD will determine a seat release for the next station and inform the AC for transmission with the inbound load message. Due to limited latrine capability, the total number of persons on board will be limited to 40 persons.

20.9.1. (Added) When notified by the MCD of an apparent death in-flight, the AC should immediately provide the C2 facility (AMOCC or command post) with the following information: "An apparent death has occurred in-flight on mission number ____. ETA to _____ is _____Z. Patient Manifest Cite number is _____." If contacting a command post, ensure information is passed to the AMOCC/TPMRC. No personal data will be transmitted, to preclude premature release prior to official notification of the next of kin.

20.9.1.1. (Added) The AMOCC/AE Cell will ensure a physician meets the aircraft. The examining physician can pronounce the patient dead on arrival. No attempt should be made to pinpoint time or place of death other than the point of examination. The MCD will provide the TPMRC with all required information concerning patient data and events prior to death.

20.10.1.1. (Added) PACAF/DO waives requirement for AE crewmembers (AECM) to be fully qualified on at least one of the following aircraft: C-9, C-17, C-130, or C-141, if AECM is fully qualified on the C/KC-135 aircraft per PACAF/DOT approved KC-135 AE Training/Qualification Program. Aircraft certification for other aircraft will be as directed in AFI 11-2AE, Volume 1.

20.10.2.1. (Added) The normal crew complement for PACAF KC-135 AE channel missions will be two pilots, one boom operator, one MCD, one Flight Nurse (FN), three medical technicians, and two crew chiefs. The normal crew complement for PACAF KC-135 AE alert missions will consist of two pilots, one boom operator, one FN, two medical technicians, and two crew chiefs. The AES/SGN is the final authority for increasing or decreasing the number of AECMs assigned to the mission to meet patient requirements.

20.10.4. (Added) **Alerting Procedures:**

20.10.4.1. (Added) **Scheduled AE Channel Missions:** Crew alert will be 3+30 hours prior to scheduled departure if front-end crew mission plans the previous day (NOTE – Mission timing is based on previous day mission planning). For same day mission plan/flys, the front-end crew alert will be 4+15 hours prior to departure. AECMs will alert with the front-end crew. After coordination with the PACAF AMOCC/AE Cell, the Mission Scheduler/Operations Supervisor will alert the aircrew. Typically, the Mission Scheduler/Operations Supervisor will alert the aircraft commander (AC) and MCD for the mission. The AC and MCD will then alert their respective crewmembers. Crew show-time will be one hour after alert. To provide time for medical equipment configuration and patient enplaning, AECMs will attempt to be at the aircraft no later than 1+45 prior to departure. Front-end crews will show to the aircraft NLT 1+30 prior to departure. Crew Duty Time (CDT) and Flight Duty Period (FDP) begin when the crew shows for duty.

20.10.4.2. (Added) **AE Alert Missions:** Alerting procedures will be the same as **20.10.4.1. (Added)**, *Scheduled AE Channel Missions*, above. Alert mission posture will be *BRAVO Standby Force.* Crew alert will be 3+00 hours prior to departure. Crew show will be one hour after alert. CDT and FDP begin at scheduled crew show (1 hour after alert). These times should be used as planning factors and should not preclude an early launch if able.

20.10.4.3. (Added) **Crew Duty Time End:** CDT for AECMs ends when the patients have been delivered to the receiving medical representative or medical treatment facility and/or when aircraft medical equipment has been secured, whichever is later. CDT for aircrew members will be IAW 11-2KC-135, Vol 3, para 3.6, if there is no follow-on AE leg. If the mission is to continue, the AC and MCD will coordinate the CDT end time and the follow-on leg alert/takeoff time based on the latest CDT end.

20.10.4.4. (Added) **Crew Rest Requirements for Oceanic Travel:** If not on a continuing mission, AE aircrew will not fly:

20.10.4.4.1. (Added) Within 24 hours of traveling between CONUS and Alaska/Hawaii when crossing 4 or more time zones.

20.10.4.4.2. (Added) Within 24 hours of traveling between Alaska/Hawaii and 5 AF, 7 AF and 13 AF bases.

20.10.4.4.3. (Added) Within 48 hours of traveling between CONUS and 5 AF, 7AF and 13 AF bases.

20.10.4.4.4. (Added) These time restrictions: (i) Run concurrently with any post/pre-mission crew rest requirements; (ii) Apply to flying duties and do not prevent individuals from accomplishing ground training, office duties, etc. as long as crew rest requirements are met; (iii) Also apply to aircrew members returning from non-flying TDY and leave; and (iv) Do not apply to individuals preparing to fly in ACM status.

20.10.4.5. (Added) For the purposes of oceanic travel crew rest, aircrew members are considered on a "continuing mission" from the time they depart home station until return to home station, regardless of refrags or changes in aircraft or patient population.

20.10.4.6. (Added) **Standby Force Duty:** AE squadrons are tasked with a 24-hour alert commitment. This commitment will count against the daily commit rate bogey (AMOCC-taskable aircraft). Alert duty will be accomplished as *BRAVO Standby Force.* Maximum alert period for an alert crewmember is 48 hours.

20.10.4.7. (Added) **Alert Force Regeneration:** Standard time period for alert force regeneration is 13 hours from alert crew notification. This timing provides one hour to identify the new alert aircrew/crew chief(s) and place that aircrew into crew rest, and provides for a 12-hour crew rest period. If an alert crew or KC-135 aircraft cannot be regenerated to meet alert force requirements, AE squadrons will immediately notify the AMOCC/AE Cell so coordination for another aircraft/crew to pick up the alert commitment can be accomplished as required.

20.10.4.8. (Added) Crewmembers alerted for a mission that cancels prior to departure, or subsequently returns to home station, may be kept on duty for up to 16-hours. The Squadron CC/DO will consider the impact of using such a crew for a full duty day.

20.10.4.9. (Added) A Bravo Alert crew may be alerted to fly a local trainer at the end of their alert period. Prior to launch of the local trainer, a new AE crew must be designated legal for alert (LFA).

20.13.5.1. (Added) **Anti-Hijack Inspection of Baggage.** AMC Form 81, Patient Baggage Data, is only required from the MTF for unaccompanied baggage. A computer-generated form will be given to the 3MT from the MCD mission pouch. It should consist of an original and one copy per en route stop. The 3MT will annotate all baggage tag numbers on the original automated manifest and those numbers for baggage deplaned on the copy for the AE clerk. The original automated manifest will be given to the MCD at the end of the mission. Unaccompanied baggage must be manifested separately on an AMC

Form 81 and must include an anti-hijacking statement. The MCD receives a locally generated form to verify all patients and hand carried baggage has been inspected from the AE clerk. Both of these forms will be included in the mission pouch turned into the TPMRC. The 3MT will coordinate with the MCD to ensure there is a patient/NMA/MA for all bags aboard the aircraft, except unaccompanied bags.

20.13.6. (Added) **Standard KC-135 AE Fuel Load:** Units will develop standard KC-135 fuel loads for AE missions (channels and alerts) which will minimize refueling stops during channel/alert missions while allowing for appropriate fuel reserve and safe landing gross weights at destinations.

20.13.7. (Added) **Standard KC-135 AE Turn Times:** Standard PACAF KC-135 AE turn-time for en-route stops when aircraft fuel servicing is planned is 2+00 hours. Standard PACAF KC-135 AE turn-time for en-route stops where no aircraft servicing is planned (deplaning/enplaning patients only) is 1+00 hour.

20.13.8. (Added) **Hearing Protection:** All crewmembers, patients, attendees, and passengers will wear hearing protection from engine start to engine shutdown and anytime the APU is in operation.

20.13.9. (Added) **Standard Cardiac Arrest Procedures:** The MCD may brief cardiac arrest procedures by simply stating, “Standard cardiac arrest procedures.” Division of FN duties should be assigned. Assignments for medical Additional Crew Members (ACMs) should also be given at this point.

20.13.9.1. (Added) The placement of patients during Cardiac Arrest should be as follows: Litter patients located on the PSP (Patient Support Pallet) should be placed on break over seats located on the opposite side of PSP. All ambulatory patients should be placed on the floor space between the left and right over wing escape hatches. Final patient placement is at the discretion of the MCD.

20.13.10. (Added) **Aft Cabin Coverage In-flight with Patients/Passengers Aboard:** AECMs qualified/certified in the KC-135 and current in KC-135 emergency egress procedures may be used to meet the crewmember requirements as specified in AFI 11-2KC-135, Vol 3, paras 3.2.3 and 13.5.3.8.

20.13.10.1. (Added) In flight, cabin coverage is defined as “a sufficient number of qualified crew members located throughout the aircraft cabin permitting maximum response to patient/passenger needs, emergencies, questions, etc”. AECMs/medical attendants not qualified/certified on the aircraft can provide cabin coverage to meet patient medical requirements, but there must be two qualified AECMs (one FN) on the aircraft at all times. AECMs/medical attendants not qualified/certified on the aircraft cannot be used to meet crewmember requirements specified in AFI 11-2KC-135, Vol 3, paras 3.2.3 and 13.5.3.8.

20.13.11. (Added) **AECMs in ACM Status on AE Missions:** All AECMs in ACM status will attend the Medical Crew Briefing conducted by the MCD on all actual AE missions with patients (not applicable for AE Readiness Missions with mannequins or simulated patients). Briefing attendance serves to educate ACMs on pertinent patient medical information in the event they are assigned specific responsibilities during potential in-flight emergencies. MCDs may direct AECMs in ACM status to assist the AE crew with their duties when conditions warrant. If this is necessary, the ACM will log secondary flight time for the amount of time that he/she was required to perform duties.

20.13.12. (Added) **AECM Instructor/Evaluator Seating:** AECM instructors/evaluators will be assigned a passenger seat. The MCD will coordinate with the AC if it is necessary for an instructor or evaluator to have an assigned passenger seat. On no-notice flight evaluations, it is the responsibility of the flight examiner to notify the appropriate command and control agency to adjust the seat release as appropriate.

20.13.13. (Added) **Seat Belts:** AECMs need not use a seat belt for takeoff and landing when duties require them to be out of their seat for patient care. If patient care requires an AECM be out of their seat for take-off, they will be secured to the patient litters with three litter straps. The MCD should notify the AC when this occurs.

20.13.14. (Added) **Wear of FLAK Vests/Aircrew Body Armor on AE Missions:** Flak vests/aircrew body armor may be worn while doing flight line ops, refueling, etc. Flak vests/aircrew body armor will not be worn while handling exposed explosives. When the flak vest/aircrew body armor is worn, individuals are required to frequently ground themselves (ungloved hand) in order to dissipate static electricity.

20.13.15. (Added) **On-Time Takeoffs:** At en-route stops, scheduled takeoff time is based on fragged departure time or chock time plus scheduled ground time (chock time = actual land time + 5 min), whichever is later. ACs should notify the appropriate command post/AMOCC of deviations from scheduled takeoff time greater than 20-minutes early or 14-minutes late.

20.13.15.1. (Added) . Takeoff times for alert missions are ASAP. When on an alert mission, do not delay departing (either from home station or en-route stops) to remain within fragged mission timing.

20.13.16. (Added) **KC-135 AE Training Missions:** AES personnel may conduct training on KC-135 air refueling training missions. AE aircraft configuration changes should be coordinated with life support/maintenance in advance to ensure proper AE equipment is loaded and secured prior to the mission. AE personnel should accomplish required training during aircraft preflight and en-route to/from the air refueling area. AE training requiring personnel to be standing/moving in the aircraft cabin will not be accomplished during in-flight air refueling operations due to the possibility of an emergency separation between the tanker and receiver aircraft.

20.14.2.1. (Added) If a patient's condition deteriorates in-flight, the MCD will immediately notify the AC of the situation and, if required, of the need to divert the aircraft to an en-route MTF. If a divert is required, the AC will notify the AMOCC/AE Cell as soon as possible so that coordination with new destination MTF and other scheduled stops can be accomplished.

20.14.3.1. (Added) **Aircraft Emergency:** If an aircraft emergency develops (i.e. loss of an engine), land as soon as feasible. Inconvenience to passengers and patients are a secondary consideration to flight safety.

20.15.2.1.1. (Added) **Patient Enplaning/Deplaning:** The preferred method for enplaning/deplaning ambulatory patients is via air stairs. If enplaning/deplaning litter patients, the Patient Loading System (PLS) (if available) should be used. If PLS capability is in question due to weather or operational concerns, a K-loader or elevator truck may be used as a substitute. Ensure one AECM accompanies the patients. The maximum weight capacity for the PLS will not exceed 1500 lbs.

20.15.2.1.2. (Added) Overweight Litter (OWL). Patients on an OWL should not be loaded via the PLS. Request a Halverson lift, Tunner, Hi-Lift truck, etc for patient enplaning/deplaning. **NOTE**: The OWL is an 84-inch x 30-inch litter and will not be placed in the litter stanchions of the Patient Support Pallet (PSP) due to dimensional/weight constraints. When transporting OWL patients, remove the right forward PSP litter tower and floor load the patient in this area. For safety reasons, seats on the left side of the PSP should be removed/broken over prior to on-load/offload and replaced when patient is secured.

20.15.4. (Added) **Air-Conditioning/Heating Aircraft:** KC-135 aircraft ground environmental control poses a problem for AE missions. In an attempt to offset this shortfall, ACs/MCDs should request a ground air-conditioning unit be positioned at the aircraft for preflight/en-route stops anytime the outside

temperature exceeds 70 degrees Fahrenheit. Ground heating units should be positioned for preflight/ en-route stops anytime the outside temperature is less than 55 degrees Fahrenheit. The MCD will be responsible for making the decision as to the use of these units. The boom operator will coordinate placement of the units.

20.18.1.1. (Added) On scheduled KC-135 AE channels, Patient Support Pallets (PSP) should be loaded the day prior to flight per the standard KC-135 AE aircraft configuration. Designated KC-135 AE Alert aircraft will be configured with at least one PSP while functioning in that capacity.

20.18.1.2. (Added) **Standard PACAF KC-135 AE Configuration:** Standard KC-135 AE configuration for channels missions will be two Patient Support Pallets (PSPs). Standard configuration for KC-135 alert aircraft will be one PSP (a second PSP can be added as mission dictates).

20.18.1.3. (Added) Currently, KC-135 aircraft are approved to carry no more than three PSPs. (Ref to Interim Guidance for KC-135 AE Operations, Atch 1, 2, and 3 for pallet placement positions). The PSP pallets will be transported to the aircraft by aerial port personnel, positioned and secured on the aircraft by the boom operator and configured by the AE crew. The MCD will ensure a plan for patient positioning is given to the aircraft commander or boom operator NLT 2 ½ hours prior to scheduled departure time. The PSP is a standard 463L pallet designed to carry a combination of two litter towers holding 3 litters for a total of 6 litter patients, two rows of 3 seats for a total of 6 ambulatory patients or a litter/seat combination of 1 litter tower (3 litters) with one row of 3 seats. PSP seats should be configured to face aft. Flight configuration is as follows:

20.18.1.3.1. (Added) **PSP-W**: Two litter tiers along the outer aspect of the pallet supporting up to three patients per tier. Empty weight: 826 lbs.

20.18.1.3.2. (Added) **PSP-M**: Three PSP seats and one litter tier along the outer aspect of the pallet supporting up to three litter and three ambulatory patients. Empty weight: 820 lbs. During an in-flight medical emergency, seats can be removed and placed to the side to increase working space.

20.18.1.3.3. (Added) **PSP-S**: Six PSP seats supporting up to 6 ambulatory patients, medical attendants or crewmembers. Empty weight: 814 lbs.

20.18.1.3.4. (Added) **AE-1:** One PSP positioned in the number one pallet position, Station 505 centroid. All possible omni rollers should be removed for minimal roller exposure. Utilize PSP-M with litters on the right side of the aircraft or PSP-S in pallet position one. The litter tower will be located on the right side of the aircraft and a row of seats will be placed on the left side. To facilitate litter loading, break over or remove the PSP seats. Each seat will have the storage capacity for required pre-positioned life support (EPOS and life vest). Small hand carried personal baggage (not to exceed 10 pounds per person) may be stored on the pallet underneath the seats. To allow access to the lavatory, the left aircraft side aisle-way should be kept clear of all obstacles at all times.

20.18.1.3.5. (Added) **AE-2:** Two PSPs in pallet position 1 & 2, Stations 505 and 615 centroid respectively. May utilize PSP-M, PSP-W, or PSP-S in pallet position 2.

20.18.1.3.6. (Added) **AE-3:** Three PSPs placed in pallet position 1,2, and 3, Stations 505, 615, and 765 centroid respectively. May utilize PSP-M, PSP-W, or PSP-S in pallet position 3. Hardware such as extenders or a combination of extenders with a spacer will be placed to cover the exposed rollers at the right overwing hatch. If sufficient hardware is not available, AE-3 cannot be utilized.

20.18.1.3.7. (Added) The Charge Medical Technician (CMT) will estimate equipment weights using the In-flight Kit Packout Guide and provide weights per pallet and total weight to the Boom Operator.

20.18.1.3.8. (Added) **Cabin Safety with PSP:** The PSP itself and the exposed roller systems are potential tripping hazards. The entire crew must ensure extreme caution is used when personnel move about the cabin. Patients/passengers will be briefed on this tripping hazard prior to aircraft entry. High visibility tape will be used to identify tripping hazards for patients, passengers, and crew or the hazard may be painted a high-visible color. A spacer will be used to minimize the gap between the two PSPs.

20.18.1.3.9. (Added) Slight forward-aft pallet movement may occur as the PSP shifts against the pallet lock. To prevent this occurrence, secure the PSP with a cargo tie-down strap. Use the second PSP tie down ring and forward roller ring as securing points.

20.18.1.3.10. (Added) Pallet stops protrude into egress routes. Forward and aft pallet stops will be removed by the Boom Operator along with excess rollers after all pallets are locked in place. The Boom Operator will ensure the roller system is properly configured prior to unlocking the pallets during unloading operations.

20.18.1.3.11. (Added) Patients and medical equipment will not be placed on the PSP during pallet loading or off-loading.

20.18.1.3.12. (Added) Do not use PSP seat track/stanchion fitting ring(s) to secure any equipment.

20.18.1.4. (Added) The entire crew and all patients/passengers aboard must exercise extreme caution when moving in the main cabin. Lighting is consistent with C-141 and C-130 lighting. Additional light sources (flashlights, head-mounted lights, etc) are recommended.

20.18.1.5. (Added) Additional airline type seats may be required for ambulatory patients. Aft facing stud mounted seats are the only approved seats for use on the KC-135. These airline seats will be floor mounted to avoid tripping hazards associated with uneven floors with pallets. Do not use palletized seats. A total of 8 sets/16 airline seats may be floor mounted from Body Stations 740-940 or 2 seat pallets (4 sets/8 seats each) may be placed in pallet positions 3, 4, and/or 5. The Boom Operator will ensure the floor-mounted seats are not covering the access panel for the landing gear.

20.18.1.6. (Added) Baggage bin or bins will be placed at or between Body Stations 920-1140. Bins should be placed as far aft as possible and 20 inches left of normal centerline position (no aisle required between baggage bin and APU). When using baggage pallets, place pallets in positions 6 and/or 5.

20.18.4.1. (Added) **AE Equipment Electrical Requirements:** The PSP does not have any electrical provisions. Electrical power for 400 Hz AE-equipment will be provided by an approved pigtail (P/N 8564034-135) kept in the Electrical Cord Assembly Set (ECAS). Connect to KC-135 110v, 400 Hz cannon plug receptacle (# 3 receptacle on KC-135E model aircraft and “galley outlet” on KC-135R model aircraft). The aircraft galley oven power cord must be disconnected in order to supply power to AE equipment. The ECAS pigtail will be plugged into this receptacle. (Note: Galley oven and associated equipment are now inoperative).

20.18.4.2. (Added) Electrical power for 60 Hz medical equipment is provided by “modified” Avionics Frequency Converter (AFC) and Adaptive Electrical Pigtail (P/N 041238). Use only “modified” AFCs identified by black on orange placard on the top of the unit with the statement, “Approved for use in a fuel vapor environment, Contract No. F41622-01-D-0001, DO 5010.”

20.18.4.3. (Added) Maximum amperage provided by approved aircraft receptacle is limited to 15 amps. Total amperage exceeding 15 amps will trip the aircraft circuit breaker and cause the equipment to transfer to battery backup or fail. The CMT will calculate total amperage prior to connecting equipment to the aircraft or “modified” AFC. For reference on medical equipment amp requirement or equipment power

capabilities refer to Table A2.1. of AFI 41-309, *AE Equipment Standards.* **Note:** The AFC requires 1 amp to drive the unit; therefore, only 14 amps would be available for equipment through the approved aircraft electrical receptacle.

20.18.4.4. (Added) Maintenance personnel will lock out/tag all incompatible power receptacles and document such in the maintenance 781 forms. The Receptacle #3 (KC-135E model)/Galley outlet (KC-135R model) provides power for equipment with 400 Hz capability. The crew chief/maintenance personnel will confirm use of the galley plug outlet prior to outlet use. The number 3 receptacle is the only approved source for electrical power on the KC-135E for AE equipment and the galley receptacle is the only approved source for electrical power on the KC-135R. Using any other aircraft outlet is not authorized and may result in equipment malfunction.

20.18.4.4.1. (Added) AECMs will wear gloves when working with electrical system.

20.18.4.4.2. (Added) AECM's should refer to applicable guidance for proper preflight and securing of electrical systems.

20.18.4.2.3. (Added) The boom operator should supervise/assist AECMs when these personnel are working with, conducting a preflight on, or securing equipment to the aircraft electrical system.

20.18.5.1. (Added) **Oxygen Requirements:** PTLOX will provide therapeutic oxygen for patients. A minimum of 2 PTLOX or 8 liters is required for departure from home station. As always, part of AECM planning is to calculate patient oxygen requirements and secure appropriate number of PTLOX units.

20.18.6.1. (Added) Patient emergency oxygen requirement will be met by the use of the Emergency Passenger Oxygen System (EPOS) or Passenger Oxygen Kit (POK).

20.18.6.2. (Added) If MA-1A oxygen bottles are not readily available, the EPOS or Personnel Breathing Equipment (PBE) may be used to meet AECM emergency oxygen requirements. For extended over-water operations (in excess of four hours), two EPOS/PBE units per AECM should be made available. If EPOS/PBE units are used to meet AECM emergency oxygen requirements, altitude will be restricted to FL350 and below.

20.18.9.1. (Added) **Life Support Equipment:** Three 20-man life rafts will be located on each AE-configured KC-135 aircraft. The life rafts will be located at each over-wing exit and the aft escape hatch. Life support equipment should normally not be removed from other aircraft to meet AE mission requirements.

20.18.11. (Added) **KC-135 Latrine:** The KC-135 latrine is limited in capacity. PACAF KC-135s will be configured with maximum latrine facilities for AE missions, taking into consideration mission duration and the number of personnel on board. Space-A/Duty passenger airlift may be limited to ensure proper patient requirements are met. The crew chief will verify that the latrine functions prior to departure.

20.18.12. (Added) **Neonatal Transport System (NTS):** The Neonatal Transport System (NTS) has been approved for use on the KC-135. An occupied NTS will be loaded with the use of a K-loader/high-lift vehicle. The weight of the unit makes it unsafe to be loaded via the PLS. At least four people will enplane/deplane the NTS. When securing the NTS on the aircraft, wooden blocks must be placed under the frame to elevate the unit's wheels off the aircraft floor/PSP/pallet. This removes stress to and from the NTS wheels. Four cargo tie-down straps must be used to secure the NTS to the aircraft floor/PSP/pallet. Using the four straps and wooden blocks will insure that the NTS is safely and securely tied down without damaging the wheels or the aircraft floor/PSP/pallet. The clip-hook of each strap should be attached to the hole at each corner of the NTS handles and the straps should be secure to D-rings in the floor/PSP/pallet.

Crewmembers may not secure themselves to the NTS for take-off and landing. Doing so will create undue stress to the NTS and aircraft structure.

20.18.13. (Added) The Airdyne 3500 Air Compressor is not approved for use on the KC-135.

20.18.14. (Added) Improper use of the Lifepack-10, Defibrillator external paddles may cause an electrical arching hazard, which could be detrimental in a fuel vapor environment. This risk is mitigated by using 25 lbs of defibrillator paddle delivery pressure and through use of appropriate conductive gel IAW Advanced Cardiac Life Support Guidelines. **Note:** Do not defibrillate if front end crew confirms a fuel vapor hazard.

20.19.1.1. (Added) **AE Alert Missions:** ACs should not release seats on the patient pickup/drop-off legs of an alert mission. This will ensure undue delays are kept to a minimum. The applicable KC-135 airlift SQ/DO is the approval authority for deviations to this requirement.

20.19.6.1. (Added) Lab specimens preserved in small amounts of formaline or formaldehyde may be transported if they are sealed in leak-proof containers and properly manifested. Transportation of these specimens will be at the AC's discretion with MCD concurrence. They will not be manifested on a Form 81, Patient Baggage Data. Dry-iced biologicals will not be carried.

20.19.6.2. (Added) Oxygen carried for medical use by patient or passenger is authorized without restriction. It must be accessible in flight.

20.19.7. (Added) **Requirements for Children:** An adult must be seated next to a child when, in the MCD's judgment, that child is too young or too small to reach and utilize the EPOS.

20.19.8. (Added) **Use of Car Seats on AE Aircraft:** The use of car seats for children processed through PACAF/AMC-owned (or controlled) passenger terminals is no longer mandatory. In addition, holding infants during take off and landing is allowed. However, it is encouraged children be restrained in car seats which are appropriate to their size and weight (The FAA has banned the use of booster seats, harnesses and child vest restraints). Relief from mandatory use of car seats and restrictions on holding infants does not eliminate the requirement that all passengers, regardless of age, must be assigned their own seat. Assigned seats will provide an infant and their sponsor a dedicated seat for use, with or without a car seat, at their discretion, while mirroring current FAA (Commercial) standards. The HQ PACAF/DO waives the requirements for car seat use and restrictions from holding infants during take offs and landings (critical phases of flight) from the AFI 11-2MDS-series Vol 3, Chapters 5 and 13. (Reference: HQ PACAF Message 041805Z Jun 01). **Note:** In no case does this eliminate the requirement for infant car seats for <u>patients</u> on AE missions. Car seats are required for all patients under the age of 2 or less than 40 pounds IAW AMCR 164-1 and AMCSP 164-50. This requirement will be carried over in the forthcoming AFI 11-2AE, Vol 3. (Reference: HQ AMC/DOTV)

20.19.9. (Added) **Passengers at En route Stops (Bumping):** When offloading (bumping) passengers due to patient requirements, space-required (funded) emergency leave travel are categorized just below duty passengers. These passengers have the highest priority and will be offloaded only when all other options have been exhausted. In addition, when determining the priority of duty passengers, those personnel en-route to TDY have priority over those returning.

20.19.10. (Added) Patients/passengers will always be escorted around the aircraft due to the potential for injury from flaps, antennas, etc.

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