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Flying Operations

AEROMEDICAL EVACUATION (AE) OPERATIONS PROCEDURES

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This volume implements AFPD 11-2, *Aircraft Rules and Procedures*. It establishes policy for Aeromedical Evacuation Crewmembers (AECMs) to safely and successfully accomplish their worldwide missions. The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the United States Air Force. This instruction is applicable to Air Force Reserve Command (AFRC), Air National Guard (ANG) units, Pacific Air Forces (PACAF), U. S. Air Forces in Europe (USAFE), and Air Mobility Command (AMC). (ANG is considered to be a Major Command (MAJCOM) throughout this publication.) This AFI applies to aircrew members, support personnel, and managers involved with Aeromedical operations. This AFI provides necessarily broad guidance and cannot address every conceivable circumstance. Medical Crew Director (MCD)s are expected to use their best judgment to ensure the safe conduct of the flight. The MCD will ensure compliance with the following: This AFI and MAJCOM guidance. Mission Designed Series (MDS)-specific instructions and supplements. Flight Crew Information File (FCIF), Notices to Airmen (NOTAMs), AMC/SG NOTAMS/AMC SG Policy Letters, aircraft technical orders, Air Force directives, MAJCOM directives. (See Table 6.1. for related publications.)

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Publications: AMCI 11-206, AMCI 11-208, AMCI 11-301, AMCVA 11-302

Forms: AMC Form 41, 43 and 97 and AF Form 3897, 3898 and 3905.

SUPPORTING INSTRUCTIONS

AFI 11-2AE Addenda A, Aeromedical Evacuation Configuration and Mission Planning

AFI 11-2AE V3 CL-1, Flying Operations Checklist

AFI 11-2AE V3 CL-2, Nursing Considerations Checklist

AFI 11-2AE V3 CL-3, Equipment Functional Checklist

SUMMARY OF CHANGES

This document is substantially revised and must be completely reviewed. Major changes include deleting unused chapters. Some paragraphs and chapters were renumbered as a result: The C-141 is removed from this guidance. AFI 10-2909 *Aeromedical Equipment Standards*, is incorporated. The AECM expanded checklist is substantially revised and must be completely reviewed. Defines Command and Control Responsibilities (paragraph **2.1**.), defines Operational C2 Reporting (paragraph **2.5**), revises 618 TACC Mission Controller Phone Nunmbers (table **2.1**), explains Aircrew Complement (table **3.1**), defines Supplemented Crew (paragraph **3.7.1.3**), revises Post Mission Crew Rest (paragraph **3.10.5**), revises Standby Force Duty (paragraph **3.13**), updates Minimum Equipment for All Patient flights (table **4.1**), updates Portable Electronic Devices (paragraph **5.9.3**), revises AECM Minimum Publication Requirements (table **6.1**), adds **Chapter 9**, *Training Policy*, changes **Chapter 13**, *Flight Nurse and Aeromedical Evacuation Technician Procedures*, changes **Chapter 20**, *AE Mission Safety*, total revision to **Attachment 2**, *Aeromedical Evacuation Crew Member Expanded Checklists*.

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Chapter 1

GENERAL INFORMATION

1.1. General.

1.1.1. This Air Force Instruction (AFI) provides policy for Aeromedical Evacuation (AE) Operations. It is an original source document for many areas but, for efficacy, restates information found in aircraft flight manuals, flight information publications (FLIP), and other Air Force directives. When guidance in this AFI conflicts with another basic/source document, that document takes precedence. For matters where this AFI is the source document, waiver authority is in accordance with (IAW) paragraph **1.4.2** For matters where this AFI repeats information in another document, follow waiver authority outlined in the basic/source document.

1.1.2. Unit commanders (AE and MTF) and Command and Control (C2) agency directors of Patient Movement Requirements Center (PMRC), Tanker Airlift Control Center (618 TACC), and Airlift Operations Center (AOC) shall make current copies of this AFI available to appropriate personnel. Transportation and base operations passenger manifesting agencies will maintain a current copy of this AFI. This AFI will be used by all units and agencies involved in or supporting AE operations. Copies will be current and available to planning staff from HQ to aircrew level.

1.1.3. Airlift Resources. The primary USAF aircraft supporting intratheater AE are the C-130 Hercules, C-17 Globemaster, C-21 and the KC-135 Stratotanker. Overseas theater commanders have operational control of theater-assigned or attached aircraft through the Airlift Operations Center (AOC), who allocates those airframes as required to meet operational mission requirements. Primary intertheater aircraft are KC-135 Stratotanker, C-17 Globemaster. Additionally, the Civil Reserve Air Fleet (CRAF) can be used when tasked through activation.

1.1.4. Opportune Airlift. Opportune airlift is preferred to launching a special airlift aircraft. C-5 Galaxy and the KC-10 Extender can be used when available and if suitable to meet patient requirements. The C2 agency should direct the move. Use of opportune airlift is considered an unscheduled AE mission, and managed/reported in the same manner as any other AE mission, to include the change of the mission number when patient(s) is/are onboard. Aeromedical Evacuation Crewmembers (AECMs) on these missions will be universally qualified and follow quick response training IAW AFI 11-2AE V1, *Aeromedical Evacuation Aircrew Training*.

1.1.5. Patient Preparation. A validating flight surgeon (FS), will determine the patient's suitability for AE. Medical authorities requesting the patient's evacuation must be informed of the impact of in-flight physical stresses on the patient. In the event the Medical Crew Director (MCD) has determined a patient is not stable/stabilized, is at significant risk for flight, or requires care beyond the scope of the AE crew, the MCD will coordinate with the PMRC and one of the following: 618 TACC, or AOC before refusing the patient. Depending on the contingency/tactical environment, refusing a patient for flight may not be applicable.

1.1.6. In determining the risk for the patient in flight versus remaining in place, consideration must be given to the medical capability of the sending facility, the receiving AE crew, and the current operational situation.

1.1.7. Determining Factors. Consider the following factors when transporting patients on aircraft; patient's diagnosis, condition, equipment, oxygen requirements, in-flight time, in-flight patient care requirements, and the number of medical personnel required. Emphasis must always be on providing quality, safe and appropriate care while minimizing potential risks during transport.

1.1.8. Patient Load Planning Factors. The tasking C2 agency (PMRC, 618 TACC, etc.) determines the size/composition of the patient load on AE missions IAW this instruction and AFI 11-2AE V3 Addenda A, *Aeromedical Evacuation Operations Configuration/Mission Planning*.

1.1.9. Mission. The mission of the worldwide AE system is to provide fixed-wing movement of regulated casualties using organic and/or contracted mobility airframes with AE aircrew trained explicitly for this mission. AE forces can operate as far forward as fixed-wing aircraft are able to conduct airland operations and may be tasked across the spectrum of military operations.

1.1.10. AECMs prepare for the AE mission during peacetime by:

1.1.10.1. Organizing, training and equipping assigned personnel.

1.1.10.2. Instructing Department of Defense (DoD) medical treatment facilities on the use of the AE system.

1.1.10.3. Exercising and evaluating contingency AE capabilities.

1.1.10.4. Identifying medical and support equipment necessary to meet mission requirements.

1.1.11. Aircraft Availability. AE missions are supported by:

1.1.11.1. Dedicated aircraft (scheduled or designated channel missions).

1.1.11.2. In system select (ISS - opportune aircraft).

1.1.11.3. Patient/cargo mix missions.

1.1.12. In all cases, use of specific aircraft are based on:

1.1.12.1. Specific clinical requirements.

1.1.12.2. Specific AE equipment needs.

1.1.12.3. Timeliness of patient movement.

1.1.12.4. Airfield constraints.

1.1.12.5. Aircraft availability.

1.1.12.6. Financial constraints.

1.2. Applicability. This AFI applies to aircrew members, support personnel, and managers involved with employing Aeromedical Evacuation.

1.3. Key Words Explained.

1.3.1. "Will" and "shall" indicate a mandatory requirement.

1.3.2. "Should" is normally used to indicate a preferred, but not mandatory, method of accomplishment.

1.3.3. "May" indicates an acceptable or suggested means of accomplishment.

1.3.4. **"NOTE"** indicates operating procedures, techniques, etc., that are considered essential to emphasize.

1.3.5. **"CAUTION"** indicates operating procedures, techniques, etc., which could result in damage to equipment if not carefully followed.

1.3.6. **"WARNING"** indicates operating procedures, techniques, etc., which could result in personal injury or loss of life if not carefully followed.

1.4. Deviations and Waivers. Do not deviate from policies in this AFI except when the situation demands immediate action to ensure safety. The Pilot in Command (PIC) is vested with ultimate mission authority and responsible for each course-of-action they choose to take.

1.4.1. Deviations. The PIC shall report deviations or exceptions taken without a waiver through command channels to their Chief, Major Command (MAJCOM) Stan/Eval, who in turn shall notify Chief, AMC Stan/Eval (lead command) as appropriate for follow-on action.

1.4.2. Waivers. Unless otherwise directed, waiver authority for contents of this instruction is the MAJCOM/A3 with mission execution authority. Obtain waivers to deviate from provisions in this AFI via MAJCOM Stan/Eval.

1.4.2.1. Permanent waivers affect theater unique circumstances and are enduring in nature. List MAJCOM/A3 approved permanent waivers in the MAJCOM supplement (see para. **1.5**)

1.4.2.2. Long-term waivers affect multiple aircraft/multiple missions but are not permanent in nature (expire at a specific date/time). MAJCOM Stan/Eval shall send HQ AMC Stan/Eval (lead command) copies of MAJCOM/A3 approved long-term waivers.

1.4.2.3. Short-notice waivers are for specific missions in execution. PIC shall use the Waiver Protocol procedure in Chapter 4 to secure MAJCOM/A3 approval for short-notice waivers.

1.5. Supplemental Procedures. Units will supplement this instruction to clarify policies, procedures, and unique mission requirements. Comply with AFI 33-360 V1, *Air Force Content Management Program--Publications*, guidance regarding publication supplements.

1.5.1. Unit supplements will not be less restrictive than this instruction.

1.5.2. Unit Supplements. Forward MAJCOM/A3-approved supplements, with attached AF Form 673, *Air Force Publication/Form Action Request*, to lead command (HQ AMC/A3) for review. HQ AMC/A3 will provide a recommendation and forward to AF/A3O-AT for approval (according to AFPD 11-2,). Use the following OPR's address: HQ AMC/A3V, 402 Scott Dr., Unit U3A1, Scott AFB IL, 62225-5302. Electronic copies may be sent via e-mail to HQ AMC/A3V's AE branch organizational box at: HQ AMC/A3VM. When supplements

are published, notify or send a final copy to AF/A3O-AT and lead command (HQ AMC/A3V).

1.5.2.1. If necessary, request and include approved long-term waivers to this AFI (including, approval authority, date, and expiration date) in the appropriate unit supplement.

1.6. Local Supplement Coordination Process. AFRC/National Guard Bureau (NGB) units will coordinate supplements to this AFI through OG, NAF and MAJCOM/A3V branches for review prior to submitting to HQ AMC/A3VM. All units will send one copy of their supplement to the parent MAJCOM Standardization/Evaluation OPR (HQ AMC/A3V for AMC, ANG, and AFRC units).

1.7. Requisition and Distribution Procedures. Unit commanders may provide copies to aircrew members and associated support personnel.

1.8. Improvement Recommendations. Send comments and suggested improvements to this instruction on AF Form 847, *Recommendation for Change of Publication*, through channels to HQ AMC/A3V, 402 Scott Drive Unit 3A1, Scott AFB IL, 62225-5302 according to AFI 11-215, *USAF Flight Manuals Program (FMP)*, and MAJCOM Supplement.

1.9. Definitions. Find explanations or definitions of terms and abbreviations commonly used in the aviation community in Code of Federal Regulations (CFR) Title 14, Part 1; DoD FLIP General Planning, Chapter 2; and Joint Pub 1-02, The DoD Dictionary of Military and Associated Terms. See **Attachment 1** for common terms used herein.

1.10. Aircrew Operational Reports. The reporting requirements in this instruction are exempt from licensing IAW paragraph 2.11.10 of AFI 33-324, *The Information Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information.*

Chapter 2

COMMAND AND CONTROL

2.1. General. The Mobility Air Forces (MAF) command and control (C2) network consists of multiple C2 centers. The 618th Tanker Airlift Control Center (618 TACC) serves as the AFTRANS Air and Space Operations Center (AOC) providing global C2 for AMC-assigned inter-theater air mobility missions. Theater AOC's such as the Air Forces Pacific (AFPAC) 603 AOC and the Air Forces Europe (AFEUR) 613 AOC, through their respective Air Mobility Division's (AMD), provide C2 for intra-theater-assigned air mobility missions and coordinates with the 618 TACC on inter-theater missions transiting their theaters. Additional C2 centers involved in the process are the Air National Guard (ANG) Readiness Center, Air Force Reserve Command (AFRC) Command Center, Joint Operational Support Airlift Center (JOSAC), Unit Command Posts, Air Mobility Control Centers (AMCC), Contingency Response Groups (CRG), Contingency Response Elements (CRE), and Special Tactics Teams (STT). C2 centers are action agents for the MAF commander with execution authority (operational control) over mobility missions/forces.

2.1.1. HQ AMC is the lead command for worldwide AE. HQ AMC Directorate of Operations (AMC/A3) is the executive agent for operational AE missions.

2.1.2. AE crewmembers serve in the following commands: Air Mobility Command (AMC), United States Air Forces in Europe (USAFE), Pacific Air Forces (PACAF), Air Force Reserve Command (AFRC), and National Guard Bureau (NGB). AMC is the gaining MAJCOM for all non-theater assigned AE forces.

2.1.2.1. HQ AMC/A3 establishes, in coordination with the AFRC, NGB and other MAJCOMs, the standards for system-wide organization, equipage and training of the AE force.

2.1.2.2. Total Force, multi-command coordination ensures standards for system-wide AE crew and AE mission support training requirements, for clinical and in-flight care, and for AE crew performance.

2.1.2.3. HQ AMC Command Surgeon (AMC/SG) is responsible for providing clinical standards and procedures concerning the treatment of patients in-flight.

2.2. Execution Authority. Headquarters commanders with command authority over MAF resources hold execution authority for directed missions. Commanders with execution authority formulate plans, allocate assets, and approve missions through a local command post or C2 element. OG/CCs serve as execution authority for local training missions. The PIC will execute missions operating outside normal communication channels (use last known mission orders or best course of action). C2 of AE missions is the same as for any other airlift missions.

2.3. Pilot in Command (PIC)/Aeromedical Evacuation Crew (AEC) Responsibility and Authority. SQ/CCs shall designate an aircraft commander (AC), instructor pilot (IP), evaluator pilot (EP) as the PIC for all flights, on a flight authorization form, IAW AFI 11-401, *Aviation Management*, and applicable supplements. An unqualified or non-mission ready pilot may not be designated as PIC.

2.3.1. PICs are:

2.3.1.1. In command of all persons aboard the aircraft.

2.3.1.2. Vested with authority to accomplish the assigned mission. The PIC shall only fly events authorized in the mission tasking unless, in the PIC's judgment, an emergency condition demands otherwise. Fly unscheduled training events (for example, air refueling (AR) or transition training) after obtaining approval of the execution authority.

2.3.1.3. The final mission authority and will make decisions not assigned to higher authority.

2.3.1.4. The final authority for requesting or accepting aircrew or mission waivers.

2.3.1.5. Responsible for passing mission progress reports (at least daily) to C2 agents.

2.3.1.6. Responsible for interaction between aircrew members and mission support personnel and will establish a point-of-contact (POC) with the appropriate C2 agent prior to entering crew rest. Local C2 agents are responsible for coordinating mission support requirements on the PIC's behalf.

2.3.1.7. Responsible for the welfare of aircrew members, Mission Essential Personnel (MEP), passengers, and the safe accomplishment of the mission.

2.3.2. SQ/CCs shall designate a MCD on a flight authorization form, IAW AFI 11-401, *Aviation Management*, and applicable supplements.

2.3.2.1. MCD is a qualified flight nurse responsible for the overall supervision of patient care and management of AEC assigned to AE missions. He/she advises the PIC on patients' conditions and the use of medical equipment that may affect aircraft operations. The MCD is directly responsible for the safety and medical well-being of patients on the aircraft and coordinates enplaning and deplaning procedures with supporting agencies. In matters of patient care, the decisions of the MCD are final.

2.3.2.2. Charge Medical Technician (CMT) is a qualified Aeromedical Evacuation Technician (AET) responsible for the supervision and management of AETs assigned to perform duties on the mission. The CMT will ensure that medical supplies and equipment are on the aircraft and installed equipment is operational.

2.4. Not Used.

2.5. Operational C2 Reporting. AMC C2 facilities will normally transmit arrival, departure, and advisory messages to the 618 TACC as appropriate. Aircrews on AMC 618 TACC-controlled missions are responsible for transmitting these messages via L-Band SATCOM, HF, DSN, etc., when transiting stations without an AMC C2 (fixed or mobile) presence. Crews on missions not controlled by the AMC 618 TACC will report to their appropriate controlling agency.

2.5.1. Stations with MAF C2 Agency. Local MAF C2 agents will enter mission data (arrival, departure, and advisory messages) in the MAF C2 system.

2.5.1.1. Crews not on AMC missions will report to their appropriate C2 agency, i.e. AOC/AMD.

2.5.2. Stations without MAF C2 Agency. Transmit mission data to the controlling C2 agency by any means available (i.e. DSN, HF, iridium phone, and L-Band SATCOM, etc.).

HF Radio is the primary method of communication for routine mission information. For critical C2 communications, i.e. aircraft waiver request, maintenance delay, etc., voice communications are the primary method with L-Band SATCOM as the backup.

2.5.3. Enroute Reporting.

2.5.3.1. Make the following enroute calls to 618 TACC:

2.5.3.1.1. Airborne call when departing from a location without an AMC presence.

2.5.3.1.2. Maintenance call whenever aircraft alpha status changes to code 3.

2.5.3.1.3. On AE missions, no later than 1 hour prior to landing, to update arrival time.

2.5.3.2. CONUS. Periodic "ops normal" calls/transmissions are not required; however, the controlling C2 agency may increase reporting requirements.

2.5.3.3. OCONUS. MAJCOM C2 agencies will specify increased reporting procedures through a communications plan in the Operation Plan (OPLAN), Operation Order (OPORD), Fragmentation (FRAG), Mission Directive, or FLIP. Aircrews will maintain listening watch in accordance with the communications plan within aircraft equipment capabilities (e.g. HF-Automatic Link Establishment (HF-ALE), L-Band SATCOM).

2.6. Not Used.

2.7. Not Used.

2.8. C2 Agency Telephone Numbers. Units should publish a listing of telephone numbers to assist crews in coordinating mission requirements through appropriate C2 agencies. It should be made readily available to crews and published in the FCB, Read File, or other appropriate publication. **Table 2.1** contains a list of 618 TACC phone numbers. Crewmembers may also use the 618 TACC toll-free number, 1-800-AIR-MOBL, to contact other offices within the 618 TACC, including flight managers.

Table 2.1. 618 TACC Mission Controller Phone Numbers.

TYPE OF MISSION	618 TACC PHONE NUMBER
Contingency and Air Refueling	DSN 779-0320
Channel	DSN 779-0321
JAATT	DSN 779-0322
SAAM and Exercise	DSN 779-0323
AE Desk	DSN 779-0330
All Other	DSN 779-0324

2.9. Not Used.

2.10. Not Used.

2.11. Enroute Maintenance Support. 18 AF 618 TACC/XOCL will support all mobility aircraft requests for parts and/or maintenance assistance regardless of type of mission or component. Refer to paragraph **2.8** for 18 AF 618 TACC telephone numbers.

Chapter 3

AIRCREW COMPLEMENT/MANAGEMENT

3.1. General. This chapter provides guiding principles to form/manage mobility aircrews. Commanders at all levels shall follow this policy to form aircrews and to develop aircrew related work/rest schedules that optimize efficiency of mobility forces engaged in worldwide operations.

3.2. Aircrew Complement. SQ/CCs shall form aircrews based on fragmentation order/mission directive, Crew Duty Time (CDT) and Flight Duty Period (FDP) requirements, aircrew member qualifications, and other constraints to safely accomplish the mission tasking. **NOTE:** Augmented aircrew members must be current, qualified and Mission Ready (MR) in accordance with AFI 11-2AE, V1, *Aeromedical Evacuation Aircrew Training*. In those situations requiring augmentation, the crew will be augmented from the start of the duty period. MAJCOM/A3 approval is required for crewmembers to join the mission en route for augmentation. If augmentees join the mission en route, the crew's FDP will be computed based on the FDP of the most limited person.

Table 3.1. Aircrew Complement.

Crew Position	C-21 Basic	Basic	Augmented FDP	Supplemented Patient Acuity (1)
MCD	1	1	1	1
FN		1	2	2
CMT	1	1	1	1
2 AET		1	2	2
3 AET		1	1	1

NOTES:

(1) AFSC's and number of additional AECMs may vary for supplemented patient acuity. For guidance on AE crew supplementation see paragraph **3.7.1.3.**

3.2.1. Aircrew or Crew. The full complement of officers and enlisted members required to complete an assigned mission. AFI 11-401, *Aviation Management*, and this AFI validate AECM requirements for flight and define crew complement.

3.2.2. Basic AE Crew. AE crew positions are required for the mission as explained in AFI 11-401 and this AFI.

3.2.2.1. A basic AE crew consists of two FNs and three AETs. **NOTE:** For deployments and Aeromedical Readiness Missions (ARMs), basic AE crew will be tasked. **EXCEPTION:** Refer to para **3.2.2.2** for C-21 missions.

3.2.2.1.1. Chief Nurse Executive (CNE) may reduce/increase the crew complement based on Operational Risk Management (ORM) Worksheet. Minimum AE crew complement will consist of no less than one (1) Flight Nurse (FN) and two (2) AETs.

Notify controlling C2 agency if crew complement differs from fragmentation order/mission directive.

3.2.2.2. Basic AE Crew (C-21). The basic crew complement for a C-21 mission is one (1) FN and one (1) AET.

3.2.2.2.1. For C-21 transports with a Neonatal or Critical Care Air Transport Team (CCATT), the AE crew may be limited to one (1) AECM due to weight and space limitations.

3.3. Aircrew Member Qualification. An aircrew member will be qualified or in qualification training to perform duties as a primary aircrew member.

3.3.1. Aeromedical Evacuation Crewmember**.** An individual who meets all the following:

3.3.1.1. Is a non-rated aircrew member as explained in AFPD 11-4, *Aviation Service*, specifically trained to operate safely during ground and flight operations of the aircraft and is proficient with onboard emergency procedures and operation of emergency equipment. Individuals must be on aeronautical orders and perform their principal duties in-flight. Duties must be essential to performing patient care and operating associated equipment used for completing a mission.

3.3.1.2. Is required for the mission as described in AFI 11-401.

3.3.1.3. Is designated on the flight authorization to fulfill specific aeronautical tasks.

3.4. Not Used.

3.5. Not Used.

3.6. Not Used.

3.7. Aircrew Management. SQ/CCs and en route C2 agents shall ensure work/rest cycles are adequate to permit an aircrew time to safely accomplish mission duties and personal time for rest.

3.7.1. FDP. FDP is the time period starting at mission report time and ending immediately after the aircrew completes the final engine shutdown of the day. SQ/CCs shall form aircrews based on worst-case FDP in the mission directive. Once en route, the mission directive or C2 agent will inform the MCD of expected FDP at show time.

3.7.1.1. Basic Crew FDP. The maximum FDP for a basic aircrew is 14-16 hours (see **Table 3.2**). Once an aircrew begins a basic FDP, only MAJCOM/A3 may extend to augmented day regardless of aircrew composition (MAJCOM/A3 shall augment basic crew to extend FDP).

3.7.1.1.1. When extended en route ground times, non-optimum routing/winds, weather delays or other extenuating circumstances will increase a basic to an augmented FDP, the PIC with an augmented crew may accept an augmented FDP as long as:

3.7.1.1.2. The C2 agent or PIC discovers the extenuating circumstances before the first takeoff of the day.

3.7.1.1.3. The PIC verifies all augmenting aircrew members can get adequate rest en route.

3.7.1.1.4. The PIC with a basic crew may seek MAJCOM/A3 (mission execution authority) approval to extend the FDP as much as 2 hours to complete a scheduled mission. Only use this provision to recover from unscheduled/unplanned en route delays. C2 agents shall not ask the PIC to exercise this option.

3.7.1.2. Augmented Crew FDP. Maximum FDP for an augmented aircrew is 18-24 hours (see **Table 3.2**).

3.7.1.2.1. CC/Operations Officer or CNE will augment an aircrew when FDP exceeds 16 hours and the mission profile will allow augmenting aircrew members adequate time to rest en route. Two additional litter spaces will be reserved for crew rest purposes when crew augmentation is required.

3.7.1.2.2. Physicians, nurses, medical technicians, or other personnel designated as medical attendants (i.e. CCATT members) assigned to specific patients do not constitute an augmented AE crew and will not extend crew duty time. **NOTE**: AFTO Form 781 Documentation Procedures: When AE crews are augmented for time, only five personnel will log primary time when accomplishing flight duties. When crewmembers are in rest cycles, log other time. Reference AFI 11-401 for further guidance.

3.7.1.3. Supplemented Crew (N/A for C-21). The CNE may adjust the crew complement to meet patient acuity and en route nursing care requirements based on ORM Worksheet. If the AE crew must be supplemented due to patient acuity or large patient loads, additional AECMs will be added. Number of AECMs and AFSC may vary. For example, an additional FN and AET may be added for large patient loads or 2 additional FNs may be added to assist with increased medication administration requirements. Notify controlling C2 agency if additional AECMs are required.

3.7.1.4. Basic or augmented crews may be supplemented. **NOTE**: AFTO Form 781 Documentation Procedures: When AE crews are supplemented for patient acuity, all personnel will log primary time. Reference AFI 11-401 for further guidance.

Table 3.2. AE Duty Periods.

Aircraft	Max FDP Basic Crew	Max CDT Basic Crew	Max FDP Augmented Crew	Max CDT Augmented Crew
C-130	16	18	18 + 00	20 + 00
C-17	16	18	24 + 00	24 + 45
KC-135	16	18	24 + 00	24 + 45
C-21	14	16	N/A	N/A
C-5	16	18	24 + 00	24 + 45
KC-10	16	18	24 + 00	24 + 45

3.7.2. CDT. CDT is that period of time an aircrew may perform combined ground/flight duties. Plan the mission so aircrew members may complete post-mission duties within maximum CDT. An aircrew member may perform mission-related duties for other missions when approved by member's home station SQ/CC or equivalent. See **Table 3.2** for MDS specific maximum CDT for a basic aircrew.

3.7.3. Except as outlined below, CDT/FDP begins 1 hour after aircrew alert notification. SQ/CC or equivalent may task aircrew members to perform other duties before they begin flight-related duties or MAJCOM/A3 may authorize a C2 agent to alert an aircrew member early: begin CDT/FDP when the first aircrew member reports for those duties. For AECMs, CDT ends when the patients have been delivered to the receiving medical representative and/or when aircraft medical equipment has been secured, whichever is later. If the mission will Remain Over Night (RON), the PIC and MCD will coordinate alert/take-off time based on the latest crewmember CDT end point.

3.7.3.1. For self-alerts, the PIC shall coordinate early individual/crew mission report times with C2 agents. Begin CDT/FDP when the first aircrew member reports for duty.

3.7.3.2. ANG and AFRC crews may perform mission-related events on local training missions provided their time from start of duty does not exceed 16 hours and actual flight duty does not exceed 12 hours. **NOTE:** (AFRC/ANG) CDT/FDP includes both military and civilian work. It begins when the individual reports for his or her first duty period (military or civilian).

3.7.3.3. CDT/FDP Extensions. See AFI 11-202V3, *General Flight Rules*.

3.7.4. Deadhead Time. Deadhead time is the time computed traveling in passenger status. MAF aircrew members may deadhead for the purpose of positioning or de-positioning to perform a mobility mission or mission support function. Crew members may deadhead for a maximum of 24 hours. OG/CC or equivalent may approve crewmembers to deadhead in excess of 24 hours. Current/qualified aircrew members may perform primary aircrew duties after deadheading, provided they do not exceed a basic FDP (FDP starts at report time for deadhead flight).

3.7.4.1. Aircrew members may fly in deadhead status after performing primary crew duties for a maximum of 24 hours from the time the crewmembers FDP began.

3.7.5. Aircrew Member Support of Aircraft Generation Activities (Pre-flight, cargo up-/off-load, start, and taxi aircraft). Crew rest is required IAW AFI 11-202V3, paragraph 9.7.2. The duty day begins when the aircrew member reports for official duties.

3.8. Scheduling Restrictions. SQ/CCs shall not schedule an aircrew member to fly nor will an aircrew member perform aircrew duties (PICs shall not violate any of the following restrictions with an early takeoff):

3.8.1. When the flight will exceed maximum flying time limitations of AFI 11-202V3, *General Flight Rules*.

3.8.2. Within 12 hours of consuming alcoholic beverages (based on scheduled takeoff or ALFA/ BRAVO standby force legal for alert time) or while under the influence of alcohol.

3.8.3. Within 12 hours following a hypobaric (altitude) chamber flight above 25,000 feet MSL. Aircrew members may fly as passengers during this period provided the mission is

planned for no more than a 10,000 foot MSL cabin altitude. An aircrew member who participates in an altitude chamber flight to, at, or below 25,000 feet may fly without delay (primary/deadhead) as long as subsequent cabin altitude does not exceed 15,000 feet.

3.8.4. Within 24 hours after compressed gas diving (scuba or surface supplied diving), a hyperbaric (compression) chamber mission, or aircraft pressurization checks that exceed 10 minutes. Aircrew members will not perform multiple pressurization checks.

3.8.5. Within 72 hours of donating blood. Aircrew members in mobility positions or subject to flying duties within 72 hours may donate blood with SQ/CC approval (donation requires a 72 hour Duties Not to Include Flying (DNIF) period).

3.8.6. When taking oral/injected medication unless the Command Surgeon grants an individual medical waiver. Except as noted in AFI 48-123, *Medical Examinations and Standards*, aircrew members will not self-medicate. An aircrew member may use the following medications without medical consultation as long as he/she understands the root cause of the ailment and that root cause will not impact flight duties:

3.8.6.1. Skin antiseptic, topical anti-fungal, 1 percent Hydrocortisone cream, or benzyl peroxide for minor wounds and skin diseases which do not interfere with the performance of flying duties or wear of personal equipment.

3.8.6.2. Single dose of over-the-counter aspirin, acetaminophen or ibuprofen to provide analgesia for minor self-limiting conditions that do not impede performance of aircrew duties.

3.8.6.3. Antacid for mild isolated episodes of indigestion.

3.8.6.4. Hemorrhoidal suppositories.

3.8.6.5. Bismuth subsalicylate for mild cases of diarrhea.

3.8.6.6. Multivitamin (one per day).

3.8.6.7. An aircrew member shall only use dietary/herbal supplements following consult and approval of a FS. The FS should consider aeromedical implications and probability of the supplement to actually enhance performance.

3.8.6.8. An aircrew member may use oxymetazoline or phenylephrine nasal sprays following an unexpected ear or sinus block during flight. Do not use these products to treat symptoms of head congestion that exist before flight.

3.8.7. Immunizations: Crewmembers are not DNIF after receiving immunizations. However, a standard observation period is required. If adverse reaction occurs, the individual is considered DNIF until cleared by a flight surgeon to fly.

3.9. Counter Fatigue Management Program.

3.9.1. The counter-fatigue management program for mobility aircrew consists of a range of options. First, aircrew should follow a healthy lifestyle to include proper diet, vigorous exercise, and most importantly take personal responsibility to get adequate rest. Second, leaders at all levels should set up flight schedules that permit aircrew opportunities to rest. Additionally, en route or deployed commanders and stage managers should ensure aircrew access to timely and nutritious meals and provide quiet, cool, and darkened billeting quarters.

Finally, aircrew may use medications (with prior approval) that enhance natural rest during off-cycle crew rest periods. This section provides guidance with regard to the use of No-Go pills (prescriptions) that help aircrew initiate and maintain restful sleep during off-cycle crew rest periods. Go-Pills are not approved for use in flight.

3.9.2. It is USAF policy that aircrew shall never use No-Go pills as a first choice counter-fatigue management tool. Unit commanders should plan missions to allow aircrew crew rest during their normal nighttime sleep cycle. This program permits commanders and unit flight surgeons an avenue to educate, test, and provide No-Go pills to individual fliers. No-Go Pills can provide a benefit for aircrew members to obtain satisfactory rest during off-cycle crew rest periods.

3.9.3. Responsibility for counter-fatigue management of aircrew medicinal products rests with the home station FS, OG/CC, and with each individual aircrew member. To minimize potential for harmful interaction, the FS will judge whether or not each aircrew member may use No-Go pills with any another medication, to include nutritional supplements and over the counter (non-prescription) medications.

3.9.4. Unit ORM programs shall include use of No-Go medication with OG/CC and FS oversight.

3.9.5. A home station or deployed FS trained using the AMC/SG-approved (lead command) counter fatigue program is the point of contact for No-Go prescription. Upon request, the FS will advise/assist the local OG/CC to identify missions that may impair crew rest caused by duty day length, departure and arrival times, and other mission timelines.

3.9.6. Aircrew members on Personnel Reliability Program (PRP) status will follow PRP notification procedures if prescribed No-Go Pills.

3.9.7. The OG/CC shall establish a system to inform the FS when missions fall into any of the following categories (may cause sleep disruptions and are therefore candidates for No-Go medications):

3.9.7.1. Home station night launch missions greater than four hours duration.

3.9.7.2. Crew rest facilities lacking an optimal sleeping environment (quiet, cooled, and darkened).

3.9.7.3. Off-station missions that are four or more time zones from home station.

3.9.7.4. Rotating schedules (stair-stepped flying schedules) with greater than 6-hour flight time duration.

3.9.7.5. Missions that run consistently near a 14-hour (or greater) duty day.

3.9.8. SQ/CC will not schedule crewmembers to fly or perform crew duties within 12 hours of consuming No-Go Pills.

3.9.9. Aircrew member’s responsibilities:

3.9.9.1. Aircrew members shall not take No-Go-pills within 12 hours of consuming alcohol.

3.9.9.2. Aircrew members shall not operate equipment within 12 hours after consuming a No-Go pill. **EXCEPTION:** Commanders may reduce the 12 hour timeline after consult

with a flight surgeon to confirm prescribed No-Go pills have short duration effect. In no case will crewmember consume No-Go pills on a timeline where they are under the effect of medication while they operate equipment.

3.9.9.3. Aircrew will inform the FS of any other medications (including nutritional supplements and over the counter medications) they are taking so the FS can evaluate potential interactions.

3.10. Crew Rest/En route Ground Time. OG/CCs shall establish procedures to place crew members in crew rest. Mission planners/schedulers shall create mission itineraries that afford aircrew members sufficient time to perform aircrew-related ground duties and still meet physiological needs (relax, sleep, and/or dine). MAJCOM/A3 may waive any portion of the crew rest period or ground time as needed to meet mission tasking.

3.10.1. Home-station Pre-departure Crew Rest. For all missions crewmembers will enter crew rest 12 hours prior to reporting time. This 12-hour period is inviolate; no official duties may be performed. Infringement of the inviolate crew rest period will require the start of another 12 hour inviolate crew rest period. For missions that will keep aircrew members away from home station for more than 16 hours, unit commanders will enter primary and deadhead aircrew members into pre-departure crew rest 24 hours before they are legal for alert time. Aircrew members may perform limited non-flying duties (mission planning, launch/recovery) during the first 12 hours of pre-departure crew rest. OG/CCs may waive any portion of the first 12 hours of pre-departure crew rest. Do not manifest deadhead aircrew members as passengers to deny pre-departure crew rest.

3.10.2. Off-station/En route Crew Rest. The minimum en route crew rest period is 12 hours before legal for alert or scheduled report time when self-alerting.

3.10.2.1. Except during emergencies or as authorized by MAJCOM/A3, C2 agents shall not disturb an aircrew member in crew rest. When necessary to interrupt aircrew members' crew rest period, re-enter that aircrew in a subsequent minimum 12 hour crew rest period after they complete official duties.

3.10.2.2. Do not enter aircrew members into crew rest until they complete official post-flight duties. Those duties may include, but are not limited to, storing medical equipment/kits, update C2 on patient/mission status, aircrew arming, or mission debriefing.

3.10.3. Off-station/En route Ground Time. Mobility planners shall provide aircrews allotted ground time between engine shutdown and subsequent takeoff IAW MDS specific Vol 3.

3.10.3.1. Mission planners, PICs, MCD, or C2 agents may modify ground time as follows:

3.10.3.1.1. In the interest of safety.

3.10.3.1.2. To start (mission reporting time) no earlier than 12 hours from the time the aircrew entered crew rest. Before reducing ground time, PICs will consider time to complete mission planning, cargo up-/off-load, and non-standard mission related duties. C2 agents will not ask PICs/MCD to accept less than allotted ground time.

3.10.3.2. Mobility planners should construct mission itineraries with en route ground times longer than allotted hours to afford aircrew members opportunities to recover from

the cumulative affects of fatigue caused by flying on several consecutive days or due to transiting several time zones. If practical, make the en route ground time 36 hours (maximum) after three consecutive near maximum FDPs.

3.10.4. Crew Enhancement Crew Rest (CECR). CECR is not an alternative to a safety-of-flight delay but provides PICs/MCDs a means to minimize the adverse effects of a crew alert and report period outside normal duty time. CECR periods should be of minimum duration and are normally used during de-positioning legs. Tasking authorities shall approve PIC/MCD requests to delay alert time to normalize the work-rest cycle or increase messing options when mission allows. When requests are disapproved, the C2 agent will inform the PIC/MCD of the reason for disapproval.

3.10.5. Post Mission Crew Rest (PMCR). SQ/CCs shall give aircrew members returning to home base sufficient time to recover from cumulative effects of the mission and tend to personal needs. PMCR begins upon return to home base. (Not applicable to ANG and AFRC when returning to civilian status).

3.10.5.1. For missions that keep an aircrew off station 16 or more hours, the SQ/CC shall provide 1 hour (up to 96 hours) PMCR for each 3 hours off-station. Do not enter aircrew members in pre-departure crew rest until the PMCR period expires.

3.10.5.2. PMCR is not applicable to continuing missions and MAJCOM/A3 may suspend PMCR during contingency operations.

3.10.5.3. OG/CCs (or equivalents) are PMCR waiver authority.

3.10.6. Not Used.

3.10.7. The lead USAF component will publish MAJCOM/A3 approved crew rest criteria in the Exercise or Contingency OPORD, OPLAN or Concept of Operations (CONOPs).

3.10.8. Air Crew billeting. Prime Knight is designed to minimize the time aircrews spend getting into billeting at crew rest locations. Billeting success depends on the accuracy of the aircrew information. The ultimate responsibility for ensuring billeting requirements are passed rest with the PIC; however, the C2 agency will assist the PIC as much as possible. The following guidance applies to all aircrews and C2 agencies:

3.10.8.1. C2 agency Notification Responsibilities. MAJCOM C2 will ensure current aircrew orders are transmitted to the next crew rest station's C2 agency NLT 30 minutes after the mission departs.

3.10.8.2. Aircrew Responsibilities. If a mission is departing from a non-AMC facility, the aircrew will call the next crew rest station, when able, to pass crew count/make-up, expected arrival time, number of officers, number of enlisted, male and female, etc.

3.10.8.3. Units must ensure the fund cite is clearly indicated on the orders for reservations to be made in advance. Lack of a fund cite will require the aircrew to make their own advance reservations through use of a government credit card.

3.10.8.4. AE units will fax a copy of the AEC's AF Form 4327a, *Crew Flight (FA)Authorization* to local C2 agency where the AE mission is staging from, or will RON, and 618 TACC (as applicable) NLT 24 hours prior to scheduled mission date. This

fax copy will notify C2 agencies of mission dates, AE POC (MCD) and assist with billeting arrangements. At a minimum, include the following:

3.10.8.4.1. Where the AE mission is staging from and/or RON locations.

3.10.8.4.2. Identify the MCD.

3.10.8.4.3. Mission number.

3.10.8.4.4. Mission date(s).

3.10.8.4.5. AE Crew names/ranks/gender.

3.10.8.5. The local C2 agency will provide PIC/MCD AE mission information when he/she checks on mission status. The Local C2 agency will be the link between the AE crews and the PIC, thus permitting mission status updates to both parties without interruption of crew rest.

3.10.8.6. The MCD will interface with local C2 agencies for all AE missions. The MCD will ensure:

3.10.8.6.1. Orders have been received.

3.10.8.6.2. C2 agencies have MCD's contact information.

3.10.8.6.3. Any mission irregularities are discussed. This will occur prior to crew rest, at en route mission stops, and at AE mission termination.

3.10.8.7. In coordination with MCD, the PIC may modify normal ground time (with concurrence of controlling agency):

3.10.8.7.1. In the interest of safety.

3.10.8.7.2. To no less than 12 hours from the start of crew rest until mission reporting. Before reducing normal ground time consider mission preparation time, time to load patients and cargo, and other factors peculiar to the mission. The controlling C2 agency will not ask the PIC to accept less than a normal ground time. Waivers for exercises and contingencies are IAW AFI 11-202V3.

3.10.8.7.3. To a maximum of 36 hours, when the crew has completed three consecutive near-maximum FDPs. **NOTE:** Flight crews should be afforded crew rest times in excess of the minimum at en route stations, when possible, to give crews the opportunity to overcome the cumulative affects of fatigue while flying on several consecutive days or transiting several time zones.

3.11. Alerting Procedures. MAJCOM C2 agents shall establish a legal for alert time with the PIC and when appropriate, the MCD of AE crews. C2 agents will inform PICs and MCDs of aircraft status, expected patient up load time, and other pertinent mission details that will streamline mission launch.

3.11.1. Crew alerts will be per applicable MDS. Alert times usually allow 1 hour for reporting and an adequate number of hours for mission preparation. Refer to **Table 3.3** **EXCEPTION:** Crew alerts for local training sorties will be per applicable AFI 11-2MDS V3 and local operating procedures. Self-alert procedures may also be used for normal local training missions.

Table 3.3. AE Crew Alert Times.

Aircraft	Alert Time
C-21	3 + 00
C-130	3 +15
C-17	3 + 45
C-5	4 +15
KC-135	4 +15
KC-10	4 +15

3.11.1.1. For AMC missions, AMC C2 agency will alert the PIC/MCD. The MCD will alert the medical crew. The goal is to link the primary PIC, local AMC C2 agency and the MCD before mission execution.

3.11.1.2. When the AE crew is staged separate from the front-end crew, the MCD will contact AMC local C2 agency and establish alert, showtime, etc. with the C2 agency. The MCD will make every effort to communicate with the front-end crew any mission irregularities prior to crew rest. Utilize local AMC C2 agency to leave messages for non-emergencies. Crew rest will be based on scheduled launch time. Do not violate crew rest.

3.11.1.3. AE mission requirements can change depending on clinical status of the patient(s) and aircraft availability. There will be occasions when aircraft cannot depart (i.e. maintenance problems) or emergency patient movement that may separate an AE crew from the front-end crew. The MCD is responsible for communicating these changes with the PIC and local AMC C2 agency to de-conflict problems.

3.11.1.4. C2 agents shall not alert outbound crews when inbound aircraft is on A-2 or A-3 status until maintenance technicians determine required parts are available and the aircraft will be repaired within the target ground time.

3.11.1.5. Self-Alerts. Crews will self-alert at locations without a C2 agency, but must coordinate with controlling C2 agency. The PIC may elect to self-alert on operational missions at locations with a C2 agency. Coordinate the alert time with local C2 agents to avoid FDP limitations that result from unexpected changes in the mission.

3.11.2. The aircrew release policy is as follows:

3.11.2.1. On the aircrew's initial entry or re-entry into crew rest, the controlling C2 agent, or PIC during self-alerts, will establish an expected alert time.

3.11.2.2. For all missions, the latest allowable alert time is 6 hours after the expected alert time. The PIC may extend that window to 8 hours when flying as primary crew or 12 hours when deadheading. The controlling C2 agent will not ask the PIC to accept more than the 6 hour window. ANG/AFRC aircrew members may extend the window as necessary to deadhead to home station to meet the Firm Scheduled Return Time (FSRT).

3.11.2.3. When a C2 agent determines circumstances will not allow for aircrew alerting during the legal for alert window, at that time but not earlier than the expected alert time, he/she will contact the PIC and establish a new expected alert time at least 12 hours from the time of notification.

3.11.2.4. At the end of the legal for alert window or if the mission risk becomes elevated and the aircraft commander determines the overall risk of the mission prohibits safe continuation, he/she will contact a C2 agent and establish a new expected alert time.

3.12. Stage Management.

3.12.1. Stage Posture. Stages operate on a positive launch principle. C2 agents shall alert aircrews using the following priority/hierarchy:

3.12.1.1. Aircrews that require an emergency return to home station.

3.12.1.2. De-positioning stage crews will be prioritized by their SRTs.

3.12.1.3. Aircrews in sequence of arrival time.

3.12.1.4. If the stage manager returns an aircrew in the stage to crew rest because of a mission delay or abort, that aircrew becomes first out when legal for alert.

3.13. Standby Force Duty. MAJCOM C2 Agents shall task units for Standby Force Duty not later than 18 hours prior to Legal for Alert time. This allows crewmembers 6 hours for pre-flight duty and 12 hours of pre-standby crew rest. When aircrews are unable to complete all preflight duties within 6 hours of crew show time, provide an additional 12-hour pre-standby crew rest. If MAJCOM C2 agents are unable to provide 18 hours prior notification, SQ/CC shall place the pre-standby crew in 12 hour crew rest. SQ/CC may keep an aircrew in ALPHA and BRAVO status up to 48 hours. MAJCOM/A3 may extend this period for contingencies. After 48 hours, launch, release, or re-enter aircrew into 12 hour pre-departure crew rest. ALPHA/BRAVO Standby Force status is inviolate; no official duties may be tasked. Infringement of the inviolate standby force status will require the start of another 12 hour inviolate crew rest period. OG/CCs may provide additional local procedures for management of Standby Force Duties.

3.13.1. ALPHA Standby Force. When tasked, SQ/CC shall posture an aircrew as an ALPHA Standby Force able to launch within 1 hour. Once SQ/CC forms an ALPHA Standby Force, that aircrew will accomplish follow-on pre-flights required by technical manuals. Follow-on pre-flights done during normal waking hours do not interrupt crew rest. Begin CDT/FDP when C2 agent directs the aircrew to launch from crew rest or while performing pre-flight (begin CDT/FDP when the aircrew arrived at the aircraft to do the pre-flight).

3.13.2. BRAVO Standby Force. When tasked, SQ/CC shall posture an aircrew in BRAVO Standby Force to permit launch within 3 hours. **EXCEPTION:** C-21 aircraft launch in 2 hours. Follow-on pre-flights, if required, interrupt crew rest. Begin CDT/FDP when aircrew shows for duty.

3.13.3. CHARLIE Standby Force. When tasked, SQ/CC shall posture aircrews as a CHARLIE Standby Force ready to enter crew rest within 2 hours. Tasked aircrews will be legal for alert 12 hours after entering crew rest. SQ/CC may keep aircrews in CHARLIE status up to 72 hours. After 72 hours, release aircrews from CHARLIE Standby or enter them into 12 hours crew rest for directed mission, training mission, or subsequent Standby Force duty.

3.13.4. Wing Standby Force. OG/CC may place aircrews in Wing Standby status. After a 12 hour pre-departure crew rest period, aircrews are legal for alert for 12 hours and must be able to launch within 3+15 hours. After 12 hours, launch, release, or re-enter aircrews in 12 hour crew rest period before subsequent 12 hours Wing Standby duty.

3.13.5. Post-Standby Missions. On completion of standby duty, aircrew members may be dispatched on a mission. If started, post-standby crew rest must be completed before the start of pre-departure crew rest. If an aircrew member is dispatched on a mission, compute the post-mission crew rest time on standby time plus mission time.

3.13.6. Post Standby Crew Rest. Aircrew members not dispatched on a mission following standby duty will receive post-mission standby crew rest as follows:

3.13.6.1. If standby duty is performed away from normal quarters, crew rest time is computed from this standby time on the same basis as for mission time.

3.13.6.2. If standby duty was performed in normal quarters, no crew rest time is authorized.

3.14. Orientation Flights and Incentive Flights. Refer to DoD 4515.13-R, *Air Transportation*, AFI 11-401, and the appropriate MAJCOM supplement.

3.15. Interfly. Interfly is a temporary arrangement between OG/CCs or equivalent to permit the exchange or substitution of aircrew members and/or aircraft between mobility units to accomplish flying missions. Normally, interfly should be limited to specific operations, exercises, or special circumstances. However, it may be used for events of longer duration such as unit conversion to another MDS. Participating aircrews shall use guidelines established by the lead command or as specified in the OPLAN or CONOPS. ***EXCEPTION:*** AE crewmembers are exempt from interfly requirements. Conduct interfly operations as follows:

3.15.1. Aircrew members shall be current and qualified.

3.15.2. Aircrew members will follow operational procedures established by the lead command. The Mission Commander or PIC will brief MAJCOM-specific items.

3.15.3. Each effected group commander who commits resources (personnel or aircraft) must concur with interfly proposal.

3.15.4. Not Used.

3.16. Additional Crewmembers (ACM). Crewmembers qualified in mobility aircraft are authorized ACM status on any mobility aircraft to pre/de-position in support of mobility operations. MAJCOM designated crewmembers who are assigned or authorized to accompany the normal crew complement are allowed ACM status.

3.16.1. Crewmembers in ACM status are not authorized to:

3.16.1.1. Displace manifested passengers.

3.16.1.2. Maintain currency and/or log flying time.

3.16.1.3. Use for transportation while on leave. **EXCEPTION:** ANG/AFRC Air Technicians may be in a civilian leave status while traveling en route to perform in a military duty status.

3.16.1.4. Travel on Special Air Missions/Command Support Mission (SAM/CSM) aircraft unless authorized by HQ AF/CVAM through the PIC.

3.16.1.5. Travel on Special Assignment Airlift Missions (SAAM) when specifically restricted by the mission directive (AF Form 59).

3.16.1.6. Travel on Operational Support Airlift (OSA) aircraft unless authorized by Joint Operational Support Airlift Command (JOSAC) through the PIC.

3.16.2. All ACMs require valid travel/flight orders or supporting message authorizing ACM status. OG/CCs may authorize ACM status for their mobility aircrews.

3.16.3. ACMs normally travel in the crew compartment. If the number of ACMs desiring travel exceeds the capacity of the crew compartment, the C2 agency will notify the ATOC, who in turn will coordinate with the passenger terminal; seats not previously assigned may be used for ACMs.

3.16.4. The PIC or designated representative will brief ACMs on seat assignment, appropriate mission information, emergency procedures including egress, and armed crewmembers. The PIC may assign an ACM aircrew related duties for which the ACM is qualified.

3.16.5. ACMs will coordinate their travel with the appropriate C2 agency prior to travel. They will process through the C2 agency as early as possible but NLT 3 hours prior to planned block time.

3.17. Mission Essential Personnel (MEP). Procedures and policies regarding MEP are contained in AFI 11-401 and AMCI 11-208, *Tanker/Airlift Operations*. PICs will ensure personnel traveling in this status are properly authorized.

3.18. Mission Mobility Observers (MMO). MAJCOM supplements or additional directives may establish programs authorizing senior military and civilian personnel to fly for mobility mission familiarization. For AMC MMO information reference AMCI 11-208.

3.19. Flight Attendants on Distinguished Visitor Missions. Flight attendants may fly as primary crewmembers on designated C-17 missions. They fall under the authority of the PIC, or MC (if assigned), throughout the mission. An egress briefing will be given to the flight attendants prior to the first mission leg.

3.20. Policies Governing Attendants.

3.20.1. If an attendant is determined to be unacceptable, the MCD contacts the C2 agency for resolution.

3.20.2. Medical Attendants (MA) provide patient care, documentation, and support under the direction and supervision of the MCD.

3.20.3. MAs and Non-Medical Attendant (NMAs) accompany patients from point of origin to point of destination MTF. AECMs should offer relief to MAs/NMAs when mission requirements allow. **NOTE:** AE system is not responsible for returning attendants to their originating location.

3.20.4. A CCATT/specialty team will fly with an AE crew. CCATT members are classified as Operational Support Flyers and will only fly missions with an assigned AE crew.

3.20.5. Attendants (except flight surgeons, CCATT) do not log any type of flight time.

3.20.6. Guards of Prisoner Patients:

3.20.6.1. Accompanies assigned prisoner-patients to their destination facility.

3.20.6.2. Turns in weapons and ammunition to the PIC/Loadmaster (LM)/Boom Operator (BO), as required by appropriate AFI 11-2MDS V3 instructions.

3.20.6.3. Coordinates with the MCD when handcuffs (if applicable) may be removed from the prisoner-patient while the aircraft is airborne.

3.20.6.4. Prohibited from handcuffing prisoner patients to any portion of the aircraft.

3.20.7. Enemy Prisoners of War (EPW). When/if EPWs are moved through the AE system, originating medical facilities will coordinate/arrange for appropriate host support agencies to provide guards for prisoners on AE missions. The AE system does not have the capability to provide guards, and prisoners will not be accepted into the AE system without guards. Guards assigned to medical prisoners must accompany them to the destination facility. AECMs will not accept custody of prisoners. The AE system is not responsible for returning guards to the originating location.

3.20.8. Detainee Transport. Detainee missions fall under the responsibility of Security Forces and are politically sensitive. Providing AE medical support for detainee missions will not normally be practiced unless detainees require in-flight medical care. AECMs will follow Security Force guidelines if supporting a detainee mission.

Chapter 4

AIRCRAFT MEDICAL EQUIPMENT OPERATIONS

4.1. Objective.

4.1.1. Some medical equipment is incompatible with the airborne environment. AE approved medical equipment is identified in AFI 10-2909, *Aeromedical Evacuation Equipment Standards*.

4.1.2. All medical equipment will be tested, deemed airworthy and approved for use through HQ AMC/A3VM. A specific test protocol establishing test and evaluation methods is developed for each piece of equipment. Tests include altitude/rapid decompression, vibration, electromagnetic interference and in-flight performance. In addition, explosive vapor testing has been added to all applicable equipment to ensure safety of operation in Fuel Vapor Bearing Area (FVBA) i.e. KC-135 aircraft. All applicable equipment listed in AFI 10-2909, *Aeromedical Evacuation Equipment Standards*, has passed explosive vapor testing. **WARNING:** The Airdyne 3500 Air Compressor® is not approved for use on the KC-135.

4.1.3. Medical equipment and supplies are vital to the AE mission. There are many hazards associated with the changing in-flight environmental conditions that are not encountered in fixed facilities. Equipment used onboard AE aircraft must continue to operate properly under flight conditions. It is essential AECMs know the capability and performance limitations of each specific equipment item.

4.1.4. HQ AMC/A3VM ensures standardization for equipment used system wide to enhance AECM equipment training, and provide for better equipment management.

4.2. Not Used.

4.3. Waiver Protocol. HQ AMC/A3VM is the waiver authority for non-certified/non-standard medical equipment required for patient moves. Waiver requests will be routed as follows: hospital/MTF will notify appropriate Patient Movement Requirements Center (PMRC). The validating flight surgeon makes the medical recommendation for use of non-certified equipment. PMRC will contact appropriate Command and Control (C2) agency, C2 agency will contact Tanker Airlift Control Center (618 TACC) AE Cell, and AE Cell will contact A3VM. A3VM will consult with 77AESG/TFL (AE Equipment Lab) during their hours of operation. Further consultation on clinical impact will occur with the GPMRC/ TPRMC FS on duty. Approval/disapproval is sent back to the AE C2 through the 618 TACC AE Cell. The AE C2 then makes the following notifications: PMRC, AEC and CCATT, as applicable flying the mission and supporting ground medical elements. The attending physician must be advised of the known operational limitations of the equipment and the possible effect this equipment may have on the patient's status in-flight. PMRC will input waiver information into the TRANSCOM Regulating and Command and Control Evaluation system (TRAC2ES).

4.3.1. Waiver will be obtained prior to use of non-certified/non-standard equipment onboard the aircraft and applies only to that specific mission. In order to prevent mission delays verbal waivers from A3VM are authorized.

4.3.2. For non-certified/non-standard medical equipment required for patient moves, the mission MCD/CCATT will complete DD Form 2852, *AE Event/Near Miss Report* IAW AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care.*

4.3.2.1. The MCD must inform the flight crew when waived medical equipment is used and any characteristics that may affect aircraft systems.

4.3.3. Long-term (permanent) waivers to carry non-certified equipment must be initiated by 618 TACC AE Cell with coordination between HQ AMC/A3. HQ AMC/A3 is the approval authority for long-term waivers.

4.4. Not Used.

4.5. Not Used.

4.6. Not Used.

4.7. Not Used.

4.8. Not Used.

4.9. Not Used.

4.10. Use of Medical Equipment Onboard Aeromedical Evacuation Aircraft.

4.10.1. Patient Movement Clinical Coordinators (PMCCs) and AECMs must ensure that equipment brought to the aircraft from originating hospitals is airworthiness approved for in-flight use.

4.11. Special Considerations:

4.11.1. Certain items, such as anti-shock trousers, will require special precautions when taken to altitude. Altitude restrictions may possibly be imposed or patient transfer delayed. The Validating FS will be consulted when such items are required. The Validating FS will advise on any special nursing care requirements and the best method to affect the transfer.

4.11.2. All air filled balloon devices (e.g. ET tubes, foleys, etc.) will usually be filled with normal saline by the originating MTF to avoid the repeated pressure exposure by expansion/contraction of the balloons during changes in altitude. AECMs will check to ensure this precaution has been accomplished to prevent soft tissue damage and/or irritation. The C2 agency will also coordinate with the MTF. **NOTE:** The CCATT physician may elect to fill endotracheal and tracheostomy tube cuffs with air and then attach to a cuff pressure monitor to minimize tissue trauma and complications of reintubation.

4.11.3. Water seal drainage systems, which use fluid to establish suction, will be checked frequently to ensure evaporation/changes in pressure does not reduce suction.

4.11.4. Emergency drug kits will contain current Advanced Cardiac Life Support (ACLS) Algorithms.

4.11.5. At RON stations without an AE element/detachment, MCD/CMT will accomplish the following:

4.11.6.1. Ensure there are adequate and secure storage facilities for medical equipment.

4.11.6.2. The mission assigned AE crew is responsible for the actual cleaning of the medical equipment. If the AE crew is required to clean any AE medical equipment, the

crew duty day does not end until all duties are completed. CCATT personnel are responsible for cleaning, maintaining, inventorying, and storing their medical equipment.

4.12. Minimum Equipment List Required For Flight.

4.12.1. AECMs are responsible for all AE medical supplies and equipment.

4.12.2. AE In-Flight Kit, Packaging Guide/Allowance Standard establishes a standardized packaging guide for all medications, supplies, and equipment carried in the AE In-flight Kit. Each unit is provided a minimum of two operational in-flight kits (increments one and two). Increment one supports 1-25 patients. Increment two is added to support 26-50 patients. The CNE is the final authority to determine which increments will best meet patient care requirements.

4.12.3. Personnel will use the Allowance Standard to inventory the kit and when completed, turn in the completed form to the AE equipment management section. Units will not deviate from the equipment standard without concurrence from HQ AMC/A3VM. Unit procedures will be established to replenish medications, equipment, and supplies and ensure proper equipment maintenance at home and RON stations. Units will download most current AE Packaging Guide on the first day of each quarter (Jan, Apr, Jul, and Oct).

4.12.4. When the in-flight kit is formally tasked for deployment, both increments will be deployed.

4.12.5. Each mission has unique equipment requirements based on aircraft type, available aircraft systems, distances/times and the types of patients being airlifted and the frequency of urgent patient movement requests. In order to ensure a minimum level of equipment on all patient flights, the following will be carried:

Table 4.1. Minimum Equipment for All Patient Flights.

	C-17	**C-130**	**KC-135**	**C-21**
Electrical Cable Assembly Set (ECAS)	X	X	X	
Cardiac Monitor/Defibrillator	X	X	X	X
Continuous/Intermittent Suction Unit	X	X	X	
In-flight Kit [1]	X	X	X	X[a]
IV Infusion Pump	X	X	X	X
Oxygen Analyzer	X	X	X	X
Oxygen	75 L	X[3]	X[3]	X[2]
Propaq ®	X	X	X	
Frequency Converter	X	X	X	
Spectrum ®				X[4]

NOTES:	
1. In-flight Kit is packed IAW current AE In-Flight Kit, Packaging Guide/Allowance Standard. a. Unit will develop local packing guides/allowance standards and forward to HQ AMC/A3V for approval. 2. Alternate O_2 and suction source must be brought on without Spectrum.	3. Utilize PTLOX. (Determine amount) (min of 5 liters) 4. Only necessitated on missions with a litter patient.

4.12.5.1. The Sq CC/Operations Officer/CNE shall be kept appraised of the unit's ability to meet minimum equipment requirements by the medical equipment section.

4.12.6. **Controlled Medications.** HQ AMC/SGPN establishes the authorized controlled medications list indicating types of controlled substances approved for AE missions. Any additions or deletions to this list must be forwarded to the AES pilot unit, and then approved by HQ AMC/SGPN. **EXCEPTION:** For C-21 missions, controlled medications will be carried IAW HQ AMC approved C-21 AE In-Flight Kit, Packaging Guide/Allowance Standard.

4.12.6.1. Procedures to requisition, manage, re-supply, and turn in controlled medications will be established at the unit level. Operating instructions for these procedures will complement existing USAF and AMC directives.

4.12.6.2. Medications will be inventoried monthly by either a disinterested officer or senior noncommissioned officer appointed by the unit commander in the presence of the squadron pharmaceuticals nurse.

4.12.6.3. The administration of any controlled drug to any patient will be annotated on AF Form 579, *Controlled Substances Register*.

4.12.6.4. Medications will be secured and inventoried as described in AFI 44-102, *Community Health Management*, AFI 31-101, *The Air Force Installation Security Program*, and this AFI.

4.12.7. **Equipment Accountability/Responsibility.**

4.12.7.1. It is the responsibility of the medical equipment section to accomplish the following:

4.12.7.1.1. Maintain equipment IAW AFI 10-2909, *Aeromedical Evacuation Equipment Standards.*

4.12.7.1.2. Ensure all medical equipment is properly scanned into the Plexus Tracking System. Follow guidelines established in Plexus Tracking Procedures for Center Operations and Plexus Tracking Procedures for Ground Operation.

4.12.8. The AE crew is responsible for accomplishing the following:

4.12.8.1. Perform preflight on equipment IAW AFI 10-2909, *Aeromedical Evacuation Equipment Standards* and a functional check at the aircraft to ensure the equipment functions on aircraft power. If ground support has completed the full equipment preflight check prior to aircrew arrival then the mission assigned crew will, as a minimum, perform a functional check at the aircraft.

4.12.8.2. Ensure all medical equipment that is removed from the mission is first scanned into the Plexus Tracking System to identify location and personnel assuming accountability. Follow guidelines established in Plexus Tracking Procedures for Aircrew Operations.

4.12.9. The Portable Therapeutic Liquid Oxygen (PTLOX) system will be filled with liquid oxygen for each mission.

4.12.9.1. The PTLOX system, will be stored with nitrogen IAW T.O. 15X-2-8-1, *Liquid Oxygen Converter Type CRU-87/U*.

4.13. Not Used.

4.14. Resource Protection.

4.14.1. Resource protection is the responsibility of all Air Force personnel; however, medical materiel specialists, because of the very nature of their job, must be particularly sensitive to the protection of materiel for which they are responsible.

4.14.2. Medical materiel is susceptible to theft, vandalism, or unintentional damage; therefore, procedures to prevent such occurrences will be established for all units.

4.14.3. Medical equipment supplied with protective cases will be kept in its case except when in use or when circumstances or maintenance dictate otherwise. Equipment items will be protected to preclude them from being accidentally damaged or destroyed.

4.14.4. Equipment items will be permanently bar-coded (Plexus) to identify the unit. This marking should be coordinated with the host medical treatment facility and accomplished so as to not deface the equipment.

Chapter 5

OPERATIONAL PROCEDURES

5.1. Checklists. A checklist is not complete until all items have been accomplished. Notes amplifying checklist procedures or limitations may be added to the checklists (in pencil). Currency of notes is a crewmember's responsibility.

5.1.1. Checklist Inserts. MAJCOM Stan/Evals shall approve the use of checklist inserts IAW AFI 11-215, *Flight Manual Program (FMP)*. For AMC and AMC-gained units, AMC/A3V is the checklist insert approval authority. The inserts should be placed at the end of the appropriate checklist or in an in-flight guide. All checklist inserts must have a POC. OGVs shall approve local in-flight guides and inserts not affecting T.O. guidance and procedures.

5.1.2. Only MAJCOM/A3 approved inserts/briefings pertaining to crew positions will be kept in the abbreviated flight crew checklist binders. Information in the AECM checklists will not be changed except by published revisions or changes.

5.1.3. During all aircraft operations, AECMs will carry and use the guidance contained in their current abbreviated flight crew checklist.

5.2. Duty Station. AECMs occupying a primary crew position will be at their duty stations during all critical phases of flight (takeoff, aerial refueling [AR], approach, and landing) unless crew duties dictate otherwise. During other phases of flight, crewmembers may leave their duty station to meet physiological needs and to perform normal crew duties. Notify the MCD or CMT prior to leaving primary duty station/work area.

5.3. Not Used.

5.4. Not Used.

5.5. Not Used.

5.6. Not Used.

5.7. Seat Belts.

5.7.1. All occupants will have a designated seat with a seat belt.

5.7.2. Crewmembers will have seat belts fastened when occupying a duty position, unless crew duties dictate otherwise.

5.7.3. All crewmembers will have seat belts fastened during takeoff and landing. For tactical/AR operations, all crewmembers and passengers will have seat belts fastened (unless authorized by the PIC or crew duties dictate otherwise). Crewmembers performing instructor or flight examiner duties are exempt from seat belt requirements if not occupying a primary crew position; however, they will have a seat available with an operable seat belt.

5.7.4. Litter patients, actual or simulated, must remain secured on litters for takeoff and landing.

5.8. Not Used.

5.9. Portable Electronic Devices.

5.9.1. Do not connect unauthorized equipment (video equipment, food preparation equipment, radios/tape players, CD players, etc.) to the aircraft intercom, PA, radio systems, or electrical system.

5.9.2. Aircrew members shall not use uncertified Government Furnished Equipment (GFE) or personal devices with RF transmit/receive capability on AMC aircraft carrying hazard class 1 explosive cargo at anytime. Prohibited devices include cellular phones, and laptop computers/PDAs with wireless capability enabled (i.e. Bluetooth).

5.9.3. AECMs are prohibited from using portable music listening devices (i.e. iPods, DVD players) while performing in-flight duties. These items may be utilized when in deadhead status or depositioning/repositioning. Laptop computers may be used for Official Duties only.

5.10. Tobacco Use on Air Force Aircraft. Tobacco use of any type is prohibited on Air Force aircraft.

5.11. Not Used.

5.12. Communications Policy. The Air Force does not give a promise of confidentiality to aircrews regarding their recorded aircraft crew communications. Crewmembers are expected to maintain a high degree of cockpit professionalism and crew coordination at all times.

5.12.1. Sterile Cockpit. Limit conversation to that essential for crew coordination and mission accomplishment during critical phases of flight: takeoff, AR, approach, landing, and any flight below 10,000 feet MSL (except cruise).

5.12.2. Aircraft Interphone. The MCD or designated AECM should monitor interphone (headset) during flight. The MCD will be on headset with the PIC during critical phases of flight as annotated in 5.2. and during in-flight emergencies. The MCD will notify the flight crew when going off headset. **EXCEPTIONS**: Headset is not required for the C-21. If the PA is inoperative on the KC-10, the inter-phone cable will not be available for the MCD to use during take-off and landing.

5.12.2.1. Both high and low impedance headsets can be used on the C-17. The interphone receptacle panel located midway right side cargo compartment is equipped with a switch to allow low-impedance headset use. C-17 high impedance headsets will not work on the KC-135, KC-10, C-5 or C-130.

5.12.2.2. Units may purchase David Clark high impedance headset (NSN 5495-01-424-3297) to facilitate communication with the flight crew on the C-17.

5.12.2.3. The Aircraft Wireless Intercommunication System (AWIS) is approved for use on the C-17, C-130, and KC-135. The purpose of the AWIS is for wireless communication between AECMs and CCATT. The system consists of a Bose® active noise reduction aviation headset and a Telephonics TruLink® portable transceiver. This system will be maintained as part of the 887A allowance standard. Each in-flight kit contains 7 AWIS.

NOTE: The Bose® headset will not be plugged into the C-17 aircraft intercom system or loss of vital crew communication can occur. It is only approved to be used wirelessly in conjunction with the TruLink® system on the C-17 for communication between AECMs.

NOTE: At this time the flight crew cannot monitor the AWIS. The MCD must switch to the aircraft system to communicate with the flight crew.

5.12.3. Crew Resource Management (CRM) Assertive Statement “Time Out."

5.12.3.1. "Time Out" is the common assertive statement for use by all crewmembers. The use of "Time Out" will:

5.12.3.1.1. Provide a clear warning sign of a deviation or loss of situational awareness.

5.12.3.1.2. Provide an opportunity to break the error chain before a mishap occurs.

5.12.3.1.3. Notify all crewmembers that someone sees the aircraft or crew departing from established guidelines, the briefed scenario, or that someone is simply uncomfortable with the developing conditions.

5.12.3.2. As soon as possible after a "Time Out" has been called, the aircrew will take the following actions:

5.12.3.2.1. The initiating crewmember will voice his or her concerns to the crew.

5.12.3.2.2. The PIC/MCD will provide all other crewmembers with the opportunity to voice inputs relative to the stated concerns.

5.12.3.2.3. After considering all inputs, the PIC/MCD will direct the aircrew to continue the current course of action or direct a new course of action. **NOTE**: The PIC is the final decision authority. The MCD is final decision authority regarding AE related issues.

5.13. Transportation of Working Dogs. Security Force working dogs may be manifested on AE missions as patients. The dog will be transported in a kennel and accompanied by a trained handler who will provide in-flight care to the dog. All equipment and supplies should also accompany the working dog. Refer to para **4.3** for unapproved equipment.

5.14. Not Used.

5.15. Not Used.

5.16. Not Used.

5.17. Not Used.

5.18. Not Used.

5.19. Not Used.

5.20. Not Used.

5.21. Not Used.

5.22. Not Used.

5.23. Not Used.

5.24. Not Used.

5.25. Not Used.

5.26. Not Used.

5.27. Not Used.

5.28. Not Used.

Chapter 6

AIRCREW PROCEDURES

Section 6A— Pre-Mission

6.1. Aircrew Uniform.

6.1.1. Aircrew will wear the aircrew uniform, as outlined in AFI 36-2903, *Dress and Personal Appearance of Air Force Personnel*, and appropriate MAJCOM supplement/theater OPORD, on all missions, unless otherwise authorized. When the Foreign Clearance Guide requires civilian attire, wear conservatively styled civilian clothing.

6.1.2. OG/CCs will determine clothing and equipment to be worn or carried onboard all flights commensurate with mission, climate, and terrain involved.

6.1.3. All crewmembers will:

6.1.3.1. Have Nomex gloves in their possession. **NOTE:** Primary crewmembers will wear Nomex gloves during engine start, takeoff, and landing.

6.1.3.2. Remove rings, earrings, and scarves prior to performing aircrew duties.

6.1.3.3. Have goggles/eye protection in their possession.

6.1.3.4. Wear appropriate footgear as described in AFI 36-2903, *Dress and Personal Appearance of Air Force Personnel*, applicable MAJCOM Supplements and AFI 11-301, Vol 1, *Aircrew Flight Equipment (AFE) Program*.

6.1.4. Personnel will have the appropriate items of clothing in their possession when flying in Arctic and Antarctic regions. **EXCEPTION**: Not applicable to transoceanic flights.

6.1.5. See AFI 10-403, *Deployment Planning*, and theater OPORD for mobility requirements.

6.2. Personal Requirements.

6.2.1. ID Card.

6.2.2. Passport. Carry a valid passport on all missions outside the CONUS. **EXCEPTION:** Unit commanders may authorize newly assigned personnel who have applied for, but not yet received, a passport to act as crewmembers on missions not scheduled to transit locations where passports are required.

6.2.3. Shot Record. Crewmembers must maintain worldwide shot requirements and carry their shot records on all missions outside the CONUS (except overseas units on local training missions).

6.2.4. Spectacles and Contact Lenses.

6.2.4.1. Spectacles. Wear IAW AFI 11-202V3.

6.2.4.2. Contact Lenses. Crewmembers who desire to wear contact lenses must consult with their unit flight surgeon and will meet criteria and follow guidelines outlined in AFI 48-123, *Medical Examinations and Standards; Attachment 17*.

6.2.4.3. Spare Sets. Crewmembers who wear corrective spectacles or contact lenses must carry a spare set of clear prescription spectacles on their person while performing aircrew duties.

6.2.5. Driver's License. A valid state driver's license is required on each TDY where use of US government general-purpose vehicles may be required.

6.2.6. Identification Tags. Two identification tags will be worn for all flights.

6.2.7. FOD Hazards. Crewmembers will not wear wigs, hairpieces, rings, ornaments, pins, clips, other hair fasteners, or earrings in the aircraft or on the flight line. **EXCEPTION:** Crewmembers may wear plain elastic hair fasteners and/or barrettes. These fasteners must not interfere with the wearing of headsets or the donning of oxygen equipment and will be accounted for before and after flight.

6.2.8. Each crewmember will carry an operable flashlight on all missions.

6.2.9. A reflective belt or suitable substitute will be worn on unlit flight lines during hours of darkness or periods of reduced visibility (IAW AFOSH Standard 127-100, *Aircraft Flight Line - Ground Operations and Activities*).

6.2.10. AECMs will be issued and will have a CPR pocket protective mask on their person during all AE missions.

6.2.11. Hard copy of Individual Training Summary and Individual Data Summary.

6.2.12. AF Form 1199, *Air Force Entry Control Card*.

6.3. Pre-mission Actions.

6.3.1. Before transiting areas outside the CONUS, aircrews will review theater-specific information necessary to survive and operate.

6.3.2. Not used.

6.3.3. For extended TDYs/deployments: review applicable OPORD.

6.3.4. Not used.

6.3.5. Obtain required customs declaration forms, as required.

6.3.6. Not used.

6.3.7. Ensure physiological training, annual physical, immunizations, Emergency Medical Technician (EMT) certification, Cardio Pulmonary Resuscitation (CPR), ACLS certification, nursing licensure and flight evaluations will remain current for all crewmembers throughout the TDY period.

6.3.8. Ensure visas have been received, if required.

6.3.9. Not used.

6.3.10. Compile sufficient spare forms, flight orders, etc. to cover the TDY period.

6.3.11. Release available seats to passenger terminal. Coordinate with C2 agency to release available seats to the passenger terminal.

6.4. Aircrew Publications Requirements. Primary crewmembers will carry a current hard copy of the publications specified in **Table 6.1** on all missions. Units may specify additional publications in their local unit supplement. Additional publication may be either hard copy or electronic. (For electronic publications a software reading device must be available on the mission).

Table 6.1. AECM Minimum Publication Requirements.

Publication	FN	AET
AFI 11-2AEV3, CL1 – Aeromedical Evacuation Crew (AEC) - Flying Operations - Emergency Procedures Checklist	X (1)	X (1)
AFI 11-2AEV3, CL2 – Aeromedical Evacuation Crew (AEC) - Nursing Considerations	X	X
AFI 11-2AEV3, CL3 – Aeromedical Evacuation Crew (AEC) - Equipment Functional Checks	X	X
NOTE: 1. AECMs will carry CL-1 checklist based on crew position (MCD/FN or AET). Section IV is not required for CMT, 2AET or 3AET. Section V is not required by MCD or FN.		

6.5. Not Used.

6.6. Aircrew Intelligence Briefing. Aircrews will receive an intelligence briefing that will emphasize terrorist, enemy, and friendly political and military development in the area in which they will be flying. Obtain timely intelligence updates prior to entering a specific area of operations (AOR). In theater, aircrews should receive intelligence updates on initial arrival at a forward operating location (FOL), or en route stop, and thereafter when significant developments occur. Report information of possible intelligence value to the local intelligence office as soon as practical to ensure timely dissemination of mission reports (MISREPs).

Section 6B— Predeparture

6.7. Not Used.

6.8. Flight Crew Information File (FCIF) Procedures.

6.8.1. Review FCIF, volume 1, (Index and Current Read File, as a minimum) before all missions or ground aircrew duties. Update the FCIF currency record with the latest FCIF item number, date, and crewmember's initials or as specified.

6.8.2. Crewmembers delinquent in FCIF review or joining a mission en route will receive an FCIF update from a primary aircrew member counterpart on the mission.

6.8.3. Crewmembers not assigned or attached to the unit operating a mission will certify FCIF review by entering the last FCIF number and their initials behind their name on the file copy of the flight authorization.

6.8.4. Current editions of *Flight Nursing Principles and Practice* or *Air and Surface Patient Transport* will be maintained in FCIF library.

6.9. Flight Crew Bulletins (FCB).

6.9.1. FCBs are issued under provisions of AFI 11-202, V2, *Aircrew Standardization/Evaluation Program*, Organization and Administration, and MAJCOM supplements. Operations group Stan/ Eval will be the OPR for FCBs. Items in FCBs may include local procedures and policies, concerning equipment and personnel generally not found in any other publications.

6.9.2. All crewmembers should be knowledgeable of local FCB contents and should familiarize themselves with deployed FCB contents.

6.10. AE Mission Kits. Mission kits will be carried on all operational and training AE missions. Mission Kit will be a paper copy. AE Mission Kit(s) include as a minimum:

6.10.1. **Publications.**

6.10.1.1. AFI 10-2909, *Aeromedical Evacuation Equipment Standards*.

6.10.1.2. AFI 11-2AE, V1, *Aeromedical Evacuation Aircrew Training*.

6.10.1.3. AFI 11-2AE, V2, *Aeromedical Evacuation Evaluation Criteria*.

6.10.1.4. AFI 11-2AE, V3, *Aeromedical Evacuation Operations Procedures*.

6.10.1.5. AFI 11-2AE, V3, Addenda A, *Aeromedical Evacuation Operations/Configuration/Mission Planning*.

6.10.1.6. AFI 11-401, *Aviation Management*.

6.10.1.7. AFI 41-301, *Worldwide Aeromedical Evacuation System*.

6.10.1.8. AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards*.

6.10.1.9. AMCI 11-208, *Tanker/Airlift Operations*.

6.10.1.10. Current Aeromedical Evacuation In-flight Kit–Packaging Guide/Allowance Standard.

6.10.1.11. Current AMC Aeromedical Evacuation Aircrew Forms Guide.

6.10.1.12. Current Local FCB (if locally published).

6.10.1.13. Lippincott Manual of Nursing Practice (current edition).

6.10.1.14. Current ACLS Guidelines.

6.10.1.15. Current Edition Nursing Drug Book.

6.10.2. **Forms.**

6.10.2.1. DD Form 600, *Patient Baggage Tag*

6.10.2.2. DD Form 601, *Patient Evacuation Manifest*

6.10.2.3. DD Form 1854, *US Customs Accompanied Baggage Declaration*

6.10.2.4. DD Form 2852, *Aeromedical Evacuation Event/Near Miss Report*

6.10.2.5. AF Form 3829, *Summary of Patients Evacuated by Air*

6.10.2.6. AF FORM 3838, *Do Not Resuscitate (DNR) Certification for AE*

6.10.2.7. AF FORM 3841, *Certificate of Release*

6.10.2.8. AF FORM 3851, *Patient Baggage Data*

6.10.2.9. AF Form 3854, *Receipt for Patient's Valuables*

6.10.2.10. AF Form 3858, *C-130 Aeromedical Evacuation Mission Offload Message*

6.10.2.11. AF Form 3859, *Turn-In of Unaccompanied Narcotics*

6.10.2.12. AF Form 3860, *Aeromedical Patient Record Data*

6.10.2.13. AF Form 3899, *Patient Movement Record*

6.10.2.14. AF Form 3899A, *Patient Movement Record Progress Note*

6.10.2.15. AF Form 3899B, *Patient Movement Physician Orders*

6.10.2.16. AF Form 3899C, *Patient Movement Physical Assessment*

6.10.2.17. AF Form 3899D, *Patient Movement Hemodynamic/Respiratory Flowsheet*

6.10.2.18. AF Form 3899E, *Patient Movement Intake/Output*

6.10.2.19. AF Form 3899F, *Patient Movement Physician Orders for Behavior Management and Restraints*

6.10.2.20. AF Form 3899G, *Patient Movement Restraint Observation Flowsheet*

6.10.2.21. AF Form 3899H, *Patient Movement Neurological Assessment*

6.10.2.22. AF Form 3899I, *Patient Movement Medication Record*

6.10.2.23. AF Form 3899J, *Patient Movement Rhythm/Hemodynamic Strip*

6.10.2.24. AF Form 3899K, *Patient Movement/In-flight Resuscitation Flow Sheet*

6.10.2.25. AFTO 350, *Repairable Item Processing Tag*

6.10.2.26. Patient Positioning Plans for All AE Aircraft

6.11. Not Used.

6.12. Briefing Requirements.

6.12.1. **MCD Briefings.** The MCD shall brief the PIC in regards to the AE mission utilizing appropriate checklist. PIC will brief all crewmembers on the details of the mission. Include the following:

6.12.1.1. Verify mission itinerary, threats, flight profile, etc.

6.12.1.2. Brief pilot on non-US citizens, altitude restrictions, unique patient requirements, and electrical and oxygen requirements in-flight or on the ground, only if it limits aircraft operation.

6.12.1.3. Obtain escape and evasion (E & E) briefing (as required). Identify armed crewmembers (as required).

6.12.1.4. Obtain briefing on weather, en route times, total number of crew, refueling stops, planned flying/cabin altitudes and possible delays.

6.12.1.5. Identify emergency and communication signals/methods with pilot and LM/BO.

6.12.1.6. Discuss enplaning/ERO requirements (time constraints, loading requirements, i.e., ramps, AMBUS, safety observer, etc.).

6.12.1.7. Identify Aeromedical Readiness Mission (ARM) requirements (as required).

6.12.1.8. Discuss emergency requirements (radio transmissions/use of headsets).

6.12.1.9. Brief LM/BO on anticipated patient load, number of Aeromedical Evacuation Crew (AEC), souls on board verification, and cabin secure prior to take-off.

6.12.1.10. Coordinate egress plan, meal times, special diets, and mission unique items with LM/ BO.

6.13. Call Signs.

6.13.1. AIR EVAC Priority. If a medical emergency occurs during flight, and is determined by the MCD to be an urgent situation, a request for AIR EVAC Priority will be requested. The PIC may request "AIR EVAC priority" for preferential ATC handling if a delay will affect a patient's well being. AIR EVAC priority will only be used for that portion of the flight requiring expedited handling. Do not request priority for routine air evacuations to avoid ATC delays or inconveniences. It is the PIC's responsibility to use this option only for bona fide medical situations that demand priority handling. Use this status judiciously.

6.14. Not Used.

6.15. Not Used.

6.16. Not Used.

6.17. Not Used.

6.18. Not Used.

6.19. Not Used.

6.20. Not Used.

6.21. Not Used.

6.22. Operational Risk Management (ORM). ORM is a logic based, common sense approach to making calculated decisions on human, material, and environmental factors before, during, and after all operations. USAF policy on ORM is contained in Air Force Policy Directive 90-9, *Operational Risk Management*. MCDs will accomplish ORM worksheets IAW MAJCOM and local guidance as part of preflight activities.

Section 6C— Preflight

6.23. AFTO Form 781A. AFTO Form 781A, **Maintenance Discrepancy and Work Document** is used to report unserviceable/missing aircraft emergency equipment items. This form is usually maintained by the LM/BO/FE onboard the C-5, C-130, C-17, KC-10, and KC-135. All aircraft discrepancies observed by AECMs will be reported for inclusion on the AFTO Form 781A.

6.24. Aircraft Servicing and Ground Operations.

6.24.1. Aircraft Refueling. Refueling normally begins after deplaning patients are off the aircraft and prior to enplaning that station's patients.

6.24.1.1. Simultaneous fuel and oxygen servicing is not authorized.

6.24.1.2. If cabin lights, electrical power to operate medical equipment, and aircraft inter-phone are operating prior to refueling, use may be continued during servicing operations provided it does not radiate energy. (Do not turn electronic equipment on or off during refueling.) **EXCEPTION:** Only those systems, switches or electrical circuits needed to operate equipment to sustain life, may be turned on and used during refueling.

6.24.2. Concurrent Ground Operations. Concurrent servicing (CS) is the simultaneous servicing of fuel or oxygen with or without patients on board while cargo loading/unloading or maintenance operations are being performed.

6.24.2.1. The PIC and Chief Servicing Supervisor (CSS) shall ensure aircrew members and servicing personnel accomplish Concurrent Servicing (CS) per AFI 32-2001 The Fire Protection Operations and Fire Prevention Program and TO 00-25-172. The CSS will coordinate with all personnel involved prior to beginning concurrent operations.

6.24.2.2. CS may be accomplished with patients onboard the C-17 and C-130. CS will not be accomplished on the C-5, KC-10 and KC-135. For C21 aircraft, utilize MDS-specific guidance for CS per para 6.24.4.

6.24.2.2.1. Prior to starting concurrent servicing, the total number of patients, passengers, and crew on board the aircraft will be given to the fire department.

6.24.2.2.2. A current and qualified crewmember for the type of aircraft being serviced will be appointed as a Passenger Compartment Monitor (PCM) and shall continuously monitor patients/passengers during CS. PCMs will not perform other duties during servicing. **EXCEPTION:** see MDS guidance below. AECMs and passenger service representatives will not serve as PCMs.

6.24.2.2.3. The PCM will brief patients on emergency egress, exit prohibitions, and hazards. Ambulatory patients will remain seated but will not wear seatbelts during CS. When possible, the PCM should conduct the briefing prior to servicing.

6.24.2.2.4. Loading ramps/stairs are in place for immediate use and exits (excluding the overhead escape hatches) are opened for egress.

6.24.2.2.5. At least two qualified AECMs (one must be a FN) will remain onboard to observe patients and assist patients in the event of an egress.

6.24.2.2.6. The PIC, designated aircrew representative, or CSS will advise PCMs and AECMs when to evacuate patients.

6.24.2.2.7. Patients will not enter or exit the aircraft during servicing. Crewmembers may enter or exit the aircraft only when performing essential duties associated with the concurrent servicing operation. Individuals must properly ground themselves before boarding the aircraft.

6.24.2.2.8. Activities around the aircraft will be kept to a minimum during the refueling process. Onload/Offload patient and passenger baggage prior to or after refueling.

6.24.2.2.9. The PCM will set the interior lighting as bright as possible to suit the combat environment.

6.24.2.2.10. Do not use the on board toilet facilities during servicing.

6.24.3. **Crash/Fire/Rescue (CFR).**

6.24.3.1. When concurrent fuel servicing with patients/passengers on board a major aircraft, rescue and fire vehicle will be available to respond within three minutes or as determined by the base Fire Chief. (**NOTE**: When servicing with JP-4 or Jet B Fuel, a major aircraft rescue and fire vehicle will be positioned at the aircraft).The flight crew will coordinate CFR requirements.

6.24.3.2. At non-AMC bases, non-U.S. military bases, and civilian airfields, the controlling agency will coordinate CFR coverage, as necessary. The request for CFR vehicle coverage may be denied. This will not prevent refueling operations from occurring.

6.24.4. **C-21 Aircraft.**

6.24.4.1. IAW Interim Operational Supplement T.O. 00-25-172S-3, concurrent servicing is authorized for the C-21. However, the decision to refuel with patients on board must be made judiciously and only after the PIC briefs the MCD and the patient, on the emergency evacuation plan prior to commencing refueling operations. Concurrent servicing is only authorized under the following conditions:

6.24.4.1.1. If deplaning a critical patient would increase risk by an additional move off and back on the aircraft, or

6.24.4.1.2. If there is no suitable location on the airfield to house the patient during the refueling, or

6.24.4.1.3. If no suitable transportation (ambulance) is available to move the patient from the aircraft, or

6.24.4.1.4. If the patient would be exposed to inclement weather.

6.24.4.1.5. The aircraft door will remain open during all phases of the refueling operation with patients onboard. External power may be applied and cockpit aeromedical switches may be placed to the ON position prior to the start of refueling operations. Medical life support equipment may also be operated on battery power during refueling operations.

6.24.4.1.6. As an additional safety measure, one C-21 pilot must remain at the aircraft at all times during refueling. Stable, ambulatory patients will routinely be deplaned during refueling if there is a suitable area to provide them shelter.

6.25. Not Used.

6.26. Aircrew Life Sustaining Equipment Requirements. Aircrew Flight Equipment (AFE) includes those systems, subsystems, emergency survival equipment, and techniques that will sustain life in-flight, afford varying degrees of protection and enhance survival potential during and after in-flight emergencies, crash landing, or ditching.

6.26.1. AFE requirements are in AFI 11-301, Volume 1, *Aircrew Flight Equipment (AFE) Program*. Emergency/aircrew life sustaining equipment required onboard AE missions are contained in the AECM Support Kit. Each kit contains 7 Survival Vests, 7 Aircrew Body Armor, 7 Anti-Exposure Suits, and 7 LPU-10/P Life Preservers.

6.26.1.1. For C-5, C-17, C-130, KC-10 and KC-135 missions, the LM/BO is responsible for checking AFE. The CMT must coordinate with the LM/BO to determine that sufficient aircrew life sustaining equipment is onboard prior to departure. The CMT must ensure all AFE is distributed and immediately available to all patients before mission departure. The LM/BO is responsible for noting unserviceable/missing aircrew life sustaining items on the AFTO Form 46, *Preposition Life Support Equipment*. For C-21, the PIC is responsible for checking AFE.

6.26.1.2. The MA-1 portable walk-around bottle is the primary emergency oxygen source for AECMs. **EXCEPTION:** Given the shortage of MA-1 portable walk-around bottles, the Protective Breathing Equipment (PBE) may be used as a primary oxygen source while performing crew duties.

6.26.1.3. The A-21 regulators of some MA-1 bottles are modified to restrict flow of oxygen during servicing. The modification is designed to reduce risk of fire when servicing bottles off aircraft. Restricted flow increases on-aircraft fill time from 30-45 seconds (unmodified regulator) to as much as 3.5 minutes (modified regulator). Under certain conditions, bottles are depleted faster than they can be refilled.

6.26.1.3.1. Identification. Regulator type is determined by viewing the inside of the fill nozzle. Unmodified regulators have a push valve inside the nozzle resembling a standard tire valve stem. Modified regulators have a brass plate/filter covering inside of nozzle. Modified 2 regulators have a brass plate/filter covering inside of the nozzle and no valve stem is visible.

6.26.1.3.2. Basic Operation. Except for fill times, operation of bottles are identical

6.26.1.3.2.1. AECMs will check regulator type during pre-flight. Modified, modified 2, or unmodified MA-1 bottles may be used. If an AECM is using a modified bottle, they must ensure it is full at mission preflight. If emergency oxygen is required during flight and the walk-around bottle is depleted, the AECM will don a Protective Breathing Equipment (PBE) as the second source of emergency oxygen. Once the PIC has determined it is safe to move about the cabin and AECMs may remove emergency oxygen, AECMs will check the patients. After all patients' needs are met AECMs will refill their MA-1 bottle.

Should emergency oxygen be required before the walk-around bottle is refilled, a PBE will be used. If a PBE is not available and the Emergency Passenger Oxygen System (EPOS) is the only available source, the AECM will cease crew duties and be seated until the PIC has directed crew members to remove emergency oxygen.

6.26.1.4. AECMs will not remove the LM/BO emergency equipment (cargo compartment quick dons/smoke masks) for use.

6.26.1.5. AE units will not service MA-1 portable oxygen bottles. Dash 21/Alternate Mission Equipment (AME) shops will ensure MA-1 portable oxygen bottles are serviceable and properly maintained. **NOTE:** If a MA-1 bottle is accidentally left open or the system is depleted and not recharged within two hours, bottles will be purged as follows:

6.26.1.5.1. Fill the bottle using oxygen recharger hose until full (300 psi [+/- 25 psi]).

6.26.1.5.2. Turn MA-1 bottle upside down and turn to “EMERGENCY” setting until empty.

6.26.1.5.3. Repeat for a total of three times.

6.26.1.6. EPOS will be distributed and their use demonstrated prior to flight. Ensure EPOS are readily available for litter patients.

6.26.1.7. Crewmembers will check their emergency oxygen equipment during the preflight inspection. Oxygen equipment will be immediately available at each crew position, individual masks will not be disconnected until all patients/attendants have deplaned.

6.26.1.7.1. MA-1 portable walk-around bottle preflight (PRICE Check).

6.26.1.7.1.1. P- Pressure: Ensure portable walk-around bottle indicates 300 psi +/- 25 psi.

6.26.1.7.1.2. R- Regulator: Ensure there are no signs of visible damage to the regulator gauge, and view inside of the fill nozzle to identify if bottle is modified or unmodified.

6.26.1.7.1.3. I- Inspection: Ensure Quick-don Mask and goggles are properly secured and clean. Check for holes, tears, cuts or abrasions. Inspect bottle for signs of damage.

6.26.1.7.1.4. C- Connections: Ensure Quick-don Mask is connected to O2 bottle. Adjust harness to expedite donning in emergency. If connected to aircraft communication system, confirm communication capability.

6.26.1.7.1.5. E- Emergency: Don mask with goggles, pull purge valve, rotate through all settings (Normal – Emergency). Oxygen should be felt inside goggles. Leave purge valve in the OPEN (pulled out) position for flight.

EXCEPTION: Where smoke or fumes are not present and goggles are not required, push the pin in the CLOSED (pushed in) position.

NOTE: AECMs will adjust and fit leg straps to ensure inadvertent swinging of the bottle when used in an emergency situation.

EXCEPTION 1 - The 3AET may disconnect and off load his/her mask if duties require him/her to depart the flight line.

EXCEPTION 2 - If all patients and attendants have been deplaned and the AECMs are deplaning at that station; AECMs may remove oxygen masks if the passengers will be supervised by the flight crew.

6.26.2. PBE, if available, is excellent for use in smoke, fume, or fire environments. They need not be limited to "escape" only conditions; these devices can be used as an oxygen source in a rapid or slow decompression.

6.26.3. Rafts. On over water flights do not carry more patients, passengers, and crewmembers than on board life rafts will accommodate.

6.26.4. LPUs. The loadmaster/BO/AEC will place an LPU within easy reach of each patient (litter/ambulatory)/medical attendants and aircrew member prior to takeoff on over water flights. Crewmembers will fit and adjust LPUs (if applicable) for over water flights and will wear them on over water missions below 2000 feet. (EXCEPTION: LPUs do not need to be worn for takeoffs, landings, or approaches). Ensure the appropriate number of LPU-6/P's are aboard for over water missions carrying infants. Use the Adult/ Child life preserver for litter patients. The use of the LPU-6/P Infant Cot is limited to infants 18 months of age or less and up to 30 lbs.

6.27. Fleet Service. Ensure the required fleet service items are aboard the aircraft early enough to permit inventory prior to engine start.

6.28. Not Used.

6.29. Airlifting Hazardous Cargo.

6.29.1. Cargo may be carried with patients unless a clear detriment to the health and well being of the patient or passengers can be demonstrated. EXCEPTION: Cargo will not be carried on the KC-135 with patients onboard. The decision will be made by the MCD and PIC, considering the need for maximum utilization of the aircraft. Refer to AFMAN 24-204, *Preparing Hazardous Materials for Air Shipments* for hazardous product special provisions rating. P4 and P5 rated hazardous material have no AE restrictions. Conflicts will be referred to the respective tasking AE command element for decision.

6.30. Handling of Classified Cargo, Registered Mail, Not Mission Capable Supply (NMCS), Very, Very Important Part (VVIP), Forward Supply System (FSS) Shipments, and Courier Material.

6.30.1. NMCS/VVIP/FSS shipments should not be moved on AE missions without the consent of the 618 TACC AE Cell for CONUS and intertheater AE missions or the respective theater Air Operations Center (AOC) for AE missions within the overseas theater.

Section 6D— Departure

6.31. On Time Takeoffs. Mission departures are on time if the aircraft is airborne within -20/+14 minutes of scheduled takeoff time or as specified in a MAJCOM supplement.

6.31.1. Early Departures. Early departures are authorized to prevent a delay due to weather, ATC restrictions, airfield or aircraft operational limitations, to adjust mission flow during a large-scale operation, or if approved through C2 channels provided the impact on local and downrange facilities and crew duty is evaluated.

Section 6E— En route

6.32. Not Used.

6.33. Not Used.

6.34. Not Used.

6.35. Not Used.

6.36. Not Used.

6.37. Communications.

6.37.1. Load Message.

6.37.2. At military bases, the flight crew will pass inbound load messages to the proper C2 personnel. At civilian airfields, notify ground control.

6.37.3. The MCD will complete an appropriate Aeromedical Evacuation Mission Offload Message, IAW current Aeromedical Evacuation Forms Guide.

6.38. Not Used.

6.39. Not Used.

Section 6F— Arrival

6.40. Not Used.

6.41. Not Used.

6.42. Not Used.

6.43. Not Used.

6.44. Not Used.

6.45. Not Used.

6.46. Border Clearance. Customs, Immigration, and Agriculture require certain forms for border clearance. The 3AET is the custodian for border clearance and will ensure all required forms are onboard the aircraft before takeoff. The 3AET will also distribute the forms to the AEC, patients and attendants, ensure completion prior to landing and deliver completed forms to LM/BO. **NOTE:** Ensure sufficient customs forms are available for all personnel. Passenger service personnel should provide forms for passengers prior to departure.

6.47. Insect and Pest Control. AEC will coordinate this process with PIC, LM/BO IAW AR 40-12, *Quarantine Regulations of the Armed Forces*. **CAUTION:** Aircraft should not be sprayed with patients onboard.

Section 6G— Miscellaneous

6.48. Not Used.

6.49. Not Used.

6.50. Aircrew Flight Equipment and Dash 21 Equipment Documentation. The PIC or designated representative will:

6.50.1. Before departing home station or en route stations, ensure appropriate serviceable protective clothing, aircrew life sustaining equipment, and Dash 21 equipment for the entire or remainder of the mission are aboard the aircraft.

6.50.2. Before departing home station and following en route crew changes, review AF Form 4076, *Aircraft Dash 21 Equipment Inventory*, to ensure all required Dash 21 equipment has been certified as installed by maintenance. Ensure the initial check has been signed by maintenance, and configuration documents match mission requirements.

6.50.3. Before departing home station and following en route crew changes, review, sign, and date the AFTO Form 46, *Prepositioned Life Support Equipment*, to ensure all required protective clothing and aircrew life sustaining equipment have been certified as installed by AFE personnel and that configuration documents match mission requirements. Ensure appropriate number and type of life preservers are aboard for over-water missions carrying children and infants.

6.50.4. Missing Equipment. AECMs discovering equipment missing will notify LM/BO.

6.51. Passenger Restrictions. No-show patient or passenger baggage or baggage of patients or passengers removed from flight will be off-loaded prior to departure.

6.52. Apparent Patient Death in Flight. When a suspected death occurs in-flight, the planned itinerary will not be interrupted if the next scheduled stop is that patient's destination. 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 critical phase of flight or has landed the MCD will contact AE C2 agencies and make arrangements to have physician meet the aircraft if appropriate and pronounce the patient dead. Once pronounced, the patient will be off-loaded.

6.52.1. When notified by the MCD that a suspected death has occurred, the PIC should immediately provide C2 agencies with the following information: "A suspected death has occurred on mission number_____. ETA to _____ is _____Z, patient cite number_____." The PIC relays this information to the controlling agency for relay to the appropriate C2 agencies. **NOTE:** No personal data such as name, SSN, etc. will be transmitted, to preclude premature release prior to notification of the next of kin.

6.52.2. If a physician is onboard during the flight he/she may pronounce death in-flight. The MCD will document time of pronouncement in "Z" time and the physician will co-sign the DD Form 602 or AF Form 3899. The MCD will contact C2 agencies to alert them of

situation to determine destination. Records, medication, baggage, and physical effects will be inventoried prior to offloading and documented on AF Form 1053, *Record of Patients Storing Valuables.*Document the event on the AF Form 3829 and the AF Form 2852.

6.52.3. If a patient expires on an AE mission, the MCD has several decision points. First, if the next destination is the deceased deplaning point, the body will be off-loaded at that destination regardless if military or civilian. The MCD will contact the deplaning airfield's Air Transportation Operations Center (ATOC) and request mortuary affairs at military installations or, civilian coroner at civilian airfields. Once the aircraft has landed, follow that airfield's guidelines for death certificate and body removal. Once the patient has been pronounced deceased, airlift ceases, unless the MCD/PIC contact C2 authorities for unique situations. Do not continue airlift without a death certificate.

6.52.4. Home Station. In the event of patient death in flight or patient death within 24 hours of flight, upon mission completion the AES/CC shall ground the involved AEC and conduct an investigation to determine if the AEC followed all aircrew procedures. If necessary, appropriate actions will be taken to resolve any digressions (AF Form 8, *Certificate of Aircrew Qualification*, retraining, etc.) prior to returning individual(s) involved to flying status. AE unit commander shall notify Operations Group Commander who will notify the MAJCOM A3 of incident and actions taken.

6.52.5. Deployed AECMs**.** Detachment Commander or detachment Operations Group Commander with operational control of the mission will be notified of the incident by the C2 agency. If the AEC is in the mobility system, the AE detachment commander where the crew disembarks the aircraft will conduct the investigation to determine if the AEC followed all aircrew procedures. In the event AECMS are in deadhead status, AECMs will return to deployed/staged unit.

6.53. Airlift of Human Remains. Remains of deceased personnel will not normally be carried on AE missions. However, in the interest of timely movement or other factors, which cannot otherwise be satisfied by subsequent airlift, transportation of remains may be authorized. For 618 TACC controlled missions, submit requests for movement of remains on aeromedical aircraft to the 618 TACC/APCC. The 618 TACC/XOZ, will provide approval. Approval authority will not be delegated below the 618 TACC/XOZ level. For non-618 TACC controlled mission contact appropriate C2 agency. If approval is granted to move remains on aeromedical mission, the ATOC chief will ensure loading or offloading is accomplished discreetly; not concurrently with passenger and patient loading or offloading. In such cases, the PIC will ensure the on-load, position, and off-load are conducted in a discrete manner. In most situations, a ceremony will be conducted to pay respect and honor to the deceased member.

6.54. Patients Requesting Release from AE System.

6.54.1. The MCD may release active duty patients/attendants only upon a competent medical authority's recommendation and with the concurrence of the active duty member's commander.

6.54.2. The MCD will ensure AF Form 3841, *Certificate of Release,* is completed when a non-active duty patient/attendant requests release from the AE system during a mission. If the patient is under the age of 18 years, the patient's legal guardian must sign the form prior to the patient's release.

6.54.2.1. Whenever completing this form, ensure proper AE C2 agency is informed immediately.

6.54.2.2. Prior to obtaining the signature of the requesting individual, the MCD determines if the individual is sufficiently competent to understand the purpose of the AF Form 3841. If not, the MCD requests advice from a medical authority or the staff judge advocate at the place of requested debarkation, if such personnel are available. In all instances, guidance from the C2 agency should be requested.

6.54.3. Prepare the AF Form 3841 in triplicate. The original will be placed in the patient's medical record; one (1) copy will be attached to the AF Form 3829, (or TRAC2ES equivalent) to be filed upon termination of the mission; one (1) copy will be given to the individual requesting release from the AE system. Also, complete DD Form 2852.

6.54.4. When a patient, or their authorized representative, requests release from further airlift, the MCD advises the individual requesting release, that the purpose of the AF Form 3841 is to release the U.S. Government, its' agents, and employees from all responsibility for further aeromedical airlift services arising pursuant to the patient's movement and any and all liability from resulting damages. The MCD also advises the patient, or their authorized representative, of any risks which may arise from the patient's request for release from the AE system. These risks are annotated on the AF Form 3841. Patients requesting release from the AE system should be advised that signing the AF 3841 does not prohibit the individual from receiving future AE services. **NOTE:** The individual's signature on the AF Form 3841 indicates release of the AE system from responsibility and liability for the patient requesting release from the AE system.

6.54.5. Refusal to sign the AF Form 3841 is annotated in the patient's medical record.

6.54.6. Ensure the patient is aware they may not be reimbursed for travel expenses if their orders require AE transportation.

Chapter 7

AIRCRAFT SECURITY

7.1. General. This chapter provides guidance on aircraft security and preventing and resisting aircraft piracy (hijacking) of aircraft. AFI 13-207, *Preventing and Resisting Aircraft Piracy (Hijacking)*, AFI 31-101, *The Air Force Installation Security Program*, and specific MAJCOM security publications contain additional guidance. Aircrews will not release information concerning hijacking attempts or identify armed aircrew members or missions to the public.

7.2. Security. Aircraft security at non-United States military installations is the responsibility of the controlling agency. See applicable AFI 11-2MDSV3 guidance.

7.3. Air Force Installation Security Program. The following security procedures will implement AFI 31-101, *The Air Force Installation Security Program*, requirements for each aircraft:

7.3.1. The aircraft will be parked in an established restricted area and afforded protection via a roving patrol, a two-person Internal Security Response Team (ISRT), with immediate response not to exceed 3 minutes, and a two-person External Security Response Team, (ESRT) with response capability within 5 minutes.

7.3.2. When no permanent or established restricted area parking space is available, establish a temporary restricted area consisting of a raised rope barrier, and post with restricted area signs. Provide a one-person mobile patrol, supported by a two-person ISRT capable of a 5minute response. Portable security lighting will be provided during the hours of darkness if sufficient permanent lighting is not available.

7.3.3. At non-United States military installations, the PIC determines the adequacy of local security capabilities to provide aircraft security commensurate with this chapter. If he or she determines security to be inadequate, the aircraft will depart to a station where adequate security is available.

7.3.4. The security force must be made aware of all visits to the aircraft. The security force POC must be identified to the PIC.

7.3.5. Security support is a continual requirement and is not negated by the presence of aircrew or ground crew members. Security force support terminates only after the aircraft doors are closed and the aircraft taxis.

7.3.6. Locking and Sealing. Lock or seal the aircraft during a “Remain over night” (RON) on non-secure ramps (see paragraph 7.5.1.).

7.4. Standby Aircraft Security. Ensure aircraft hatches and doors are secured to show unauthorized entry; seal the crew entrance door with a lock box, or other controllable device, which will prevent entry without damaging the door or lock. The PIC shall notify the C2 agency the aircraft is sealed and provide them a means to access the aircraft in an emergency. Annotate the forms with the time the aircraft was sealed. The C2 Senior Controller may grant access to a sealed aircraft, shall document time of entry and ensure it remains launch capable. The PIC or designated representative must be present if access to the aircraft is required and will ensure the aircraft is resealed. The aircrew pre-flight portion will remain valid if performed by one aircrew,

sealed, and flown by another aircrew. **NOTE:** WG/CCs should develop local procedures for documentation and management IAW TO 00-20-1 and MAJCOM Supplement.

7.5. En Route Security. The planning agency must coordinate with the execution agency to ensure adequate en route security is available. The PIC will receive a threat assessment and en route security capability evaluation briefing for areas of intended operation prior to home station departure and should request updates from en route C2 as required. If required, a PHOENIX RAVEN team will be assigned to the mission.

7.5.1. The PHOENIX RAVEN team will consist of three US Air Force security force members, but may include more depending on security requirements. The team's travel status is determined by MAJCOM. The team travels in MEP status and is responsible to the PIC at all times. In turn, the PIC is responsible for its welfare (transportation, lodging, etc.). Ensure security team members receive a mission briefing, aircraft egress/passenger briefing (as appropriate).

7.5.2. Arrival. On arrival, the PIC will assess the local situation and take the following actions as required:

7.5.2.1. Area patrol. Request area security patrols from local security forces. If local authorities request payment for this service, use AF Form 15.

7.5.2.2. Aircrew surveillance. During short ground times, direct armed crew members to remain with the aircraft and maintain surveillance of aircraft entrances and activities in the aircraft vicinity.

7.5.2.3. Inadequate Security. If, in the opinion of the PIC, airfield security is inadequate and the PIC determines the safety of the aircraft is in question, the PIC may waive the FDP limits and crew rest requirements and depart as soon as possible for a base considered reliable. Report movement and intentions to the controlling agency as soon as practical. If a departure is not possible, the aircrew must secure the aircraft to the best of their ability. In no case, will the entire crew leave the aircraft unattended. Crew rest requirements will be subordinate to aircraft security when the airframe may be at risk. The PIC should rotate a security detail among the crew to provide for both aircraft protection and crew rest until relief is available. Request security assistance from the nearest DoD installation, US Embassy, local military or law enforcement agencies as appropriate.

7.5.3. Entry Control Procedures. Unescorted entry is granted to aircrew members and support personnel assigned to the mission who possess their home station AF Form 1199, Air Force Entry Control Card, supported by an Entry Access List (EAL) or aircrew orders. Aircrew members and assigned crew chiefs are authorized escort authority.

7.5.3.1. Normally, non-United States nationals, such as cargo handlers, can perform their duties under escort and should not be placed on the EAL.

7.5.3.2. Personnel not on the EAL or aircrew orders must be escorted within the area.

7.6. Detecting Unauthorized Entry.

7.6.1. When parking on a secure ramp, the aircraft will normally be left unlocked/unsealed to allow ground personnel immediate access. If, in the PIC's judgment, the aircraft needs to be locked and sealed in order to detect unauthorized entry, then:

7.6.1.1. Use available aircraft ground security locking devices.

7.6.1.2. Secure the doors in a manner that will indicate unauthorized entry (e.g., tape inside of doors to airframe so that entry pulls tape loose).

7.6.1.3. Close and seal the crew entrance door (box car seal).

7.6.1.4. Wipe the immediate area around lock and latches clean to aid in investigation of a forced entry.

7.6.1.5. Report any unauthorized entry or tampering to the Office of Special Investigation (OSI), security forces or local authorities, and the C2 agency. Have aircraft thoroughly inspected prior to flight.

7.6.2. Security awareness is crucial to effective mission accomplishment. Aircrews must always remain vigilant to their surroundings, especially at high threat, low security locations. In addition to normal preflight activities, aircrews must inspect areas of the aircraft not covered by normal preflight duties, to include: inside main landing gear pods, and crew/troop O2 service panels, for personnel or other unfamiliar devices. Report any suspicious items to host security forces. Aircrews will maintain a heightened security posture throughout all pre-takeoff activities.

7.7. Preventing and Resisting Hijacking.

7.7.1. The Air Transportation Act of 1974 and the Federal Aviation Act of 1958, as amended, vest the FAA Administrator with exclusive responsibility for the direction of law enforcement activity in aircraft hijacking situations involving all aircraft (civil and military) in-flight in the United States.

7.7.2. In taking action during an aircraft hijacking situation, military forces will act under military command within the scope of their duties.

7.7.3. In the event an aircraft involved in an aircraft hijacking situation is carrying documents, equipment, or material that DoD has determined to be highly sensitive, or weapons of mass destruction, DoD will provide FAA, and where appropriate, the Federal Bureau of Investigation (FBI) with all pertinent information. Where possible, the FAA will consult and cooperate with DoD prior to directing any law enforcement activity.

7.7.4. An aircraft is most vulnerable to hijacking when the aircrew is aboard and the aircraft is operationally ready for flight.

7.7.5. A concerted effort must be made to prevent the hijacking of military or military contract aircraft by detecting potential hijackers before they board the aircraft.

7.7.6. Should preventive efforts fail, any actual attempt to hijack a military aircraft must be resisted in a manner appropriate to the situation.

7.7.7. Since air piracy may be committed by political terrorists or by individuals to whom the threat of death is not a deterrent but a stimulus, ordinary law enforcement procedures may be ineffective. Thus, successful conclusion of a hijacking situation and apprehension of the hijackers may require use of specialized law enforcement techniques and procedures.

7.7.8. Delaying actions have been most successful in overcoming hijackings without loss of life or property.

7.7.9. In the case of an aircraft carrying passengers, the primary concern is the safety of the passengers.

7.7.10. Assistance to hijacked civil or military contract aircraft will be rendered as requested by the pilot in command of the aircraft and the authority exercising operational control of the anti-hijacking effort.

7.8. Preventive Measures. Commanders at all levels must ensure preventive measures are taken to minimize access to the aircraft by potential hijackers.

7.8.1. Preventive measures include the following: The host station passenger processing or manifesting facility should conduct anti-hijacking inspections. Do not board passengers until the PIC is fully satisfied with inspection results. In the absence of qualified passenger service representatives, the PIC will ensure the anti-hijacking inspection of passengers and baggage is accomplished.

7.8.1.1. The Transportation Security Administration provides the latest guidance on passenger screening and carry on allowances. The latest guidance can be downloaded from **www.tsa.gov/press/happenings/index.shtm**.

7.8.1.1.1. Aircrew must ensure that thorough screenings are accomplished when processing passengers at locations without an AMC Passenger Terminal.

7.8.1.1.2. Carry-on restrictions apply to all passengers required to process through the passenger terminal, or equivalent when at a non-AMC location. Carry-on restrictions do not apply to those not required to process through the passenger terminal, or equivalent when at a non-AMC locations. This includes:

7.8.1.1.2.1. Aircrew members listed on the Flight Authorization for that mission.

7.8.1.1.2.2. MEPs for that mission.

7.8.1.1.2.3. OSA/VIPSAM passenger not required to process through the Passenger Terminal (primary DV, spouses/party, aides, and security details only).

7.8.1.1.2.4. Duty passengers on ANG/AFRC mission numbers.

7.8.1.1.3. Consider baggage contained in areas not readily accessible in flight as checked baggage, even if carried to the aircraft by the passengers. This includes, but is not limited to: segregated baggage compartments, floor loaded baggage tied down with cargo straps/chains, palletized baggage, baggage in baggage bins, and baggage in the aft baggage compartment of C-21.

7.8.1.1.4. Brief non-exempt passengers that baggage in these areas is not to be accessed in flight. If any non-exempt passenger attempts to access checked baggage in-flight, land the aircraft at the nearest suitable airport (preferably a military facility) with appropriate law enforcement personnel. Request assistance in removing the passenger(s) and accompanying baggage from the aircraft. Comply with all law enforcement direction.

7.8.2. Medical facility commanders are responsible for anti-hijacking inspection of patients. When patients are delivered to the aircraft by civilian sources, the aircrew will perform required inspections prior to loading.

7.8.2.1. For aeromedical evacuation (AE) missions, the Medical Crew Director (MCD) is the final authority for determining what items can be carried by/for AE patients.

7.8.3. During exercises or contingencies in support of combat operations involving the movement of large groups of personnel, the unit being supported should manifest passengers and perform anti-hijacking inspections.

7.8.4. Passengers will not carry weapons or ammunition on their person or in hand-carried baggage aboard an aircraft. **EXECPTION:** Special agents, guards of the Secret Service or State Department, RAVEN Team Members, and other individuals specifically authorized to carry weapons.

7.8.4.1. Troops or deadhead crewmembers will not retain custody of ammunition on an aircraft. They will turn it in to the troop commander or PIC. Troops may carry unloaded weapons and ammunition aboard the aircraft during combat operations. When the tactical situation dictates (in coordination with the aircrew), weapons may be loaded at the order of the troop commander or team leader.

7.8.4.2. Dummy clips that can be easily identified may be loaded for training at the order of the team leader in coordination with the aircrew.

7.8.4.3. RAVENs will only be armed in-flight on specifically designated missions identified on the mission "frag" as "RAVEN in-flight arming required."

7.8.5. If weapons must be cleared, instruct the individual(s) to:

7.8.5.1. Move to a safe, clear area at least 50 feet from any aircraft, equipment, or personnel before un-holstering or un-slinging their weapons.

7.8.5.2. Clear weapons in accordance with standard safety procedures. Ensure troop/aircraft commander retains ammunition IAW paragraph 7.8.4.1.

7.9. Initial Response. When an act of air piracy involves an Air Force installation or aircraft within the United States, response will be according to the following guidelines until such time as FAA assumes active direction of anti-hijacking efforts. Resist all attempts to hijack a military aircraft. Resistance may vary from simple dissuasion, through deception and subterfuge, to direct physical confrontation, including the prudent use of weapons.

7.9.1. The following guidelines should be used to counter a hijacking, actual or threatened, while the aircraft is on the ground:

7.9.1.1. Delay movement of the aircraft to provide time for ground personnel and the aircrew to establish communication and execute coordinated resistance actions.

7.9.1.2. The authority for determining when ground resistance will be discontinued is vested in the highest available level of command. When adequate communication cannot be established, or when time does not permit, this authority is delegated in the following order:

7.9.1.2.1. MAJCOM commander exercising operational control of the aircraft.

7.9.1.2.2. MAJCOM commanders in whose AOR the airfield lies.

7.9.1.2.3. Senior operational commander on scene.

7.9.1.2.4. PIC in compliance with MAJCOM directives.

7.9.2. A hijacked aircraft carrying weapons of mass destruction will not be allowed to takeoff. Refer to DoD 5210.41M, paragraph 9B (3), for additional guidance.

7.10. In-Flight Resistance. After airborne, success in thwarting a hijacking depends on the resourcefulness of the aircrew. Many variables of a hijacking preclude use of any specific counter-hijacking procedure. Some key factors should be evaluated before deciding a course of action to be taken, including the nature of the threat, danger to life or crippling damage to the aircraft in-flight, destination indicated by the hijacker, and the presence of sensitive material onboard. Some counter-hijacking actions the aircrew may consider are:

7.10.1. Engage the hijacker(s) in conversation in an attempt to calm them and to evaluate what course of action might be effective.

7.10.2. Dissuade the hijacker.

7.10.3. Use facts or subterfuge to convince the hijacker intermediate stops are necessary.

7.10.4. Propose more favorable alternatives, such as landing in a neutral, rather than a hostile, country.

7.10.5. Exploit any reasonable opportunity to incapacitate or overcome the hijacker physically, including the prudent use of firearms.

7.11. Communications Between Aircrew and Ground Agencies. Crews facing a hijacking threat will transmit an in-the-clear notification of hijacking to ATC. Notify ground as soon as practical and follow-up with situation reports as circumstances permit. Covert signals are no longer to be used as per FAA guidance.

7.12. Not Used.

7.13. Arming of Crew Members. When crews are directed to carry weapons, at least one flight engineer and one loadmaster will be armed. All crew members should know who is armed. The following procedures apply when arming is directed:

7.13.1. Weapons Issue. Before departing home station, obtain weapons, ammunition, box, lock and key. Crew members will be armed according to AFI 31-207, *Arming and Use of Force by Air Force Personnel* and MAJCOM publications. If an armed crew member must leave the crew en route, transfer the weapon to another authorized crew member using AF Form 1297.

7.13.2. Wearing of Weapons. Wear weapons in a holster, concealed at all times to prevent identifying armed crew members. Do not wear weapons off the flight line except to and from the C2, armories, and other facilities associated with aircrew activities. Refer to the OPORD/SPINS for theater specific guidance and procedures.

7.13.2.1. AMC Passenger Terminal Procedures. Armed crewmembers must discreetly identify themselves to AMC passenger service personnel upon arrival at security checkpoints. One crewmember will present a valid set of crew orders, military identification card, and AF Form 523, *USAF Authorization to Bear Firearms*, authorizing the carrying of concealed weapons. Once terminal personnel verify this, they will allow the crewmember to vouch for the remaining crewmembers. The entire crew will then

proceed through the magnetometer without removing objects from their pockets. This will prevent passengers from determining which crewmembers are armed.

7.13.3. Weapons Storage In-Flight. Crew members will be armed before beginning preflight, on-load or off-load duties and until completion of all post-flight duties. When no passengers are aboard, weapons may be stored in the gun box in-flight after a satisfactory stowaway check. Crew members will rearm before landing. Weapons need not be unloaded before placing them in a gun box.

7.13.4. Weapons Storage on the Ground.

7.13.4.1. Aircrews, including stage crews, will store weapons and ammunition in the most secure facility available, normally the base armory.

7.13.4.2. Non-stage aircrews may store weapons and ammunition in the aircraft gun box.

7.13.5. When storing weapons in the gun box:

7.13.5.1. Weapons should normally not be unloaded.

7.13.5.2. Inform C2 which crew member has the gun box key.

7.13.6. Crew members will ensure they are reissued the same weapon until mission termination at home station.

7.13.7. Loading and Transfer of Weapons. Load and unload weapons at approved clearing barrels if available. Do not use a hand-to-hand transfer of loaded weapons to another crew member; place the weapon on a flat surface.

7.14. Force Protection. Crews must be alert to possibility of terrorist activities at all times. Reference AFMAN 10-100, *Airman's Manual*, Joint Service Guide 5260, *Service Member's Personal Protection Guide: Combat Terrorism While Overseas*, and AFI 31-210, *The Air Force Antiterrorism/Force Protection (AT/FP) Program Standards*, for Force Protection measures.

Chapter 8

OPERATIONAL REPORTS AND FORMS

8.1. General. This chapter provides guidelines for worksheets, reports, and forms associated with operational activities. Consult governing instruction or contact wing, unit, or local flight safety officers for assistance with safety forms.

8.1.1. AF Form 711B, *USAF Aircraft Mishap Report Worksheet* (AFI 91-204, *Safety Investigations and Reports*) is a tool to notify appropriate authorities of any mishap involving crewmembers or aircraft. PICs shall complete all appropriate areas of the form in as much detail as possible. When notified, AMC command and control (C2) agents will inform their supervisor/commander to start investigation and reporting activities IAW AFI 91-204 and Operation Report 3 (OPREP-3) procedures.

8.1.2. PICs will report crewmember or patient/passenger injury, aircraft damage, or injury/damage to another organization's personnel or equipment caused by PIC's aircraft/crewmember. At a minimum, report the following:

8.1.2.1. A physiological episode is a physiological reaction, near accident, or hazard in-flight due to medical or physiological reasons. These include:

8.1.2.1.1. Proven or suspected cases of hypoxia.

8.1.2.1.2. Carbon monoxide poisoning or other toxic exposure.

8.1.2.1.3. Decompression sickness due to evolved gas (bends, chokes, neurocirculatory collapse), or severe reaction to trapped gas resulting in incapacitation.

8.1.2.1.4. Hyperventilation.

8.1.2.1.5. Spatial disorientation or distraction resulting in an unusual attitude.

8.1.2.1.6. Loss of consciousness from any cause.

8.1.2.1.7. Death by natural causes of any crewmember during flight.

8.1.2.1.8. Unintentional loss of pressurization if cabin altitude is above FL180, regardless of effects on personnel.

8.1.2.1.9. Inappropriate use of alcohol and effects of hangover that affect in-flight duties (crewmembers only).

8.1.2.1.10. Illness (both acute and pre-existing), including food poisoning, dehydration, myocardial infarction, seizure, and so forth.

8.1.2.1.11. Exposure to toxic, noxious, or irritating materials such as smoke, fumes, or liquids. **NOTE:** In the event of a physiological episode, all crewmembers involved will report to a flight surgeon as soon as practical and request that a Class E physiological episode be reported in Air Force Safety Automated System (AFSAS). If these events affected a patient, the MCD will document events and interventions on AF Form 3829, *Summary of Patients Evacuated by Air* (or TRAC2ES equivalent)

IAW current Aeromedical Evacuation Forms Guide, as well as DD Form 2852, *Aeromedical Evacuation Event/Near Miss Report*, per **8.15** of this AFI.

8.2. Not Used.

8.3. Not Used.

8.4. Not Used.

8.5. Not Used.

8.6. Not Used.

8.7. Not Used.

8.8. Not Used.

8.9. Not Used.

8.10. AMC Form 43, Transient Aircrew Facilities Report. A tool to report level of excellence for transient facilities. Any crewmember may submit this report whether or not the PIC includes an unsatisfactory item in the PIC Trip Report. Send completed AMC Form 43 to HQ AMC/MWPS, or MAJCOM equivalent.

8.11. Not Used.

8.12. Not Used.

8.13. Not Used.

8.14. Not Used.

8.15. AE Event/Near Miss Reporting Process.

8.15.1. Refer to AFI 41-307 *Aeromedical Evacuation Patient Considerations and Standards of Care*, Attachment 14, for AE Patient Safety Program.

Chapter 9

TRAINING POLICY

9.1. General. For all training related information, refer to AFI 11-2AE V1

9.2. Aeromedical Readiness Mission (ARM) Equipment Requirements. Aeromedical Readiness Missions (ARMs) are the primary means of preparing for AE airlift. These missions can be diverted to fulfill "real" versus "simulated" patient airlift requirements, therefore, all medical equipment/kits will be kept operationally ready at all times. In addition to items listed in **Table 4.1**, the ventilator will also be carried.

9.2.1. For ARMs, controlled medications are optional at the discretion of the Chief Nurse.

9.3. Contingency Exercise Training Mission (CETM). A training mission conducted during a Wing/MAJCOM/DOD sponsored exercise, JRTC, AECOT, or IG Inspection. Crew compliment is based on scenario requirements and **Table 3.1** All crewmembers will be current and qualified. Upgrade training/evaluations are prohibited on CETM flights. A trained MCC is not required for the mission. AECMs can only take credit for specific events identified in AFI 11-2AE V1, *Aeromedical Evacuation Aircrew Training*. A CETM mission has no required flight time.

Chapter 10

AIRCREW OPERATIONS IN CHEMICAL, BIOLOGICAL, RADIOLOGICAL, NUCLEAR, AND HIGH-YIELD EXPLOSIVE THREAT ENVIRONMENT

10.1. Overview. The proliferation of Chemical, Biological, Radiological, and Nuclear (CBRN) weapons and the means to deliver them present serious security threats to the global operations of air mobility forces. This chapter describes the CBRN threat, passive defense measures to mitigate that threat, and guidance for ground and flight operations in a contaminated environment.

10.1.1. It is United States Transportation Command (USTRANSCOM) policy that patients personnel, or casualties with known or suspected contamination from chemical, biological, or nuclear warfare agents will not be transported within the aeromedical patient movement system. Decontamination must be performed prior to transport to prevent the potential spread of contamination. In rare cases, transport may be essential to preserve life or continue critical missions. If such transport is deemed essential, all efforts must be made to prevent the spread of contamination. In these cases, prior approval must be given by the involved geographic combatant commanders, Commander USTRANSCOM, and the Secretary of Defense (SECDEF) in consultation with Department of Defense medical authorities.

10.1.2. Patients with known or suspected or highly contagious disease will not be transported within the patient movement system. These include infections with any agent that may pose a potential threat to national security, require special public health actions, and/or have the potential to cause public panic and social disruption. Patients known or suspected to be infected with a highly contagious disease should be treated “in place” or with minimal transportation to medical authorities. In extreme circumstances there may be a requirement to move index cases (approximately two) for evaluation or critical medical care. If patient movement is required, prior approval must be given by the involved geographic combatant commanders, Commander USTRANSCOM, and SECDEF in consultation with medical authorities.

10.1.3. AMC will train and equip Aeromedical evacuation crews and stage required equipment at key hubs to carry out these limited missions for movement of contaminated and contagious patients.

10.2. Understanding the CBRN Threat.

10.2.1. Chemical Weapons. Militarily significant chemical weapons include nerve, blister, choking, and blood agents. A key point for aircrew members to remember is that time is on your side. The ultra-violet (UV) rays of the sun, high temperatures, and high absorption rates of chemicals all decrease their lethality. Most chemical agents will either evaporate or absorb into surfaces. For decontamination, cleaning with hot soap and water and/or a 5 percent bleach solution currently appears to be the best and most practical method of removing chemical agents that may remain as a contact hazard on glass, and unpainted metal. Currently, the only decontaminate authorized for use on aircraft is soap and water. **NOTE:** Recent tests indicate that as a decontaminated aircraft dries, the absorbed chemical warfare agent (CWA) may resurface from painted surfaces causing contact and vapor hazards.

10.2.2. Biological Weapons. Biological warfare agents (BWA) are normally divided into three areas: bacteria (i.e., Anthrax) that live outside the cell, reproduce, and are normally susceptible to antibiotics; toxins (i.e., Ricin), that are poisons produced by living organisms or plants; and viruses (i.e., Smallpox) that normally require the host of a living cell to survive and reproduce. Viruses and toxins do not respond to antibiotics. It is probable that the medical community would be the first to recognize that an upsurge in "flu-like symptoms" is actually a bio attack. Although BWA are degraded by UV rays, humidity and high/low temperatures, some BWA (i.e., Anthrax spores) may have a long life, lasting decades under the right conditions. Current immunizations and good personal hygiene help prevent infection.

10.2.3. Radiological Weapons. The radiation dispersal device (RDD), or so-called "dirty bomb," is the typical radiological weapon. RDD is any device that disseminates radioactive material without using a nuclear detonation. Key points to remember are that shielding and distance are the best defenses against radiation exposure.

10.2.4. Nuclear Weapons. The threat from a nuclear device is from the initial blast, heat, and radiation. In addition, the Electromagnetic Pulse (EMP) from a nuclear detonation can damage electronic equipment. The best protection is a combination of shielding, distance from the blast, and limited time of exposure.

10.3. CBRN Passive Defense Measures. Passive defense measures are those activities conducted to negate, contain, and manage the effects of CBRN attack. Passive defense measures include pre, trans, and post-attack actions designed to mitigate the CBRN threat through contamination avoidance, protection, and contamination control.

10.3.1. Contamination Avoidance. Contamination avoidance is the most important passive defense measure. Techniques for contamination avoidance include: in-flight diversion, survival launch, and minimizing exposure to contaminated cargo, aerospace ground equipment (AGE), and material handling equipment (MHE).

10.3.1.1. In-flight Diversion. When advised that a destination airfield is under CBRN attack or has been contaminated, the aircrew will divert to an uncontaminated airfield, if at all possible. Authority to land at a contaminated airfield will be specified in the controlling OPORD.

10.3.1.2. Survival Launch. If caught on the ground during attack warning, every reasonable effort will be made to launch to avoid the attack. Upon proper clearances, aircrew may launch to survive if they have sufficient fuel and unrestricted, safe access to the runway. In practice, this option may only be practical for aircraft that have just landed or aircraft at or near the end of the runway. If launch is not possible, shut down engines and avoid running environmental control systems. Close aircraft doors/hatches/ramps, don Individual Protective Equipment (IPE), and seek personal protective cover on the base. If time does not permit using base facilities, remain in the sealed aircraft for a minimum of one-hour after the attack and/or follow host-base guidance.

10.3.1.3. Avoiding Cross Contamination from AGE, MHE, and Cargo. All formerly contaminated equipment and cargo must be marked to facilitate contamination avoidance and the use of protective measures. Additionally, the air shipment of formerly

contaminated cargo requires special precautions and must be specifically authorized by the senior transportation commander.

10.3.2. Protection. When exposure to chemical and/or biological agents cannot be avoided, protection provides the force with the ability to survive and operate in a CBRN environment. Protection is afforded by individual protective equipment, collective protection, and hardening of facilities.

10.3.2.1. Individual Protective Equipment. The current in-flight protective gear for aircrew members is the Aircrew Chemical Defense Ensemble (ACDE). The ACDE includes the CWU-66/P or CWU-77/P Integrated Aircrew Chemical Coverall (IACC). The Ground Crew Ensemble (GCE) consists of the protective mask, C2 series canister (or filter element for MCU-2A/P protective mask), and over garment, boots, and gloves. The ACDE and GCE provide protection against chemical and biological agents. They do not provide blast or radiation protection from an RDD or nuclear detonation. The ACDE requires care during donning using "buddy dressing" procedures and Aircrew Flight Equipment (AFE) expertise during processing through the Aircrew Contamination Control Area (ACCA). (**NOTE:** AECMs will utilize the MCU-2A series mask).

10.3.2.1.1. ACDE/GCE Issue. Aircrews will be issued sized ACDE and GCE at home station. Aircrews will ensure their ACDE and GCE are available at all times while in a CBRN threat area. Aircrew members will confirm the mobility bag contents and correct sizes.

10.3.2.1.2. ACDE Wear During Ground Operations. Because aircraft contamination is unlikely to occur during flight, ground operations can represent the highest threat to aircrew safety. Protection from enemy attacks and exposure to liquid chemical agents is paramount. Aircrew should limit activities to essential duties only, and separate ground duties from air duties.

10.3.2.2. Collective Protection. Collective protection provides a temperature-controlled, contamination-free environment to allow personnel relief from continuous wear of IPE such as the ACDE. The basic concept for most facility collective protective solutions is to employ overpressure, filtration, and controlled entry/exit. The intent is to provide rest and relief accommodations, as well as provide medical treatment in contamination free zone. All pressurization systems should be shut down and doors sealed if the crew finds itself in need of immediate protection. Crewmembers should avail themselves of facilities, if provided, on the airfield.

10.3.2.3. Hardening. Permanent and expedient hardening measures are used to strengthen buildings and utility systems or provide barriers to resist blast effects. To reduce the potential of vapor exposure, personnel should consider the use of facilities above the first floor.

10.3.3. Contamination Control. In the post-attack environment, contamination control measures limit the spread of chemical, biological, and radiological contamination through disease prevention measures, decontamination, and use of Exchange Zone (EZ) operations. Effective contamination control helps sustain air mobility operations by minimizing performance degradation, casualties, or loss of material.

10.3.3.1. Disease Prevention. Up-to-date immunizations, standard personal hygiene practices, and the use of chemoprophylaxis are effective biological warfare defensive measures.

10.3.3.2. Decontamination.

10.3.3.2.1. In-flight Decontamination. Air washing is a useful in-flight decontamination technique for removing most of the liquid agent from aircraft metal surfaces. However, vapor hazards may remain in areas where the airflow characteristics prevent complete off-gassing (i.e., wheel wells, flap wells, rivet and screw heads, joints, etc.). Flights of at least 2 to 4 hours are recommended, and lower altitudes are more effective than higher altitudes. Fly with the aircraft configured (gear, flaps, and slats extended) as long as possible to maximize the airflow in and around as many places as possible. Be advised that exterior contamination may seep into the aircraft interior creating a vapor hazard for aircrews. Use of ACDE is recommended.

10.3.3.2.2. Limits of Decontamination. Complete decontamination of aircraft and equipment may be difficult, if not impossible, to achieve. Formerly contaminated assets will be restricted to DOD-controlled airfields and not released from US government control.

10.3.3.3. Exchange Zone (EZ) Operations. The AMC Concept for Air Mobility Operations in a Chemical and Biological Environment (CB CONOPS) describes a method for continuing the vital flow of personnel into a contaminated airfield while limiting the number of air mobility aircraft and personnel exposed to the contaminated environment. The purpose of the EZ is to minimize the spread of contamination within the air mobility fleet, preserving as many aircraft as possible for unrestricted international flight. The EZ is an area (located at uncontaminated airfield) set aside to facilitate the exchange of uncontaminated (clean) cargo/passengers to a contaminated (dirty) airframe, or vice versa, without cross-contamination. Additional information on the EZ is available through HQ AMC/A3X.

10.4. Flight Operations.

10.4.1. Mission Planning. Aircrews must be mentally prepared to face the dangers of CBRN weapons. Flight/mission planning must be thorough. Aircraft commanders should emphasize ACDE wear, crew coordination, CBRN hazards and countermeasures, in-flight diversion, plans for onload/offload in the event of a ground attack, and plans for the return leg in the event of aircraft contamination. Alternative scenario plans should also be considered in the event MOPP conditions change.

10.4.2. Establishing the Threat Level. Aircrews should monitor command and control channels to ensure they receive the latest information concerning the destination's alert condition. Diversion of aircraft to alternate "clean" locations may be required, unless operational necessity otherwise dictates. The 618 TACC or theater C2 agency (normally through the controlling OPORD) will direct aircrew pre-exposure activities such as medical pre-treatment for chemical/biological exposure.

10.4.3. Fuel Requirements. Extra fuel may be needed to compensate for altitude restrictions as the result of CB agent exposure. During purge periods, the aircraft will be unpressurized.

Although the aircrew can use the aircraft oxygen systems, passengers wearing GCE cannot, thus restricting the aircraft cruise altitude and increasing fuel requirements accordingly.

10.4.4. Oxygen Requirements. Operating a contaminated aircraft will increase oxygen requirements. Aircrew wear of ACDE will require use of the aircraft oxygen system to counter actual/suspected contamination. Using the 100 percent oxygen setting offers the greatest protection in a contaminated environment. Appropriate oxygen reservoir levels must be planned to meet higher consumption rates. Use the aircraft Dash 1 charts to calculate the required reservoir levels.

10.4.5. Donning Equipment. Aircrew will don ACDE based on the alarm condition IAW AFMAN 10-100, *Airman's Manual*. Use the "buddy dressing" procedures, and refer to AMCVA 11-303, *AERP Donning Checklist* and AMCVA 11-304, *ACDE Donning Checklist*, to ensure proper wear. When wearing the ACDE, Atropine and 2 PAM Chloride auto injectors will be kept in the upper left ACDE pocket. If the integrated survival vest/body armor is worn, the Atropine and 2 PAM Chloride auto injectors may be kept in the lower right flight suit pocket. This standardized location will enable personnel to locate the medication should an individual be overcome by CWA poisoning. M-9 paper on the flight suit will facilitate detection of liquid chemical agents and ACCA processing. M-9 paper should be placed on the flight suit prior to entering the CBRN threat area or when an alarm "yellow" or higher has been declared. When inbound to a CBRN threat area, prior to descent, the aircraft commander will ensure crew and passengers don appropriate protective equipment IAW arrival destination's MOPP level and brief aircrew operations in the CBRN threat area. As a minimum, this briefing will include: flight deck isolation, oxygen requirements, air conditioning system requirements, IPE requirements, ground operations, and MOPP levels. Aircrew members must determine if the wear of the integrated survival vest/body armor and LPUs will restrict dexterity and mobility to the point that it becomes a safety issue. If the aircrew deems the equipment to create a safety of flight concern, then the items may be pre-positioned (instead of worn) on the aircraft to be readily available to the aircrew.

10.4.6. Communicating Down-line Support. Pass aircraft and cargo contamination information through command and control channels when inbound. This information will be used to determine if a diversion flight is required or decontamination teams are needed. Report the physical condition of any crew/passengers who are showing agent symptoms and whether they are wearing chemical defense ensembles.

10.5. Ground Operations.

10.5.1. Crew Rest Procedures. Operational necessity may require the aircrew to rest/fly in a contaminated environment. If the mission is not being staged by another aircrew or pre-flight crews are not available, the aircrew may pre-flight, load, and secure the aircraft prior to entering crew rest. The departing aircrew will perform necessary crew preparations and pre-flight briefings. Then, they will report to the ACCA for processing and ACDE donning with assistance from AFE personnel. If possible, aircrew transport should be provided in a covered vehicle. Aircrews should avoid pre-flighting the aircraft prior to departure to prevent contamination spread to them and/or the aircraft. As aircrews proceed to fly, they will require assistance from ground support personnel in removing their aircrew protective overcape and overboots prior to entering the aircraft.

10.5.2. Onload and Offload Considerations. Extreme care must be exercised to prevent contamination spread to the aircraft interior during ground operations, particularly to the flight deck area. Reduce the number of personnel entering the aircraft. Contaminated engine covers, safety pins and chocks will not be placed in the aircraft unless sealed in clean plastic bags. Aircrew members entering the aircraft will remove plastic overboots and overcape portions of the aircrew ensemble and ensure flight/mobility bags are free of contaminants and placed in clean plastic bags. Prior to entering the aircraft all personnel should implement boot wash/decontamination procedures. Aircrew exiting aircraft into a contaminated environment will don plastic overboots and overcape prior to leaving the aircraft.

10.5.3. Communications. Conducting on/offloading operations, while wearing the complete ACDE, complicates communications capability. Use the mini-amplifier/speaker or the aircraft public address system and augment with flashlight and hand signals, as required.

10.5.4. Airlift of Retrograde Cargo. Only CRITICAL retrograde cargo will be moved from a contaminated to an uncontaminated airbase. Critical requirements are pre-designated in theater war plans. Onload cargo will be protected prior to and while being transported to the aircraft. If contaminated, protective cover(s) will be removed/replaced just prior to placing the cargo on the aircraft. It is the user's responsibility to decontaminate cargo for air shipment. The airlift of contaminated or formerly contaminated cargo requires the approval of the senior transportation commander.

10.5.5. Passenger/Patients. A path should be decontaminated between the aircraft and the ground transportation vehicle to reduce interior contamination when loading/unloading passengers/patients. Normally, externally contaminated patients and those infected with contagious biological agents will not be transported onboard AMC or AMC-procured aircraft. The AMC/CC is the waiver authority to this policy. (**NOTE**: An altitude below 10,000 feet is recommended due to AECM use of the ground chemical mask.)

10.5.6. Physiological Factors. Aircraft commanders must be very sensitive to the problems resulting from physical exertion while wearing ACDE. The aircraft commander should consider factors such as ground time, temperature and remaining mission requirements when determining on/offload capabilities. Individuals involved should be closely monitored for adverse physiological effects.

10.5.7. Work Degradation Factors. Work timetables need to be adjusted to minimize thermal stress caused by wearing the ACDE. Aircrews must weigh all factors when performing in-flight and ground duties. The following are degradation factors for wearing full GCE, and may also be used to represent the Task Time Multipliers for the ACDE. To estimate how much time it takes to perform a task or operation, (1) take the Task Time Multiplier (**Figure 10-1**) for the appropriate Work Rate and ambient air temperature and (2) multiply it by the time it normally takes to perform the task. For example, given a heavy work rate and an air temperature of 70F, the crewmember should expect a normal one hour task to take 2.1 hours while wearing ACDE. A more extensive discussion of this subject is found in AFMAN 32-4005, *Personnel Protection and Attack Actions*.

Figure 10.1. Task Time Multipliers.

Work Rate	Temperature		
	20-49 F	50-84 F	85-100 F
	-6 to 9 C	10 to 28 C	29 to 38 C
Light	1.2	1.4	1.5
Moderate	1.3	1.4	3.0
Heavy	1.7	2.1	5.0

10.5.8. Outbound with Actual/Suspected Chemical Contamination. Once airborne with actual/suspected vapor contamination, the aircraft must be purged for 2 hours using Smoke and Fume Elimination procedures. To ensure no liquid contamination exists, a close inspection of aircrew, passenger ensembles, and cargo will be conducted using M-8 and M-9 detection paper. Detection paper only detects certain liquid agents and will not detect vapor hazards. Above the shoulder ACDE should only be removed if there is absolutely no vapor hazard. Be advised that residual contamination (below the detectable levels of currently fielded detection equipment) may be harmful in an enclosed space. The aircrew must take every precaution to prevent spreading of liquid contaminants, especially on the flight deck area. The best course is to identify actual/suspected contamination, avoid those areas for the remainder of the flight, and keep the cargo compartments cool. If an aircrew member or passenger has been in contact with liquid contaminants, all personnel aboard the aircraft will stay in full ACDE/GCE until processed through their respective contamination control area (CCA). Upon arrival, the contaminated aircraft will be parked in an isolated area and cordoned to protect unsuspecting ground personnel.

10.5.9. Documenting Aircraft Contamination. When it is suspected or known that an aerospace vehicle or piece of equipment has been contaminated with a radiological, biological or chemical contaminant, a Red X will be entered and an annotation will be made in historical records for the lifecycle of the equipment.

10.5.10. 10-Foot Rule. The 10-foot rule was developed in order to provide guidance for protecting personnel using or handling contaminated resources (such as pallets) or working in locations with materials that might retain a residual chemical. The 10-foot rule embodies a safety factor that goes beyond current OSD guidance (which allows removal of IPE whenever detectors no longer detect a chemical agent vapor hazard). There are two phases associated with the 10-foot rule.

10.5.10.1. Initial Phase. During the initial phase, personnel will remain in MOPP 4 whenever they stay within 10 feet of the contaminated equipment for more than a few seconds. This MOPP level provides personnel the maximum protection from the chemical agent as it transitions from a contact and vapor hazard to a vapor hazard only.

10.5.10.2. Follow-on Phase. In the follow-on phase, personnel will use gloves of a sort (i.e. leather, rubber, cloth, etc.) when operating on or handling the contaminated equipment. Although a contact hazard is unlikely, relatively small amounts of the agent may still be present. The use of gloves will ensure that unnecessary bare skin contact with agent residue is avoided.

10.5.10.3. Ten-Foot Rule Time Standards (Source: AFMAN 10-2602). **Figure 10-2** shows times associated with initial and follow-on phases of the 10-foot rule. To simplify response processes, commanders may choose to use the worst case scenario as the foundation for all 10-foot rule actions, i.e., 24 hours for the initial phase and all periods of time greater than 24 hours for the follow-on phase.

Chapter 11

NOT USED

11.1. This chapter is not used for AE operations.

Chapter 12

NOT USED

12.1. This chapter is not used for AE operations.

Chapter 13

FLIGHT NURSE AND AEROMEDICAL EVACUATION TECHNICIAN PROCEDURES

13.1. General. The primary duty of the FN and AET is to conduct AE operations. Primary duties include mission planning, coordinating and supervising enplaning and deplaning of patients and special medical equipment, and providing in-flight patient care and assistance to patients. The FN and AET:

13.1.1. Are specialists in nursing care of patients in a hypobaric environment.

13.1.2. Have advanced training in the operation of specialized medical equipment designed and approved for use at altitude.

13.1.3. Are trained and current in the aircraft systems and configurations required for safe AE operations.

13.1.4. Provide in-flight assistance to medical attendants as situations dictate.

13.2. Mission Planning

13.2.1. Aircraft seats identified in applicable T.O.s or AFI 11-2AE V3 Addenda A as ACM seats will not be used for patient passenger seating.

13.2.2. The MCD may reserve get-down litters as mission needs dictate. For mission legs exceeding four hours in length; a minimum of two litters should be set up for ambulatory patient use. An emergency litter will be set up on all AE missions. When required/mission load permits, a minimum of one seat will be reserved for every three litter patients on all AE missions. **EXCEPTION:** An emergency litter is not required for ambulatory patient movement on C-21 missions.

13.2.3. Patients and/or attendants will not be relocated to litters, in order to make seats available for passengers. Regardless of age, all patients and attendants will have their own assigned seat and will not be required to give up their seat for passengers. In-lap seating of patients and/or attendants to accommodate passengers is prohibited on AE missions.

13.2.4. For planning purposes, critical care patients should have an entire tier to accommodate patient care and additional medical equipment. **EXCEPTION**: During contingency/humanitarian missions, maximize the aircraft capability for all litter patients

13.2.5. A five (5) high configuration using the litter stanchions is approved for all C-130 AE missions.

13.2.6. When cargo requirements permit, the seat and litter stanchion ladder will be installed for all C-130 AE missions.

13.2.7. Ensure adequate space for in-flight treatment of litter patients. The vertical distance between each loaded litter will not be less than 21 inches (18 inches on C-130 when loading 5-high). **NOTE:** When litter patients are wearing personal gear (i.e. web belts, canteen, helmets, flak vests, etc.), consider loading four (4) high versus five (5) high in the center seat and litter stanchions, to increase space between litters to accommodate gear. If situation requires/permits, remove personal gear from patients and secure on ramp or in a designated area.

13.2.8. Available litter spaces and ambulatory seating will depend on the aircraft cabin's mission configuration. (i.e. life support storage containers and tool box stowage).

13.2.9. Patient/Cargo Mix.

13.2.9.1. When transporting both cargo and litter patients, litters will be transported forward of the cargo pallets, if possible. No cargo will be transported with patients on the KC-135.

13.2.9.2. If not possible, and the PIC and MCD agree, patients may be transported aft of the cargo. The LM must make every effort to stay in the vicinity of the crew and patients in-flight, and during critical phases of flight.

13.2.9.3. Cargo will not be bumped except in very unusual/abnormal cases, and only after the PIC/MCD contacts 618 TACC or appropriate C2 agencies.

13.3. Preflight Duties.

13.3.1. Ground support crew, consisting of at least one qualified AECM, may preflight the aircraft for an AE mission. It is the responsibility of the CMT to ensure the aircraft has been correctly configured/preflighted before accepting the aircraft for patient transport. A qualified AECM from the ground support crew will brief and conduct aircraft walk through with the CMT on completed abbreviated checklist items prior to the flight crew assuming responsibility.

13.3.2. Roller conveyors will be removed from all aisle way, walkway, and AE litter patient positions.

13.3.2.1. **(C-17)** On the ramp, roller conveyors will be stowed unless the baggage pallet or LSAS are in position. Before enplaning/deplaning procedures, the LSAS will be secured in the Aerial Delivery System (ADS) Rails in position 10. All rollers in position 11 will be stowed. (C-130) Patient and crew safety will be evaluated prior to enplaning/deplaning of patients. If safety concerns exist and time permits, roller conveyors will be removed from the ramp. As mission dictates, rollers required to remain on the ramp during enplaning and deplaning will be positioned as close to the ramp edge as possible.

13.3.3. If the aircraft is configured with airline seats, the CMT will check the security of all patient/passenger seats by lifting upward on the front of the seat frame and gently pushing and pulling on the seat backs. Minimal movement is acceptable.

13.3.4. Oxygen and Electrical. Lines may be run together (parallel) throughout the aircraft cabin. Electrical outlets with electrical equipment plugged into them will not have an oxygen flow meter within 12 inches of that outlet. Do not secure any oxygen and/or electrical lines on the floor, across aisles or areas where they will be walked on. **EXCEPTION:** When patients are floor-loaded, oxygen and or electrical lines may be secured on the floor.

13.3.4.1. Attach/secure oxygen and electrical lines to litter clamps, or secure with hook and pile type strapping, or on procured/developed equipment securing devices located in the in-flight kit. When securing oxygen and/or electrical lines in litter brackets, inspect the bracket for visible wear on the rubber pad of the bracket. If the bracket's rubber pad is worn, pad the bracket with available material. Do not use tape. All brackets without rubber pads will be annotated on applicable AFTO IMT 781A, for turn-in to maintenance

for repair or replacement. **WARNING:** The only acceptable options to run oxygen and electrical lines without the concurrence of the LM/BO is to utilize the stanchion poles, stanchion straps, C-17 fuselage or PSP securing devices. Crews must coordinate with the LM/BO prior to securing oxygen/electrical lines outside of these parameters. Lines looped over moving parts jeopardize the safety of the aircraft, medical equipment and crew.

13.3.4.2. AECMs will wear gloves when making electrical connections, during configuration and patient loading to prevent personal injury.

13.3.4.3. Equipment will not be plugged in until after the aircraft electrical system has been turned on.

13.3.4.4. Electrical lines will be positioned/secured and a completed functional check of medical equipment performed on the aircraft prior to enplaning patients. **EXCEPTION:** May be modified as situation dictates for operational contingency/combat missions.

13.3.4.5. Flight gloves will not be worn when handling oxygen equipment devices. Hands will be clean and free from oils, lotions, paints, grease, or similar materials.

13.3.4.6. Oxygen lines will be secured prior to enplaning patients. **EXCEPTION:** For operational contingency/combat missions, oxygen lines will be secured prior to take-off.

13.3.4.7. "Oxygen available" means oxygen can be made quickly available to the patients. Positioning of a flow meter, O2 adapter and unopened mask or nasal cannula somewhere in the vicinity of the patient, meets this requirement. **NOTE:** The AE crew is not required to have therapeutic oxygen immediately available for space available passengers.

13.4. Ground Operations. The CMT is responsible for all ground operations. The CMT, in coordination with the LM/BO, is responsible for vehicle movement/positioning around the aircraft. Refer to section **20.3**. for vehicle operations.

13.4.1. At locations where there is AE ground support, the CMT will coordinate enplaning/deplaning procedures with the ASF/CASF and LM/BO prior to enplaning/deplaning patients. At locations without AE ground support, the CMT will coordinate enplaning/deplaning procedures with the sending/receiving facility and LM/BO. **NOTE:** Medical facility support personnel on the aircraft will be kept at a minimum during ground operations prior to enplaning/deplaning. A maximum of 3 personnel from each facility can be utilized to brief/receive patient report.

13.4.2. Patient Preparation for Enplane.

13.4.2.1. The CMT will verify with the FN receiving report that anti-hijacking procedures were accomplished prior to enplaning. Perform anti-hijacking procedures if not accomplished.

13.4.2.2. The CMT is responsible to brief mission expectations and assess all patients prior to enplaning.

13.4.2.3. Identify patients requiring assistance. Litter patients may be enplaned/deplaned as ambulatory if in the professional judgment of the FN no contraindications exist (e.g. doctor's order for bed rest, inability to climb stairs or walk long distances, etc.).

13.4.2.4. Distribute hearing protection to all enplaning patients and attendants.

13.4.2.5. The CMT will check litter patients for security to include approved litter, strap placement, and proper backrest placement prior to enplaning. However, all AECMs will monitor for safe litter strap placement. Ensure all patient personal items located on litter are secured prior to patient movement.

13.4.2.6. Ensure that all ambulatory patient personal belongings, to include medications if self-medicating, are in their possession. **NOTE:** Patients/passengers may be allowed to use canes, crutches, or walkers for enplaning at the discretion of the MCD/FN.

13.4.3. Patient Preparation for Deplane:

13.4.3.1. The 2AET will check litter patients for security to include litter strap and backrest placement prior to deplaning. AECM's will ensure all equipment used on the patient is disconnected from aircraft systems. All patient medical devices and personal items located on the litter will be secured prior to patient movement.

13.4.3.2. Ensure that all ambulatory patient personal belongings, to include medications if self-medicating, hand carried bags, and medical supplies are in their possession. **NOTE:** Patients/passengers may be allowed to use canes, crutches, or walkers for deplaning at the discretion of the MCD/FN.

13.4.3.3. Soiled linen and sharps containers are collected for removal from the aircraft.

13.4.3.4. All contaminated items are collected, bagged, and labeled for removal from the aircraft as specified in AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care*.

13.5. Transfer of Patient Care. In the AE system, transfer of patient care occurs between AE representatives of the MTF, AE staging facilities, or external agencies to/from the AEC. Transfer of physical care is complete once the patient enters or exits the ground vehicle of transportation. **NOTE:** Enplaning/deplaning during patient report is highly encouraged. Final approval is at the discretion of the MCD.

13.5.1. Transfer of care will be to a comparable or higher level of care capability. Time will be allotted for the ground healthcare provider and AECM to have an opportunity to ask and respond to questions as needed. A verbal report will include, but is not limited to:

13.5.1.1. Patient's current condition, ongoing treatment, recent changes in condition, and any possible changes or complications to watch out for while the patient is in the AE system.

13.5.1.2. The type and amount of IV fluids/medication ordered and/or received, current settings of medical devices including PCA pumps, and total intake & output for the mission.

13.5.1.3. AECM's will ensure the AF Form 3899, *Patient Movement Record* series is complete and supports transfer of care communications between the AEC and the AE representative.

NOTE: Enlisted personnel may only take control of narcotics, or other controlled medications if they have been trained and appointed by the MTF commander.

NOTE: If any patient condition is questionable or exceeds the capabilities of the AEC, notify the MCD. The MCD may refuse a patient for AE transport if the patient's behavior is determined to be detrimental to self and others, the patient has not been adequately prepared for AE movement, or medical/therapeutic interventions are ineffective. Document on AF Forms 3829/3830/3899 or DD Form 602 information related to refusal of patient. Notify 618 TACC/AOC or PMRC at time of refusal.

13.5.2. Medical attendants will accompany patients to the destination medical facility. FNs must exercise good judgment in determining the need for an AECM to accompany patients to the destination medical facility. **NOTE:** This will extend CDT.

13.5.3. At scheduled RON stations, when an ASF/ASTS/MTF nurse is not available to receive report on the flight line, an AECM is responsible for accompanying patients to the facility if the patient's medical condition warrants clinical observation during transport.

13.5.4. All female litter psychiatric patients should be provided with a female attendant during movement between the aircraft and the destination facility. If accompanied by a responsible adult female, attendant, another non-psychiatric female patient, or military sponsor, there is no need for an additional attendant to escort the patient.

13.6. Enplaning/Deplaning Procedures. The MCD and CMT have direct and final authority over all patient enplaning and deplaning activities. AECMs are responsible to oversee all activities involved with patients in and around the aircraft.

13.6.1. During enplaning/deplaning of patients, the MCD or designated AECM will control operations from the aircraft ramp. Position on the ramp is at the discretion of the AECM. **NOTE:** On the ramp, only wireless headsets are approved during enplaning/deplaning operations.

13.6.1.1. All aircrafts should have engines shut down during enplaning and deplaning of patients unless conducting ERO procedures IAW section **13.6.7**. Safe, smooth enplaning activities depend on the coordinated efforts of the AECMs and the MTF. Consideration of climate conditions, ground support capability to include manpower and vehicular support, all play a role in safe operations.

13.6.1.2. Keep ambulatory patients grouped together.

13.6.1.3. Patients will not walk under aircraft wings.

13.6.1.4. Monitor patient use of aircraft stairs/Patient Loading System (PLS).

13.6.1.5. Ensure all patients keep one hand free for grasping the handrail. **NOTE:** Attendants may carry infants on and off the aircraft. Infants may be carried in a chest or back carrier.

13.6.1.6. Patients will not be seated in seats that do not lock in the full upright position or secure into applicable aircraft track.

13.6.2. Enplaning/Deplaning Communication: When multiple litter patients are being loaded, hand signals will be used.

13.6.2.1. The "THUMBS UP" signal indicates to the litter bearers the aircrew is prepared for litter enplaning/deplaning. An exaggerated motion, raising the whole arm above the head, must be used during ERO procedures.

13.6.2.2. . Extending crossed arms above the head indicates a “STOP” signal to the litter bearers to stop all movement.

13.6.2.3. The “SLOW DOWN” signal indicates to the litter bearers to gradually slow the pace until the signal is ceased. The signal is given by extending arms outward and raising and lowering the arms from shoulder to waist with palms facing the ground.

13.6.2.4. AECMs will direct and signal litter bearers to the proper litter tier as they enter the aircraft. This is done using exaggerated hand motions.

13.6.2.5. AECMs will physically reach out and identify the litter arm or litter bracket on the stanchion where the litter will be placed. This allows litter bearers to visualize the position before they reach the litter tier.

13.6.2.6. The AECM at the forward end of the litter will give the command to lift the litter into the litter brackets. The AECM at the forward end of the litter will ensure everyone is prepared to lift using the preparatory command “READY TO LIFT”, if no indication of a negative response, give the execution command “LIFT”.

13.6.3. General Litter Loading Considerations. Safety is the primary concern during litter transfers. Proper lifting techniques should be used at all times. At no time should patient safety be compromised. In the event of large litter loads, ensure workload is distributed among numerous litter bearers, when available.

WARNING: Litters lifted above waist level will first be brought to chest level and then lifted into place by no less than four-persons.

NOTE: Patients should have minimal exposure to the elements during enplaning/deplaning. Patients will not be staged/positioned on the aircraft ramp or flight line during inclement weather. Setting patients on either platform should be avoided.

NOTE: CCATT patients may be positioned with their head towards the flight deck if the CCATT physician determines patient condition warrants head first placement.

13.6.3.1. On the C-17/C-130 litter patients will be enplaned feet first and deplaned head first due to minimal degree of ramp incline. This eliminates the need to turn litter patients around on the cargo ramp prior to placing them in the litter tier. On the KC-135 litter patients will be enplaned head first to eliminate the need to turn litter patients around once on the aircraft.

13.6.3.2. When the cargo ramp is unavailable or if cargo is already on the aircraft prior to enplaning/deplaning litter patients, litters may be loaded through the paratroop doors/crew entrance door.

13.6.3.3. When enplaning/deplaning litters through the paratroop doors/crew entrance door on the C-130, at least four (4) people must be employed on the ground with an additional two (2) to three (3) people inside the aircraft.

13.6.3.4. On the C-17, to load through the paratroop doors or the forward emergency escape door, a minimum of six people on the ground to lift over the head and four on the aircraft is required.

13.6.3.5. Position personnel in a way that they can safely hand the litter off to others as needed.

13.6.3.6. When a comfort pallet is in place (C-17) first determine if there is adequate clearance to safely enplane/deplane the litter and any medical support equipment. **WARNING**: The preferred method to enplane/deplane ambulatory patients on the KC-135/KC-10/C-5 is the air stairs. The air stairs will not be used to enplane/deplane litter patients. If there is no other option available, the MCD will contact the appropriate C2 agency for A3VM waiver.

13.6.3.7. Both litter/ambulatory patients will enplane/deplane, using the patient loading system (PLS) or High Deck Loading Platform (HDLP). Maximum PLS weight capacity is 1500 lbs distributed and is rated to withstand 40 knot winds.

13.6.3.8. If the PLS/HDLP is not available, request a or Hi-lift truck, Halverson Lift, Tunner (K-Loader), for patient enplaning/deplaning. Ensure one AECM accompanies the patient (s). **WARNING:** Ensure all safety precautions are utilized when enplaning/deplaning patients on a K-Loader. One AECM should be directing patients during enplaning/deplaning. AECM's should coordinate with BO to utilize ramps to cover gap between aircraft and K-Loader to prevent personnel from injury.

13.6.3.9. Rollers on alternate platforms such as the Tunner will be turned over before beginning enplaning/deplaning operations. **WARNING:** Patients and medical equipment will not be placed on the patient support pallet (PSP) during pallet loading or off-loading.

13.6.3.10. Litter stanchion arms on the C-17 and PSP are designed for non-sequential loading.

13.6.3.11. AECMs will always secure the outside litter bracket immediately after loading a litter into a litter position. The inside bracket can be secured if time permits but will be secured prior to take-off.

13.6.3.12. When only one (1) patient occupies a litter tier, the patient will be placed at a level that optimizes medical care, and allows the patient to easily get on and off the litter.

13.6.3.13. When a litter, occupied or unoccupied, is placed in the lowest litter tier, a litter must be secured at waist level above it to prevent a tripping hazard. **CAUTION:** AECMs will be mindful of the potential strike hazard unoccupied litter stanchion arms (C-17 or Patient Support Pallet) present. To help eliminate the hazard: remove litter stanchion arms and store in a secure location on the aircraft. If a secure location is not available, place an empty litter in a vacant position or cover empty litter stanchion arms with blankets and secure with litter straps.

13.6.4. C-130 aircraft litter loading procedures.

13.6.4.1. It is the MCD/CMT discretion either to use a four or two person carry for C-130 enplaning/deplaning.

13.6.4.2. The four to two person switch may be performed on or off the aircraft.

13.6.4.3. The two AECMs actually loading will protect the patient from litter support brackets at all times.

13.6.4.4. Loading into the centerline #5 and #4 litter positions:

13.6.4.4.1. AECMs will hold the litter support straps to the outside of the litter area.

13.6.4.4.2. Litter bearers will bring the litter into the litter tier area.

13.6.4.4.3. Without setting the litter down, the AECMs will take the outside litter pole and then direct the litter bearer to take the inside pole.

13.6.4.4.4. The AECMs will secure the outside bracket.

13.6.4.4.5. Once the litter is in place, the litter bearers will be directed to exit the aircraft. If only one side of the aircraft is being used, litter bearers should be directed around the other side of the aircraft to avoid congestion. If loading both sides simultaneously (cross-loading), litter bearers should be sent back down the same side aisle but kept to the outside.

13.6.4.5. Loading into the centerline #3 litter position:

13.6.4.5.1. AECMs will secure the strap onto the #4 litter.

13.6.4.5.2. The litter bearers will bring the litter into the litter tier area. **NOTE*:*** AECM may need to direct the first litter bearer to bend slightly in order to walk under litter #4 depending on the configuration.

13.6.4.5.3. At the direction of the forward AECM, the litter bearers will set the litter into the inside stanchion bracket.

13.6.4.5.4. AECMs will position the outside bracket under the litter pole and secure the outside litter bracket. Direct litter bearers to exit the aircraft.

13.6.4.6. Loading into the centerline #2 and #1 position:

13.6.4.6.1. The AECMs will place the litter support strap on the litter above the position to be loaded.

13.6.4.6.2. The litter bearers will come on board and set the litter down in the aisle next to litter tier.

13.6.4.6.3. The AECMs will take the inside litter pole and direct the litter bearers to take the outside litter pole. **NOTE*:*** When loading litter position #1, it is the AECMs discretion either to use a four or two person lift into the litter brackets. If AECMs decide to use a two person lift, release the litter bearers immediately.

13.6.4.6.4. After the litter is placed in the inside litter bracket, the AECM will move the outside litter bracket into place and secure. Direct litter bearers to exit the aircraft.

13.6.4.7. Loading into the sidewall/litter track extenders #4 and #3 litter position:

13.6.4.7.1. The AECMs will hold the litter support strap to the outside of the litter tier.

13.6.4.7.2. The litter bearers will bring the litter on board and into the litter tier area.

13.6.4.7.3. Without setting the litter down, the crewmember will take the outside litter pole and then direct the litter bearer to take the inside pole.

13.6.4.7.4. Once the AECMs secure the outside brackets, direct the litter bearers to exit the aircraft.

13.6.4.8. Loading into the sidewall/litter track extenders #2 and #1 litter position:

13.6.4.8.1. The AECMs will place the litter support strap in the litter above the position to be loaded.

13.6.4.8.2. The litter bearers will come on board and stop in the aisle by the litter tier.

13.6.4.8.3. Without setting the litter down, the AECMs will take the outside litter handle and direct the litter bearers to take the inside litter handle.

13.6.4.8.4. The AECM at the forward end of the litter will give the command to lift the litter into the brackets.

13.6.4.8.5. AECMs will position the outside bracket under the litter pole and secure the outside litter bracket. Direct litter bearers to exit the aircraft. **NOTE:** Litter support straps (C-130) will be secured to the aircraft floor prior to take-off. If litters are not in the tier, loose litter support straps will be secured in a top and bottom litter support bracket on the litter stanchion. This will prevent a free-swinging strap from becoming a hazard.

13.6.4.9. Procedures for C-130 aircraft litter off-loading. Off-loading procedures are the reverse of the loading procedures for each litter position. AECM positioning will remain the same.

13.6.5. C-17 aircraft litter loading procedures.

13.6.5.1. When on/offloading patients, pay attention to the elevated area around the edge of the Litter Station Augmentation Set (LSAS) (this area could be a potential tripping hazard). Spotter(s) should be used to ensure litter bearers are aware of the hazard. When on/offloading patients of excessive weight or with excessive equipment requiring more than a four-person carry, extra caution should also be used.

13.6.5.2. The LSAS will remain onboard the aircraft during patient loading/offloading. Exception: in the rare event that a specific patient's condition, equipment needs or size raises serious safety concerns, the LSAS box may be removed from the aircraft for increased clearance. The PIC, with coordination between the MCD and LM, is the final authority in determining if the LSAS should be removed to facilitate patient on/offloading. MCD should request ground handling equipment, as required, on the offload message.

13.6.5.3. Litter arms should be positioned and secured with brackets open on all identified litter tiers. When configured to an AE-2 with the LSAS positioned on the ramp in the aerial delivery system (ADS) rails, the most aft litter arms can be removed before loading if they present a safety hazard. Reposition the removed litter arms prior to loading that specific litter tier.

13.6.5.4. A four person carry can be utilized throughout the C-17 cargo compartment. **WARNING:** To ensure patient safety when loading/unloading litter stations, two AECMs will maintain control of the litter until it is safely locked into the stanchion or cleared the stanchion for deplaning.

13.6.5.5. When loading CCATT/oversized litters up to a 6 person carry can be utilized. It is at the AECMs discretion not to release any of the litter bearers to assist with loading. AECMs are responsible for control and verbal commands of litter loading.

13.6.5.6. Litter position at or above waist level:

13.6.5.6.1. AECMs will direct the litter bearers to the litter station.

13.6.5.6.2. Without setting the litter down, the AECMs will take the inside litter handle and then direct the litter bearers to take the outside handle.

13.6.5.6.3. The AECMs will secure the outside bracket. Direct litter bearers to exit the aircraft.

13.6.5.7. Loading into litter positions below waist level:

13.6.5.7.1. AECMs will direct the litter bearers to the litter station.

13.6.5.7.2. Direct litter bearers to lower litter to the floor next to the litter station.

13.6.5.7.3. AECMs will take the inside litter handle and then direct the litter bearer to maintain outside litter handles.

13.6.5.7.4. After the litter is placed in the litter arms, the AECMs will secure the outside litter bracket. Direct litter bearers to exit the aircraft.

13.6.5.8. Procedures for C-17 aircraft litter off-loading. Off-loading procedures are the reverse of the loading procedures for each litter position. AECM positioning will remain the same.

13.6.6. KC-135/PSP Loading Procedures.

13.6.6.1. Litter stanchion arms should be positioned and secured with brackets open on all identified litter tiers.

13.6.6.2. For KC-135 operations, a four to a two person switch is performed once all litter bearers are on board. The released litter bearers will exit using the Patient Loading System (PLS) or return to the loading platform to allow for unobstructed movement of the two litter bearers.

13.6.6.3. Litter position at or above waist level:

13.6.6.3.1. AECMs will direct the litter bearers to the litter station.

13.6.6.3.2. Without setting the litter down, the AECMs will take the inside litter handle and then direct the litter bearers to take the outside litter handle.

13.6.6.3.3. The AECMs will secure the outside bracket. Direct litter bearers to exit the aircraft.

13.6.6.4. Loading into litter positions below waist level:

13.6.6.4.1. AECMs will direct the litter bearers to the litter station.

13.6.6.4.2. Direct litter bearers to lower litter to the floor next to the litter station.

13.6.6.4.3. AECMs will take the inside litter handle and then direct the litter bearer to maintain outside litter handles.

13.6.6.4.4. After the litter is placed in the litter arms, the AECM will secure the outside litter bracket. Direct litter bearers to exit the aircraft.

13.6.6.5. Procedures for KC-135 aircraft litter off-loading. Off-loading procedures are the reverse of the loading procedures for each litter position. AECM positioning will remain the same.

13.6.7. Engines Running Onload (ERO).

13.6.7.1. For AE missions, an ERO is authorized for contingency operations or during non-contingency AE missions when requirements dictate minimum ground time. EROs will not be used in a non-contingency environment unless mission essential. ERO procedures may be practiced/trained during ARMs, joint training operations, exercises, etc. Refer to 13.6.2 for proper hand signals.

WARNING: Eye protection will be worn outside the aircraft during all ERO procedures.

EXCEPTION: For the C-17, eye protection is not necessary, except when operating in parking areas where flying debris could be picked up from engine exhaust.

13.6.7.2. C-5, C-21, KC-10, and KC-135 Aircraft. AE EROs are not conducted on these aircraft for AE missions.

13.6.7.3. AECM's may exit the aircraft to conduct ground duties if not contraindicated by Intel/SPINS (Special Instructions).

13.6.7.4. The LM will be positioned at the foot of the ramp on the left side of the aircraft and on headset during actual onload procedures. The LM will observe for aircraft threats, and will enforce compliance with safety requirements.

13.6.7.5. A spotter is provided by the ground AE element and is positioned 50 feet aft of the aircraft ramp.

13.6.7.5.1. The spotter's primary responsibility is to indicate to the ground element when the AEC are ready for patient loading, and to start/slow/stop the flow of patients as needed.

13.6.7.5.2. The spotter monitors the litter-bearers to determine if assistance is needed and to ensure safe practices are maintained around the aircraft (i.e. prevent litter bearers from entering the prop wash/jet blast etc.)

13.6.7.6. Crossloading. Patients will normally be cross loaded during EROs depending on the aircraft configuration and cargo requirements.

13.6.7.7. For the C-130, litters will be brought onboard as safety considerations allow and loaded forward to aft/top to bottom.

13.6.7.8. Baggage will be loaded on the aircraft ramp and will not impede emergency egress.

13.6.7.9. If duties permit, loadmasters will assist AECMs with securing baggage.

13.6.8. **Baggage Procedures:** The 3AET is responsible for patient baggage procedures.

13.6.8.1. Accompanied patient baggage will receive expeditious handling and will be processed separately from passenger baggage. Anti-hijack inspection of all persons and hand-carried articles transported in the AE system is required. While this is normally accomplished by the originating MTF, the MCD will ensure anti-hijacking statement is included on AF IMT 3851. All baggage requires inspection.

13.6.8.2. The 3AET will ensure all baggage is tagged with a DD Form 600 and reflected on the original baggage manifest. The original baggage manifest will be given to the MCD at the end of the mission and filed with mission paperwork.

13.6.8.3. Due to space limitations onboard the aircraft, all patients and attendants are limited to one hand-carried item. If hand-carried baggage will not fit under the patient's seat and is stored in the cargo compartment, a DD Form 1839 will be accomplished.

13.6.8.4. Patients will not be permitted access to checked baggage.

13.6.9. Baggage Restrictions. Special care will be exercised by all AE agencies to ensure that stowed and hand-carried baggage does not contain unauthorized weapons, explosive devices, or unauthorized drugs.

13.6.9.1. Stowed baggage will be restricted to suitcases, duffel bags, hand bags, B-4 bags, A-2/3 bags, foot lockers, garment bags, or strong, durable cardboard boxes capable of withstanding frequent handling during transportation. Articles having dimensions exceeding 62 inches in one direction, exceeding overall dimensions of 100 inches (length plus width plus height), or exceeding 100 pounds will not be accepted as stowed baggage. **NOTE:** On the C-21, patients and attendants will be limited to one stowed bag not exceeding 30lbs. In addition one hand carried article (brief case, laptop case , purse) may be carried. If extra baggage is carried, it will be processed by the sending facility into the Traffic Management System.

13.6.9.2. Total baggage weight for each patient or attendant will not exceed 100 pounds.

13.6.10. Patient/Attendant Unaccompanied Baggage. Unaccompanied baggage will not be transported onboard AE aircraft.

13.6.10.1. No-show patient/attendant baggage or baggage of patients/attendants removed from flight will be off-loaded prior to departure.

13.6.10.2. Aircrew will not accept unaccompanied baggage unless the baggage has been processed through traffic management office (TMO) or installation transportation office (ITO) and arrives to the aircraft as freight.

13.6.10.3. Baggage that becomes separated from the owner becomes freight. Direct personnel to turn unaccompanied baggage over to TMO/ITO for proper manifesting.

13.7. En Route Duties

13.7.1. AECMs are responsible for properly securing aeromedical equipment, hand-carried baggage, and any other miscellaneous items in the aircraft cabin. Ensure all seat belts and litter straps are securely fastened; and that the cabin area is properly prepared for takeoff or landing. Unsecured items are a hazard in the event of rapid decompression or aircraft emergency. **NOTE:** Before advising the MCD of "Cabin Secure" IAW the AECM checklist, the appropriate AET must complete a final check of the cabin to ensure all loose items are

secured; seat backs are in the full upright position (if applicable), all seat belts and litter straps are securely fastened; and the cabin area is properly prepared for takeoff/landing.

13.7.2. LM/BOs, or other members of the flight crew, are responsible for ensuring information briefings highlight the following areas:

13.7.2.1. Emergency signals and passenger evacuation.

13.7.2.2. Use of emergency oxygen equipment.

13.7.2.3. Location of restroom. **NOTE:** The AEC are not passenger monitors. When crew duties permit, AECMs will make every effort to assist the LM/ BO in accomplishing their passenger-related duties.

13.7.3. **Mission Delays.** To preclude unnecessary patient holding on the flight line, aircraft departure times are not established on the basis of an estimated time in commission (ETIC). Departure times will be scheduled only on the basis of Fully Mission Capable (FMC).

13.7.3.1. The MCD must be cognizant that guidelines are not a substitute for sound judgment. Decisions should be put into action only after making a thorough assessment of the patient's medical needs and considering surrounding circumstances. With this in mind, the following guidance is offered:

13.7.3.1.1. If the delay exceeds 1 hour, ambulatory patients should be deplaned to a rest area such as a lounge or terminal facility. These patients remain the responsibility of the AECMs. If feasible, litter patients should be evaluated and appropriate action taken for their care. Meals may be obtained for patients by utilizing AF IMT 15, *United States Air Force Invoice*. Keep patients informed of the current situation.

13.7.3.1.2. Once the mission is in delay and the aircraft ETIC is more than 3 hours after scheduled departure, consider moving all patients to the nearest medical facility capable of supporting patient requirements. Before the actual movement of patients takes place, contact the FCC at the appropriate C2 agency for consultation and assistance. The C2 agency must be promptly notified of the problem as the facts are known. **NOTE:** Ground transportation time to the MTF should be considered.

13.7.4. **Unscheduled RON Procedures.** Normally, AE missions will remain overnight at bases where ASFs/ASTSs are located. Exceptions may occur due to weather, equipment failure, or patient needs. In these instances, the following procedures apply:

13.7.4.1. Coordinate with the appropriate C2 agency to ensure that the medical facility selected for patient care has the capability to meet patient needs.

13.7.4.2. On military installations, if appropriate medical personnel are not available for transfer of care, the MCD or FN is responsible for accompanying all patients to the medical facility and provide report to the staff that will take charge of interim patient care responsibilities.

13.7.4.3. Remain with patients until assured of their acceptance into the appropriate medical service and that adequate arrangements for care have been made. Include patient disposition in end of mission report to appropriate C2 agency.

13.7.4.4. If care is transferred to a civilian medical facility, the MCD or FN will accompany all patients to and from the civilian medical facility and assume responsibility for the following items:

13.7.4.4.1. Coordinate with the Director of Patient Administration, or equivalent, indicating the number of patients involved and their nursing care requirements. Problems encountered during the admission process will be managed tactfully, emphasizing patient necessity. If personnel at the facility resist the recommendation, the MCD will refer the matter to the appropriate C2 agency.

13.7.4.4.2. Furnish a complete clinical report to the receiving facility nursing/physician staff.

13.7.4.4.3. Remain with patients until assured of their acceptance and that adequate arrangement for care have been made with the appropriate medical service.

13.7.4.5. Whether military or civilian facility, AECMs will be responsible for care of their patients whenever hospital staffing is unable to provide adequate support. The appropriate C2 agency will be notified immediately when this occurs in order to task an additional AEC to complete the mission.

13.7.4.6. The MCD will ensure that all drugs and medical supplies are adequately secured. Narcotics will be placed in the custody of the MTF pharmacy section.

13.7.4.7. AETs are responsible for obtaining adequate patient baggage storage. Based on local situations and/or patient status, bags may be stored centrally or may be given to the RON patient. Regardless of process used, patients will be allowed immediate access to their baggage while staying in RON facilities at a military installation.

13.7.4.8. The MCD will coordinate all aspects of mission departure for the following day.

13.7.4.9. The MCD will ensure arrangements are made for ordering in-flight meals.

13.7.4.10. The MCD will ensure adequate preparation of patients and sufficient transportation, the hospital Patient Administration office will be notified of the estimated departure time.

13.7.4.11. FNs will report to the medical facility in sufficient time to receive patient report and to obtain narcotics and drugs that were placed under security.

13.8. Mission Termination. The following tasks must be completed by AECMs before an AE mission may be terminated:

13.8.1. Disconnect all medical equipment and personal flying gear after patients have been deplaned.

13.8.2. Accomplish applicable inventories.

13.8.3. The MCD/CMT will ensure:

13.8.3.1. AECM aircraft interior cleaning tasks are completed, which includes the cleaning and proper disposal of blood and/or body fluids from the aircraft.

13.8.3.2. Trash and all disposable medical supplies are collected for removal by aircraft services.

13.8.3.3. The aircraft is properly secured at RON points as specified in local directives.

13.8.3.4. All aircraft systems discrepancies/malfunctions have been reported to the LM/BO for repair by maintenance personnel.

13.8.3.5. All inoperative medical equipment is properly identified and tagged with an AFTO IMT 350.

13.8.3.6. All medical equipment is removed, cleaned and stowed properly.

13.8.4. A post mission debrief has been conducted to give crewmembers the opportunity to discuss all aspects of the mission. The degree of debrief formality and length will depend on the mission's complexity, but one will be conducted after all AE missions. MCD will complete End of Mission Report with AE Cell in the 618 TACC for AMC missions and appropriate AOC/AMD for theater missions.

Chapter 14

NOT USED

14.1. This chapter is not used for AE operations.

Chapter 15

AIR REFUELING

15.1. General. AR is an option which may be considered when planning AE patient movement.

15.1.1. Refueling During Training Missions. AR may be accomplished during training missions (per OG approval) when:

15.1.1.1. Conditions are encountered that, in the opinion of the PIC and MCD, will not result in minimal in-flight training opportunities for AECM's.

15.1.2. Refer to AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care*, Chapter 1, for nursing considerations related to aerial refueling.

Chapter 16

NOT USED

16.1. This chapter is not used for AE operations.

Chapter 17

NOT USED

17.1. This chapter is not used for AE operations.

Chapter 18

NOT USED

18.1. This chapter is not used for AE operations.

Chapter 19

NOT USED

19.1. This chapter is not used for AE operations.

Chapter 20

AE MISSION SAFETY

20.1. Safety Responsibilities and Precautions. All AECMs are responsible for enforcing and observing safety measures while performing the patient airlift mission.

20.1.1. Emergency procedures outlined in aircraft T.O.s, required directives, and abbreviated checklists must be reviewed frequently to ensure fully coordinated action of all AECMs.

20.1.2. AECMs must remain alert for unusual occurrences and immediately report any safety hazard to the MCD or PIC.

20.1.3. Adherence to Crew Resource Management (CRM) procedures/practices and constant situational awareness are keys to safe mission accomplishment.

20.1.4. Abbreviated checklists will be open to the appropriate phase of flight from preflight briefing through mission termination.

20.2. Ground Safety. As prescribed by AFI 11-218, *Aircraft Operations and Movement on the Ground*, personnel in the immediate area of an operating aircraft will wear hearing protection. AECMs must exercise extreme caution during all ground procedures.

20.2.1. A high accident potential exists due to noise level, vehicle activity around the aircraft, blackout/low-light conditions and inclement weather.

20.2.2. No Smoking is allowed within 50-feet of the aircraft.

20.3. Guidelines for Vehicle Drivers. Vehicle operators will follow the guidelines prescribed in AFJMAN 24-306, *Manual for the Wheeled Vehicle Driver*, and AFH 41-318, *Ambulance Bus (AMBUS) Training Standards*, and the following when enplaning/deplaning patients. Vehicle supervision, movement, and placement in and around the aircraft are the responsibility of the CMT with concurrence of the LM/BO, or PIC (as applicable).

20.3.1. All vehicular movement around the aircraft must maintain the 10-foot "circle of safety" from the nose, tail and wingtips of the aircraft. Any movement required within this circle will be directed by the CMT with concurrence of the LM/BO.

20.3.2. All vehicles approach parked aircraft with the driver side of the vehicle toward the aircraft.

20.3.3. The spotter pre-positions wheel chocks between the aircraft and vehicle within the 10 foot "circle of safety", to prevent vehicles from damaging the aircraft. Additional vehicles can be parked without chocks (no closer than 10 feet to the aircraft) providing a chocked vehicle is between the un-chocked vehicle and the aircraft. Chocks will remain in position until the vehicle(s) are ready for movement.

20.3.4. Vehicles parked on the flight-line will remain unlocked with the key in the ignition. If the vehicle driver does not remain in the drivers' seat after parking, the ignition must be turned off and the parking brake applied. In addition, the gear lever will be placed in a gear on vehicles with standard transmission, park for vehicles with automatic transmission. These requirements are not necessary if a driver remains behind the wheel at all times.

20.3.5. Only vehicles required to enplane/deplane patients or passengers or service the aircraft are permitted to approach the aircraft after it has blocked in. All vehicles will stand clear until directed to proceed towards aircraft. More than one vehicle may be positioned in the vicinity of the aircraft; however, only one vehicle may be in motion toward the aircraft at any one time.

20.3.6. AE ground support vehicles will be marshaled to the aircraft for aircraft set up, deplaning of AE medical equipment/supplies, and patient baggage by a qualified AECM.

20.3.7. The AMBUS and/or ambulances will be positioned near the ramp entrance. Additional AMBUSs and/or ambulances may be marshaled towards the aircraft and be parked next to the first AMBUS and/ or ambulance, to expedite enplaning/deplaning patients.

20.4. Emergency Exits and Safety Aisles.

20.4.1. When patients are seated in side facing seats, the LM/BO will ensure there is sufficient space between the cargo and the seats to permit patients leg room.

20.4.1.1. When the load consists of palletized netted cargo or is secured with straps or chains, a 30-inch space will be maintained between the cargo and the nearest forward litter or occupied seat. **EXCEPTION:** N/A on KC-135 and KC-10.

20.4.1.2. At least one unobstructed emergency exit is available for each 20 patients / troops. (This does not restrict over water flights if the three overhead escape hatches are available for egress.). Litters and seats erected across an emergency exit are not considered an obstruction. **WARNING:** For KC-135, PSPs and litters cannot be placed in front of hatches. Use appropriate PSP extensions to ensure egress route is unobstructed.

20.4.1.3. Do not secure aircraft or medical equipment adjacent to an emergency exit in a manner that will prevent or impede egress.

20.4.1.4. During egress, ramps on all aircraft may be used if already deployed and unobstructed.

20.5. Equipment Procedures. CAUTION: When heavy or bulky equipment is rolled up/down the aircraft ramp, ensure an adequate number of personnel are available to prevent injury to personnel, or damage to equipment.

20.5.1. Equipment that may be rolled up/down the ramp of C-130 and C-17:

20.5.1.1. Adult ventilators.

20.5.1.2. Unoccupied transport incubators, securely attached to a wheeled frame or containing integral wheels. **EXCEPTION:** An occupied neonatal transport system (NTS) may be rolled up or down ramps due to the weight of the NTS. Ensure the infant is properly secured inside the incubator. Four or more people will enplane/deplane the NTS. The MCD and CMT should use good judgment and common sense to carry out this operation in a safe manner. Occupied or unoccupied NTS will not be rolled up or down PLS, jarring may damage components.

20.5.1.3. Unoccupied ambulance-type stretchers/gurneys.

20.5.1.4. Air compressors with integral wheels.

20.5.1.5. Stryker Frame base.

20.5.1.6. Any other item that has integral wheels and is required to support a mission.

20.5.1.7. Pressurized gas cylinders secured to wheeled dollies. **NOTE:** Regulators must be removed and cylinders capped prior to enplaning/deplaning. Only cylinders with caps are accepted. **EXCEPTION:** Cylinders carried as part of a system (transport incubator, etc.) with cylinders in their applicable transport compartment do not need to be capped.

20.5.1.8. Compressed gas cylinders may be utilized as a source to provide oxygen or other compressed gas on any AE mission. These cylinders provide the drive pressure and gas mixes for ventilator patients and supplemental oxygen as required. When a patient is delivered to their final destination and the cylinders are deplaned, they will be prepared for return shipment as hazardous cargo per AFJMAN 24-204, *Preparing Hazardous Materials for Military Air Shipment*. When the same aircraft returns to home station where the cylinders originated, they may remain onboard as aeromedical equipment. Always have the regulator removed and the cylinder capped when returning cylinders.

20.5.1.8.1. H-Tank securing procedure. To secure H-size compressed air cylinders on-board the aircraft, the following components are required: two cargo tie-down straps per "H" tank, one piece of ¾" plywood sheet (20"X14") or milk crate to utilize as shoring.

20.5.1.8.2. Place ¾" plywood or milk crate on the cargo floor or PSP. A blanket is not adequate for shoring.

20.5.1.8.3. The H-tank should be placed securely against the inner aspect of the stanchion. Use non-conducting material (i.e. cotton blankets) to prevent metal to metal contact.

20.5.1.8.4. Secure the H-tank with two cargo tie-down straps placed on the upper and lower portion of the H-tank.

20.5.1.8.5. H-tanks will be capped prior to transport on and off the aircraft.

20.5.2. Minimum of a four (4) person carry is required for enplaning/deplaning the following:

20.5.2.1. . Lifting a litter patient above waist level.

20.5.2.2. Litter patients of excessive weight or those required to be carried for long distances.

20.5.2.3. Occupied civilian ambulance type stretchers/gurneys.

20.5.2.3.1. Prior to placing a patient on or removing a patient from an ambulance gurney/stretcher, ensure the gurney/stretcher is in the lowest position, side rails are down, and wheels are locked or a member from the ambulance team has control of the gurney/ stretcher.

20.5.2.4. Transport incubators with infants. (See exception in **20.4.1.2**).

20.5.2.4.1. Infant transport incubators are placed in any litter tier in the middle position. The infant's head is positioned forward or aft within the incubator

according to the manufacturer's instruction. At least two (2) securing straps will be connected around the infant for takeoff, landing and in flight.

20.5.2.5. Patients on Stryker Frames.

20.5.2.6. When inclement weather creates a hazardous condition (e.g., icy or wet ramp).

20.5.2.7. Whenever determined by the crew to be the safest method for enplaning/deplaning based on conditions. **NOTE:** Due to the limited aisle width onboard most aircraft, a switch to a two (2) person carry may be conducted in the interest of safety. Use good judgment prior to the switch, to prevent undue injury or strain to the two (2) person carry team. AECMs will switch back to 4-persons if lifting above waist level into litter stanchions. Ensure ramp extenders are placed/spaced to facilitate the safe loading/unloading of patients in the given operating environment (contingency, low-light, inclement weather etc.) Position spotters as required to ensure safe operations.

20.5.3. A minimum three (3) person carry is required for the following:

20.5.3.1. Enplaning/deplaning a litter patient with a backrest. Two individuals are at the head of the litter and the third at the foot of the litter. Per the **NOTE** above, AECMs may revert to a two (2) person carry once inside the aircraft. Backrests will not be in the 90-degree position during enplaning/deplaning or during take-off and landing. The backrest may be changed to the 90-degree angle in-flight for patient comfort and care.

20.5.4. Lifting litter patients into or out of an ambulance, AMBUS or a vehicle that does not have a ramp.

20.5.4.1. Position one person at the foot of the litter and two persons on either side of the litter at the door of the vehicle to lift and assist in moving the litter.

20.5.4.2. Vehicle doors will be physically secured or manually held in the open position when litter patients are being loaded/unloaded.

20.5.4.3. As the litter is pulled out of the vehicle, the 2 individuals positioned at the sides of the litter will grasp the litter with one hand at or above the patient's waist and one hand at the patient's head. Position personnel in a way that they can safely hand the litter off to others as needed.

20.5.5. Wheelchair patients/transporting battery powered wheelchairs.

20.5.5.1. Position one (1) individual behind and two (2) forward of the patient in the wheelchair.

20.5.5.2. Locate space in the aircraft cabin to secure the wheelchair. **NOTE:** When a wheelchair patient is scheduled for transport, the tasking C2 agency will ensure adequate space is available for wheelchair storage.

20.5.5.3. Secure the wheelchair upright in the aircraft cabin. Ensure the wheelchair does not interfere with emergency egress or pose a safety hazard. To prevent wheelchair damage, do not over tighten cargo tie-down straps.

20.5.5.4. Deactivate the battery. Remove the connection at the battery terminals or otherwise disconnect power source. **WARNING:** Do not charge the battery or electric

wheelchairs via the aircraft electrical system. Ensure the battery is securely attached to the wheelchair. Do not remove the battery from the wheelchair.

20.5.6. Neonatal Transport System (NTS) securing procedures**.** The NTS will be secured on cargo aircraft and the PSP for transport. Position wooden blocks under the NTS frame to elevate the unit's wheels off the cargo floor/PSP. (The wooden blocks prevent stress/pressure from being placed on the NTS wheels during transport.)

20.5.6.1. Use four cargo tie-down straps to secure the NTS to the cargo floor/PSP. The clip-hook of each strap will be attached to the hole at each corner of the NTS upper handles. The other end of the four cargo tie-downs will be secured to D-rings on the cargo floor or in the PSP seat tracks.

20.5.6.2. Two AECMs are required when tightening the cargo tie-down straps, one on each end. Use caution not to over tighten the straps.

20.5.7. Transport of PTLOX. The PTLOX system will be transported per provisions in AFJMAN 24-204, Preparing Hazardous Materials for Military Air Shipment. These units will be maintained per T.O. 15X-2-8-1.

20.5.7.1. HQ AFMC-24-204-97-12 waiver allows shipment of up to twenty-five 10-liter units on military aircraft without establishing a means for overboard venting. **EXCEPTION:** This waiver does not apply to C-21. To enhance safety, when shipping more than six PTLOX containers as cargo, do not cover the PTLOX pallet with plastic; this may create accumulation of high oxygen concentrations. Ensure the cargo floor is free from any oil or other petroleum based products.

20.5.7.2. An exception to policy to AMCI 24-101 V11, Cargo and Mail Policy, allows AECs to carry PTLOX as professional gear when positioning and depositioning for operational AE missions and contingency support operations. The exceptions to policy are:

20.5.7.2.1. The PTLOX does not require HAZMAT certification.

20.5.7.2.2. Venting is not required.

20.5.7.2.3. Processing through Aerial Port is not required.

20.5.7.3. AECMs will:

20.5.7.3.1. Be in additional aircrew (ACM) status.

20.5.7.3.2. Inform command post of the amount of equipment and PTLOX to be carried on the aircraft. Command post will advise the ATOC.

20.5.7.3.3. Notify the PIC and LM/BO that PTLOX will be transported.

20.5.7.3.4. Determine proper placement of PTLOX on the aircraft with direction from the PIC and LM/BO.

20.5.8. Defibrillation Procedures. To safely defibrillate a patient positioned on the aircraft floor, place a dry, woolen/cotton blanket under the patient. If any part of the patient contacts the floor, the distribution of current may be affected, resulting in the patient receiving less than the programmed amount of defibrillating current and/or possible skin burns. When

monitoring electrodes are attached to the patient, the ground electrode possesses a ground potential.

20.5.8.1. Patients may be defibrillated on litters with aluminum handles. Normal safety precautions must be followed (i.e., avoid direct contact with the patient or any portion of the litter during the procedure).

20.6. In-Flight Safety Procedures.

20.6.1. All patients, regardless of age, will be assigned a seat. The parent or guardian has the option to hold the infant or place them in an FAA approved infant car seat (ICS) in the assigned seat.

20.6.1.1. The FAA has banned the use of booster seats, harness and vest child restraints.

20.6.1.2. When a parent or attendant holds a child/infant, the seat belt is never placed around both the parent/attendant and the child/infant.

20.6.1.3. In the event of turbulence, the weight of the adult against the child/infant could result in injury to the child/infant. The attendant will secure the seat belt around their waist, with the seat belt securing mechanism secured to the aisle side of the attendant (if possible) to prevent the child/infant from sitting on the securing mechanism. A litter strap is placed through the seat belt, around the child/infant, and then secured. Additional padding should be placed between the child and the litter strap buckle.

20.6.1.4. When a small child occupies a seat, a pillow (if available) or some type of padding (i.e., blanket) should be placed between the child and the seat belt securing mechanism. Acceptable child/infant safety seats/restraints may be used during all phases of flight in forward or aft facing seats. **NOTE:** These types of seats/restraints will not normally be used in side facing (web type) seats, to transport patients or attendants. Passenger Services has approved the transport of passengers requiring child/ infant safety seats/restraints in side facing (web type) seats.

20.6.1.5. If the aircraft is equipped with airline type seats, seat children/infants in child/infant seats/restraints by the fuselage with an adult in the aisle or middle seat.

20.6.1.6. An adult must be able to reach emergency oxygen/life vest under all circumstances.

20.6.1.7. Never seat young children where they are required to distribute oxygen masks. Ensure parents with young children can reach the oxygen mask container.

20.6.1.8. Pregnant patients will be secured with a small pillow (if available) or some type of padding (i.e., blanket, etc.) between their lower abdomen and the seat belt. The seat belt is secured under the abdomen, across the hips.

20.6.2. Crewmembers should keep one hand free in-flight, if possible, to allow for stabilization in the event of turbulence.

20.6.3. Smoking in aircraft lavatories is a federal offense. Patients or passengers smoking in lavatories or tampering with detectors (if applicable) will be deplaned, medical condition permitting, at the next en route stop. Local authorities will be alerted of the offense. Notify tasking AE C2 agency for patient offenses, 618 TACC for passenger offenses and document actions/details on AF IMT 3829, (or TRAC2ES equivalent).

20.6.4. AECMs should escort patients to the latrine. Same sex AECM should accompany mental health patients to the latrine to provide supervision.

20.6.5. When required to perform crew duties for a litter patient during takeoff and/or landing, FNs, AETs, or MAs will be properly secured to the litter. Three (3) litter straps are required for the following procedure:

20.6.5.1. One (1) litter strap must be placed through the stirrups on each end of the litter and attached securely through a litter strap placed around the waist of the person standing.

20.6.5.2. The person standing should be positioned on the aisle of the litter.

20.7. Forms Adopted. AF Form 8, *Certificate of Aircrew Qualification*

AF Form 15, *USAF Invoice*
AF Form 59, *Sealed Pallet Notice*
AF Form 579, *Controlled Substances Register*
AF Form 711B, *USAF Aircraft Mishap Worksheet*
AF Form 847, *Recommendation for Change of Publication*
AF Form 3829, *Summary of Patients Evacuated by Air*
AF Form 3838, *Do Not Resuscitate (DNR) Certification for AE*
AF Form 3841, *Certificate of Release*
AF Form 3851, *Patient Baggage Data*
AF Form 3854, *Receipt for Patient's Valuables*
AF Form 3855, *In-Flight Nursing Worksheet*
AF Form 3856, *Aeromedical Patient Intake/Output Record*
AF Form 3857, *Aeromedical Evacuation Medication Requirements*
AF Form 3858, *C-130 Aeromedical Evacuation Mission Offload Message*
AF Form 3859, *Turn-In of Unaccompanied Narcotics*
AF Form 3860, *Aeromedical Patient Record Data*
AF Form 3861, *Aeromedical Evacuation Patient Medication Record*
AF Form 3895, *In-Flight Cardiac/Respiratory Arrest Worksheet*
AF Form 3899, *Aeromedical Evacuation Patient Record*
AF Form 3899A, *Aeromedical Evacuation Patient Record Progress Note*
AF Form 3899B, *Patient Movement Physician Orders*
AF Form 3899C, *Patient Movement Physical Assessment*
AF Form 3899D, *Patient Movement Hemodynamic/Respiratory Flowsheet*
AF Form 3899E, *Patient Movement Intake/Output*
AF Form 3899F, *Patient Movement Physician Orders for Behavior Management and Restraints*
AF Form 3899G, *Patient Movement Restraint Observation Flowsheet*
AF Form 3899H, *Patient Movement Neurological Assessment*
AF Form 3899I, *Patient Movement Medication Record*
AF Form 3899J, *Patient Movement Rhythm/Hemodynamic Strip*
AF Form 3899K, *Patient Movement/In-flight Resuscitation Flow Sheet*
AF Form 4076, *Aircraft Dash 21 Equipment Inventory*
AF Form 4327a, *Crew Flight (FA) Authorization*
AFTO Form 46, *Preposition Life Support Equipment*
AFTO 350, *Repairable Item Processing Tag*

AFTO Form 781, *ARMS Air-crew/Mission Flight Data Document*
AFTO Form 781A, *Maintenance Discrepancy and Work Document*
AMC Form 43,*Transit Aircrew Comments*
DD Form 600, *Patient Baggage Tag*
DD Form 601, *Patient Evacuation Manifest*
DD Form 602, *Patient Evacuation Tag*
DD Form 1839, *Baggage Identification*
DD Form 1854, *US Customs Accompanied Baggage Declaration*
DD Form 2131**,** *Passenger Manifest*
DD Form 2267, *Aeromedical Evacuation Medical Record*
DD Form 2852, *Aeromedical Evacuation Event/Near Miss Report*

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DCS, Operations, Plans and Requirements

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

AFI 10-403, *Deployment Planning and Execution*, 13 Jan 2008

AFI 10-2909, *Aeromedical Evacuation Equipment Standards*, 19 May 2008

AFI 11-202, V1, *Aircrew Training Standards*, 17 May 2007

AFI 11-202, V2, *Aircrew Standardization/Evaluation Program*, 8 Dec 2006

AFI 11-202 V3, *General Flight Rules*, 5 Apr 2006

AFI 11-218, *Aircraft Operations and Movement on the Ground*, 11 May 2005

AFI 11-290, *Cockpit/Crew Resource Management Training Program*, 11 Apr 2001

AFI 11-301 V1, *Aircrew Flight Equipment (AFE) Program*, 25 Feb 2009

AFI 11-301 V2, *Maintenance and Configuration Requirements for Aircrew and Aircraft Installed Life Support Equipment (LSE)*, 1 May 2006

AFI 11-401, *Aviation Management*, 7 Mar 2007

AFI 13-207, *Preventing and Resisting Aircraft Piracy (Hijacking)*, 15 Apr 1994

AFI 36-2903, *Dress and Personal Appearance of Air Force Personnel*, 2 Aug 2006

AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care*, 20 Aug 2003

AFPD 10-29, *Worldwide Aeromedical Evacuation Operations*, 6 Aug 2007

AFPD 11-4, *Aviation Service*, 1 Sep 2004

AFJI 41-315, *Patient's Regulated to and within the Continental United States*, 30 Mar 1990

AMCI 11-208, *Tanker/Airlift* Operations, 1 Jun 2000

AFI 24-203, *Preparation and Movement of Air Force Cargo*, 13 Apr 2007

AFMAN 33-363, *Management of Records*, 1 Mar 2008

AFPAM 10-1403, *Air Mobility Planning Factors*, 18 Dec 2003

DoD Instruction 6000.11, *Patient Movement*, 9 Sep 1998

DoD 4515.13R, *Air Transportation Eligibility*, 1 Nov 1994

Joint Pub 4-02, *Health Services Support*, 31 Oct 2006

Aeromedical Evacuation In-Flight Kit --Packaging Guide, 1 Sep 2009

Abbreviations and Acronyms

ACDE—Aircrew Chemical Defense Ensemble

ACM—Additional Crewmember

AE—Aeromedical Evacuation

AECM—Aeromedical Evacuation Crewmember

AECT—Aeromedical Evacuation Control Team

AEOO—Aeromedical Evacuation Operations Officer

AET—Aeromedical Evacuation Technician

AET—Second Aeromedical Evacuation Technician

AET—Third Aeromedical Evacuation Technician

AETC—Air Education And Training Command

AFE—Aircrew Flight Equipment

AFI—Air Force Instruction

AFRC—Air Force Reserve Command

AMBUS—Ambulance Bus

AMC—Air Mobility Command

AMCC—Air Mobility Control Center

AMD—Air Mobility Division

ANG—Air National Guard

AOC—Air and Space Operations Center

AOR—Area of Responsibility

ARC—Air Reserve Component

ARM—Aeromedical Readiness Mission

BO—Boom Operator

C2—Command and Control

CC—Commander

CD—Chemical Defense

CDT—Crew Duty Time

CECR—Crew Enhancement Crew Rest

CFR—Crash/Fire/Rescue

CMT—Charge Medical Technician

CNE—Chief Nurse Executive

CONOPS—Concept of Operations

CONUS—Continental United States

CRAF—Civil Reserve Air Fleet

CRM—Crew Resource Management

CS—Concurrent Servicing

CW—Chemical Warfare

DIRMOBFOR—Director, Mobility Forces

DNIF—Duty Not Involving Flying

DO—Director of Operations

DOD—Department of Defense

ECAS—Electrical Cable Assembly Set

ERO—Engines Running Onload or Offload

ETIC—Estimated Time to Completion

FCIF—Flight Crew Information File

FDP—Flight Duty Period

FN—Flight Nurse

FLIP—Flight Information Publications

FS—Flight Surgeon

FSRT—Firm Scheduled Return Time

FVBA—Fuel Vapor Bearing Area

GPMRC—Global Patient Movement Requirements Center

IAW—In Accordance With

ITLS— International Trauma Life Support

LM—Loadmaster

MAF—Mobility Air Force

MAJCOM—Major Command

MA—Medical Attendants

MCD—Medical Crew Director

MDS—Mission Design Series

MEP—Mission Essential Personnel

MTF—Medical Treatment Facility

NAF—Numbered Air Force

NGB—National Guard Bureau

NMA—Non-Medical Attendants

NOTAMS—Notice to Airmen

NTS—Neonatal Transport System

OG—Operations Group

OPORD—Operations Order

OPR—Office of Primary Responsibility

ORM—Operational Risk Management

PACAF—Pacific Air Forces

PBE—Protective Breathing Equipment

PCM—Passenger Compartment Monitor

PDO—Publications Distribution Office

PIC—Pilot In Command

PMCC—Patient Movement Clinical Coordinators

PMCR—Post Mission Crew Rest

PMRC—Patient Movement Requirements Center

PSP—Patient Support Pallet

PTLOX—Portable Therapeutic Liquid Oxygen

RDS—Records Disposition Schedule

618 TACC—Tanker Airlift Control Center (AMC)

TALCE—Tanker Airlift Control Element

TDY—Temporary Duty

TO—Technical Order

TPMRC—Theater Patient Movement Requirements Center

USAFE—United States Air Forces in Europe

USTRANSCOM—United States Transportation Command

UTC—Unit Type Code

Terms

Additional Crewmember (ACM)— Mobility aircrew members possessing valid aeronautical orders who are authorized to accompany the normal crew complement required for that mission.

Aeromedical Evacuation (AE)—Movement of patients under medical supervision between medical treatment facilities (MTFs) by fixed-wing aircraft by qualified AECMs.

Aeromedical Evacuation Crew (AEC)—Applies to entire crew: (MCD) Medical Crew Director, (FN) Flight Nurse, (CMT)Charge Medical Technician, (2AET)Second Aeromedical Evacuation Technician (3AET) Third Aeromedical Evacuation Technician

Aeromedical Evacuation Control Team (AECT)—A cell within the air operations center and one of the core teams in the air mobility division. Provides command and control for theater

aeromedical evacuation elements. It is responsible to the director of mobility forces for current aeromedical evacuation operational planning and mission execution. The aeromedical evacuation control team analyzes patient movement requirements; coordinates airlift to meet aeromedical evacuation requirements; tasks the appropriate aeromedical evacuation elements including special medical requirements, when necessary; and passes mission information to the patient movement requirement center.

Aeromedical Evacuation Crewmember (AECM)—Qualified Flight Nurses (FN), Aeromedical Evacuation Technicians (AET), performing AE crew duties.

Aeromedical Evacuation Operations Officer (AEOO)—Medical Service Corps (MSC) officer or medical administrative specialist or technician (AFSC 4A0X1) assigned to the AE system to perform duties outlined in applicable Air Force policy directives, instructions, 41-series handbooks, and this AFI.

Air Force Component Commander (AFCC)— In a unified, sub-unified, or joint task force command, the Air Force commander charged with the overall conduct of Air Force air operations.

Aircrew Chemical Defense Ensemble (ACDE)— Individually fitted aircrew unique chemical protective equipment for the sole purpose of protecting aircrew while flying into and out of a chemically contaminated environment.

Airlift— Aircraft is considered to be performing airlift when manifested passengers or cargo is carried.

Air Mobility Control Center (AMCC)— Provides global coordination of tanker and airlift for AMC and operationally reports to the AMC 618 TACC. Functions as the AMC agency that manages and directs ground support activities and controls aircraft and aircrews operating AMC strategic missions through overseas locations.

Air Reserve Component (ARC)— Refers to Air National Guard and AFRC forces, both Associate and Unit Equipped.

Air Route Traffic Control Center (ARTCC)— A facility that provides Air Traffic Control (ATC) services to aircraft operating on IFR flight plans within controlled airspace, principally during the en route phase of flight.

Air Traffic Control (ATC)— A service provided by an appropriate authority to promote the safe, orderly and expeditious use of the air transportation system and to maximize airspace utility.

Allowable Cabin Load (ACL)— Maximum payload that can be carried on a mission. It may be limited by the maximum takeoff gross weight, maximum landing gross weight, maximum zero fuel weight, or aircraft configuration. Maximum through load is limited to that which can be carried on the most restrictive leg of the mission.

Aeromedical Readiness Missions (ARMs)—Simulated Aeromedical Evacuation missions that are the primary means of preparing for AE airlift. These missions can be diverted to fulfill “real” versus “simulated” patient airlift requirements,

Assault Landing Zone (ALZ)—A paved or semi-prepared (unpaved) airfield used to conduct operations in an airfield environment similar to forward operating locations. ALZ runways are typically shorter and narrower than standard runways.

Augmented Crew— Basic aircrew supplemented by additional qualified aircrew members to permit in-flight rest periods.

Bird Watch Condition Moderate— Increased bird population (approximately 5 to 15 large birds or 15 to 30 small birds) in locations that represent an increased potential for strike. Keep in mind a single bird in a critical location may elevate the BWC to moderate or severe.

Bird Watch Condition Severe— High bird population (as a guide, more than 15 large birds or 30 small birds) in locations that represent an increased potential for strike. Keep in mind a single bird in a critical location may cause a severe BWC.

Block Time— Time determined by the scheduling agency responsible for mission accomplishment for the aircraft to arrive at (block in) or depart from (block out) the parking spot.

BLUE BARK— US military personnel, US citizen civilian employees of the Department of Defense (DoD), and the dependents of both categories who travel in connection with the death of an immediate family member. It also applies to escorts for dependents of military members traveling under competent orders.

Border Clearance— Those clearances and inspections required to comply with federal, state, and local agricultural, customs, immigration, and immunization requirements.

Chalk Number— Number given to a complete load and to the transporting carrier.

Charge Medical Technician (CMT)— A qualified AET who supervises other AETs in aircrew positions on AE missions and ensures completion of enlisted AE crew duties.

COIN ASSIST— Nickname used to designate dependent spouses accompanying dependent children and dependent parents of military personnel reported missing or captured who may travel space available on military aircraft for humanitarian purposes on approval of the Chief of Staff, United States Army; Chief of Staff, United States Air Force; Chief of Naval Operations; or the Commandant of the Marine Corps.

Command and Control (C2)— Exercise of direction and authority over assigned forces by a properly designated command echelon in the accomplishment of the mission.

Command and Control (C2) Center— Each C2 Center provides supervision, guidance, and control within its assigned area of responsibility. For the purpose of this AFI, C2 Centers include operations centers, command posts, air mobility elements, tanker airlift control elements (TALCE), air mobility control centers, and tanker task forces.

Command and Control Information Processing System (C2IPS)— Computer-based information transmission and information handling for C2 functions associated with the Director of Mobility Forces (DIRMOBFOR), AME fixed units, and TALCE. Interfaces to and automatically updates the Global Decision Support System (GDSS).

Concurrent Servicing—Simultaneous refueling or de-fueling while cargo or maintenance operations are being performed.

CONFERENCE SKYHOOK— Communication conference available to help aircrews solve in-flight problems that require additional expertise.

Contingency Mission— Mission operated in direct support of an OPORD, OPLAN, disaster, or emergency.

Contingency Response Element (CRE)—A provisional, deployed AMC organization established at fixed, en route, and deployed locations where AMC operational support is non-existent or insufficient. A CRE provides continuing on-site management of AMC airfield operations including C2, communications, aerial port, maintenance, security, services, weather, finance, contracting and intelligence--the critical elements needed to ensure a safe and highly efficient air base for all tanker and airlift operations. The CRE is composed of Contingency Support elements from various units and deploys in support of Special Assignment Airlift Mission (SAAM), Joint Airborne/Air Transportability Training (JA/ATT), tanker support, and contingency and emergency relief missions on both planned and "no notice" basis. Since CREs are deployed primarily to support AMC's global air mobility mission, they will normally remain under the operational control of COMAMC.

Contingency Response Group (CRG)—CRGs are designed to be first responders for opening airbases. These units will bridge the gap between the seizure forces and the follow-on combat/expeditionary combat support forces. CRGs are critical to the AF's ability to rapidly deploy U.S. military forces and initiate air operations of any type in minimal time at any base or location around the globe. CRGs may also provide C2, aerial port services, quick turn maintenance, force protection and various airbase support capabilities for AMC's Global Mobility mission. The CRG CONOPs and AFI 10-202, Contingency Response Groups, describes CRG operations.

Contingency Response Wing—The Air Forces global reach crisis response force. Rapidly deploy tailorable, multi-role, multi-skilled, expeditionary mobility teams, organized to quickly assess and effectively open forward contingency airbases and conduct air mobility support operations anywhere in the world. Exercise command authority over the respective CRGs, Global Support Squadrons (GSS) and Air Mobility Liaison Officers (AMLO) at their Operating Locations (OL) for organization, control of resources and equipment, personnel management, logistics, training, readiness, mobilization, demobilization, discipline, and any other appropriate matters. Ensures mission-ready airfield assessment teams, airfield operations, C2, aerial port, quick-turn aircraft maintenance, weather, intelligence, air traffic control, security forces, finance, fuels, supply, and contracting personnel are available to project and sustain combat forces worldwide.

Contingency Response Team (CRT)—Performs the same functions as a Contingency Response Element, but on a smaller scale. CRTs are normally led by an enlisted 7-level member certified as a CRT chief.

Contingency Support Element (CSE)—CSEs provide a specific mission support capability other than the core command and control, logistics, or aerial port services. They may be deployed as an element of a CRE or CRT, or as a small scale standalone entity.

Critical Phase of Flight— Takeoff, AR, approach, and landing.

Deadhead Time— Duty time for crewmembers positioning or de-positioning for a mission or mission support function.

Designated Courier— Officer or enlisted member in the grade of E-5 or above of the US Armed Forces, or a Department of State diplomatic courier, selected by the Defense Courier Service (DCS) to accept, safeguard, and deliver DCS material as directed. A primary aircrew member should be used as a courier only as a last resort.

Detainee—A term used to refer to any person captured or otherwise detained by an armed force. Detainees include, but are not limited to, those persons held during operations other than war

Deviation— A deviation occurs when takeoff time is not within -20/+14 minutes of scheduled takeoff time. Scheduled takeoff time may be adjusted to make good an ARCT. Notify controlling agency prior to takeoff to adjust the scheduled takeoff time.

Direct Instructor Supervision— Supervision by an instructor of like specialty.

Director, Mobility Forces (DIRMOBFOR)— Individual responsible for theater mobility force management. The Air Force component commander exercises operational control of assigned or attached mobility forces through the DIRMOBFOR. The DIRMOBFOR monitors and manages assigned mobility forces operating in theater. The DIRMOBFOR provides direction to the Air Mobility Division in the AOC to execute the air mobility mission and will normally be a senior officer familiar with the AOR.

Distinguished Visitor (DV)— Passengers, including those of friendly nations, of star or flag rank or equivalent status, to include diplomats, cabinet members, members of Congress, and other individuals designated by the DoD due to their mission or position (includes BLUE BARK and COIN ASSIST).

Double Blocking— When an aircraft is required to block-in at one parking spot, then move to normal parking for final block-in. The extra time required for double blocking will be taken into account during mission planning/scheduling. To compensate for double blocking on departure, the aircrew "legal for alert time" may be adjusted to provide additional time from aircrew "show time" to departure. When double blocking is required on arrival, the aircrew’s entry into crew rest will be delayed until post flight duties are complete.

Enemy Prisoner of War (EPW)—A detained person as defined in Articles 4 and 5 of the Geneva Convention Relative to the Treatment of Prisoners of War of August 12, 1949. In particular, one who, while engaged in combat under orders of his or her government, is captured by the armed forces of the enemy. An EPW may be, but is not limited to, any person belonging to one of the following categories who has fallen into the power of the enemy: a member of the armed forces, organized militia or volunteer corps; a person who accompanies the armed forces without actually being a member thereof; a member of a merchant marine or civilian aircraft crew not qualifying for more favorable treatment; or individuals who, on the approach of the enemy, spontaneously take up arms to resist the invading forces.

Estimated Time to Completion (ETIC)— Estimated time required to complete required maintenance.

Execution— Command-level approval for initiation of a mission or portion thereof after due consideration of all pertinent factors. Execution authority is restricted to designated command authority.

Global Patient Movement Requirements Center (GPMRC)— A joint activity reporting directly to the Commander in Chief, US Transportation Command, the Department of Defense

single manager for the regulation of movement of uniformed services patients. The GPMRC authorizes transfers to medical treatment facilities of the Military Departments or the Department of Veterans Affairs and coordinates intertheater and inside CONUS patient movement requirements with the appropriate transportation component commands of US Transportation Command.

Ground Time— Interval between engine shut down (or arrival in the blocks if engine shutdown is not scheduled) and next takeoff time.

Hazardous Cargo or Materials (HAZMAT)— Articles or substances that are capable of posing significant risk to health, safety, or property when transported by air and classified as explosive (class 1), compressed gas (class 2), flammable liquid (class 3), flammable solid (class 4), oxidizer and organic peroxide (class 5), poison and infectious substances (class 6), radioactive material (class 7), corrosive material (class 8), or miscellaneous dangerous goods (class 9). Classes may be subdivided into divisions to further identify hazard, i.e., 1.1, 2.3, 6.1, etc.

Home Station— Location where individual finance and personnel records are maintained.

Instructor Supervision— Supervision by an instructor of like specialty. For critical phases of flight, the instructor must occupy one of the seats or stations, with immediate access to the controls.

Interfly— The exchange and/or substitution of aircrews and aircraft between Mobility Air Forces (MAF) including crewmembers and/or aircraft from AETC, ACC, PACAF, and AMC-gained ANG and AFRC forces.

Local Training Mission— A mission scheduled to originate and terminate at home station (or an off-station training mission), generated for training or evaluation, and executed at the local level.

Maintenance Status:—

A-1:— No maintenance required.

A-2 (Plus Noun):—Minor maintenance required, but not serious enough to cause delay. Add nouns that identify the affected units or systems, i.e., hydraulic, ultra high frequency (UHF) radio, radar, engine, fuel control, generator, boom or drogue, etc. Attempt to describe the nature of the system malfunction to the extent that appropriate maintenance personnel will be available to meet the aircraft. When possible, identify system as mission essential (ME) or mission contributing (MC).

A-3 (Plus Noun):—Major maintenance. Delay is anticipated. Affected units or systems are to be identified as in A-2 status above.

A-4:—Aircraft or system has suspected or known biological, chemical, or radiological contamination.

Medical Crew Director (MCD)— A qualified FN responsible for supervising patient care and AECMs assigned to AE missions.

Mission Contributing (MC)— Any discrepancies that are not currently designated Mission Essential (ME).

Mission Clinical Coordinator (MCC)— A qualified/certified MCD or CMT, in addition to the basic crew and instructors and flight examiners. Responsible for coordinating training activities on ARMs.

Mission Essential (ME)— An item, system, or subsystem component essential for safe aircraft operation or mission completion.

Mission— Movement of aircraft from a designated point of origin to a designated destination as defined by assigned mission identifier, mission nickname, or both in the schedule, mission directive, OPORD, OPLAN, or Frag order.

Mission Advisory— Message dispatched by C2 agencies, liaison officers, or pilots in command advising all interested agencies of any changes in status affecting the mission.

Mobility Air Force (MAF)— Forces assigned to mobility aircraft or MAJCOMs with operational or tactical control of mobility aircraft.

Off Station Training Flight— A training flight that originates or terminates at other than home station that is specifically generated to provide the aircrew experience in operating away from home station. Off station trainers will not be generated solely to transport passengers or cargo.

Operational Control (OPCON)— Functions of C2 involving composition of subordinate forces, authority to approve allocation of assets to specific missions, assignment of tasks, designation of objectives, and authoritative direction necessary to accomplish the mission. This is a higher authority than the command that performs specific mission functions.

Operational Order (OPORD)—A directive issued by a commander to subordinate commanders for the purpose of effecting the coordinated execution of an operation.

Operational Missions— Missions executed at or above 618 TACC level. Operational missions termed "CLOSE WATCH" include CORONET missions and AFI 11-221, Air Refueling Management (KC-10 and KC-135), priority 1, 2, and 3 missions tasked by the 618 TACC. Other operational missions such as deployment, re-deployment, reconnaissance operations, operational readiness inspections (ORI), AMC channel or SAAM, and JA/ATT missions may be designated "CLOSE WATCH" as necessary.

Operational Risk Management (ORM)— A logic based common sense approach to making calculated decisions on human, materiel, and environmental factors before, during, and after Air Force operations. It enables commanders, functional managers, and supervisors to maximize operational capabilities while minimizing risks by applying a simple, systematic process appropriate for all personnel and Air Force functions.

Opportune Airlift— Transportation of personnel, cargo, or both onboard aircraft with no expenditure of additional flying hours to support the airlift.

Originating Station— Base from which an aircraft starts on an assigned mission. May or may not be the home station of the aircraft.

Over- water Flight—Any flight that exceeds power off gliding distance from land.

Patient Movement Categories:—

Urgent—. Patients who must be moved immediately to save life, limb, or eyesight, or to prevent complication of a serious illness.

Priority.—Patients requiring prompt medical care that must be moved within 24 hours.

Routine.—Patients who should be picked up within 72 hours and moved on routine/scheduled flights.

Permit to Proceed— Aircraft not cleared at the first US port of entry may move to another US airport on a permit to proceed issued by customs officials at the first port of entry. This permit lists the requirements to be met at the next point of landing, i.e., number of crew , cargo not yet cleared. The Pilot in Command is responsible to deliver the permit to proceed to the customs inspector at the base where final clearance is performed. (Heavy monetary fines can be imposed on the PIC for not complying with permit to proceed procedures.)

PHOENIX RAVEN Security Teams— Supports mobility operations by providing security protection for aircraft transiting high threat locations where host or en route security support may be marginal, unreliable, or nonexistent. PHOENIX RAVEN Security teams consist of two US Air Force security force members, but may include more depending on security requirements.

Pilot in Command—A qualified pilot responsible for command and control of all persons aboard the aircraft.

Positioning and De-positioning Missions—Positioning missions are performed to relocate aircraft for the purpose of conducting a mission. De-positioning missions are made to return aircraft from bases at which missions have terminated.

Quick Stop— Set of procedures designed to expedite the movement of selected missions by reducing ground times at en route or turnaround stations.

Ramp Coordinator— Designated representative of the C2 Center whose primary duty is the coordination of ground handling activities on the ramp during large-scale operations.

Remain Over Night (RON)—A scheduled or unscheduled mission stop that requires the aircrew to spend the night at a given location due to maintenance, crew duty or patient emergency concerns.

Scheduled Return Time (SRT)— Scheduling tool used by air mobility units to predict when crews will return to home station. It allows force managers to plan aircrew availability and provide crews visibility over monthly flying activities. AMC and AMC-gained aircrews (except those on standby at home station) will have an SRT established on their flight orders.

Scheduled Takeoff Time— Takeoff time is established in the schedule or OPORD. For air aborts and diversions, this will be engine shut down time (or arrival in the blocks if engine shutdown is not scheduled) plus authorized ground time. Early deviation does not apply to aborts or diversions unless the mission is formally rescheduled by current operations.

Special Assignment Airlift Mission (SAAM)— Funded airlift that cannot be supported by channel missions because of the unusual nature, sensitivity, or urgency of the cargo or that requires operations to points other than the established channel structure.

Special Category Patients—A special patient is any patient who can be considered at significant risk being aeromedically evacuated. To designate a patient as “special” is a matter of judgment based on many factors. Among these are the patient’s clinical status and degree of stability, amount of time between origination and destination MTF, and duration of individual

missions if more than one is needed to move. Special patients can be designated by the MCD/FN, PMCC, VFS or responsible physician and must be coordinated through the PMRC.

Stage Management System— The AMC Stage Management System is activated by TACC/XOZ when necessary to maximize airlift/air-refueling/aeromedical evacuation (AE) capability. Staging aircrews at critical locations minimizes the time aircraft spend on the ground awaiting rested aircrews. This is a force multiplier providing significantly increased airlift, air refueling and AE capability.

Stations Time (Air Force)— Normally, 30 minutes prior to takeoff time for the KC-10, KC-135, C-130, and OSA aircraft (45 minutes for C-5 and C-17). Aircrews will have completed their preflight duties and be at their crew positions. Passengers will be seated and cargo will be secured.

Tanker Airlift Control Center (618 TACC)— Operations center that controls tanker and airlift forces worldwide through a network of computer systems. The 618 TACC is organized into geographic cells consisting of East, West, and Emergency Action Cells. The 618 TACC contains the following functions: Mobility Management, Global Channel Operations, Operations Management, Current Operations, Global Readiness, Weather, Logistics Readiness Center, Aerial Port Control Center, International Clearances, and Flight Plans.

Theater Patient Movement Requirements Center (TPMRC)— The TPMRC is responsible for theater wide patient movement (e.g., medical regulating and AE scheduling), and coordinates with theater MTFs to allocate the proper treatment assets required to support its role. The primary role of the TPMRC is to devise theater plans and schedules and then monitor their execution in concert with the GPMRC. The TPMRC is responsible to the Combatant Commander through the Combatant Command Surgeon. The TPMRC is also responsible for all aspect of intratheater patient movement management. A TPMRC provides command and control for patient movement management operations in its theater of operations, as directed by its Combatant Commander's operational policy, and in coordination with USTRANSCOM, acting as a supporting combatant command, responsible for intertheater and CONUS patient movement.

Time Out— Common assertive statement used to voice crewmember concern when safety may be jeopardized.

Training Mission— Mission executed at the unit level for the sole purpose of aircrew training for upgrade or proficiency. Does not include operational missions as defined in this AFI.

Transportation Working Capital Fund (TWCF)— Formerly known as the Airlift Service Industrial Fund (ASIF) and Defense Business Operations Fund−Transportation (DBOF−T). Part of the overall Defense Working Capital Fund (DWCF). Used to finance airlift costs that are billed/reimbursed from an air mobility customer. Examples include aircrew TDY costs, utilities/maintenance and repair of TWCF-assigned facilities, civilian pay costs of TWCF-assigned personnel, airlift unit level mission planning expenses, and TDY costs for deployed TWCF units/personnel.

Unilateral— Operations confined to a single service.

Attachment 2

AEROMEDICAL EVACUATION CREW MEMBER EXPANDED CHECKLISTS

Table A2.1. AEROMEDICAL EVACUATION CREW MEMBER EXPANDED CHECKLISTS.

AEROMEDICAL EVACUATION CREW MEMBER ABBREVIATIONS The following abbreviations are used in this section to identify specific Aeromedical Evacuation Crewmembers (AECMs) and their duties: (AECM) Aeromedical Evacuation Crew Member (PIC) Pilot in Command (ACM) Additional Crew Member (LM) Loadmaster (BO) Boom Operator (CCATT) Critical Care Air Transport Team (AEC) Aeromedical Evacuation Crew (Applies to entire AEC listed below) (MCD) Medical Crew Director (FN) Flight Nurse (CMT) Charge Medical Technician (2AET) Second Aeromedical Evacuation Technician (3AET) Third Aeromedical Evacuation Technician
MEDICAL CREW DIRECTOR. The MCD ensures the aircraft is acceptable and configured for the assigned mission. The MCD supervises the nursing care and management of patients and is responsible for managing the AE crew and medical support personnel assigned to the mission. The MCD will advise and/or coordinate all pertinent aspects of the mission with the PIC. If the checklist is accomplished by one FN, accomplish all MCD and FN duties.
FLIGHT NURSE. The FN will assist the MCD as required. The FN provides professional nursing care during all aspects of AE missions, reviews and coordinates in-flight patient care requirements as required with origination and destination MTF personnel, completes appropriate forms, and performs additional duties as assigned by the MCD.
CHARGE MEDICAL TECHNICIAN. The CMT is responsible for the supervision and management of AETs assigned to perform duties on the mission. It is the responsibility of the CMT to ensure that medical supplies and equipment are on the aircraft and installed equipment is operable. The CMT is responsible for all ground operations around the aircraft. CMT will normally receive directions from and be responsible to the MCD (or assistant) and will also assist the flight crew if required.
AEROMEDICAL EVACUATION TECHNICIAN. The AETs (2AET and 3AET) will assist the CMT as required. AETs provide in-flight patient care under supervision of a qualified FN, complete the appropriate forms, and perform duties as assigned by the CMT. 3AET is responsible for all patient baggage procedures.

Mission Planning
1. Administrative Duties - Completed. (AEC)
a. Read and annotate FCIF/Special Interest Items/SPINS/NOTAMS.
b. Obtain mission paperwork and documentation.
(1). Verify flight authorization information.
(2). Calculate ORM Factors.
(3). Obtain aircraft tail number and parking spot.
(4). Obtain passport (as required).
(5). Complete personal customs declaration forms (as required).
(6). Review patient manifest.
c. Identify patient requirements and prepare nursing care plan.
d. Collect all AEC customs forms. (3AET)
2. AEC Crew Briefing - Attended/Completed. (AEC)
a. Discuss/Review ORM/CRM. (MCD)
b. Address No-Go and special interest items. (MCD).
c. Brief known mission information (i.e., U, P, 1A, 1B, prisoners, security police and armed attendants , etc.) and airlift considerations. (MCD)
d. Review CCATT/special patient requirements/equipment, and crew responsibilities and infection control procedures. (MCD)
e. Discuss medical emergency procedures. (MCD)
(1). Identify ACLS/PALS, ITLS, etc. trained crewmembers.
(2). Make cardiac arrest assignments.
(3). Discuss emergency patient placement.
f. Review/discuss aircraft emergencies and egress plan. (MCD)
g. Release 3AET for baggage procedures (as required).
h. Receive patient report from Nurse of the Day (if available) or MCD, including patient positioning plan, patient records, and patient medications.
(1). Verify patient passports and appropriate papers for non-US citizens are available (as required).
i. Create/discuss patient positioning plan and assign patient care responsibilities. (MCD/FN)
(1). Identify patient or equipment requirements that may require extended ground time/use of aircraft systems.
j. Assign specific equipment, supplies, and configuration duties. (CMT)
(1). Stanchion/straps/stanchion arms/brackets/seat set-up.
(2). Oxygen set up/02 calculation.
(3). Electrical set up/accomplish amperage calculation (all medical equip).
(4). In-flight kit set up/placement.
k. Discuss enplaning/deplaning, safety procedures, and cabin coverage. (MCD/CMT)
l. Review/discuss aircraft emergencies and egress plan. (MCD)
m. Coordinate tentative meal plan/fluid distribution for patients and crew. (MCD)
n. Coordinate refueling stop requirements (MCD).
o. Review aircraft security, theater terrorist threat, and anti-hijacking procedures.
p. If medical ACM is present, brief on duties and responsibilities. Collect copy of orders. (MCD)
3. In-Flight Kit - Preflighted/Loaded. (AEC)
a. Obtain medication kits/supplies.
b. Perform operational preflight on medical equipment. (accomplished within 24 hours prior to mission

launch or assuming alert posture by qualified Aeromedical Evacuation personnel).
c. Load medical supplies and equipment and transport to the aircraft.
4. Pilot/LM/BO Briefing - Attended/Completed. (AEC)

NOTE: This step may be accomplished on the aircraft.

a. Verify mission itinerary, threats, flight profile, etc.
b. Brief pilot on non-US citizens, altitude restrictions, unique patient requirements, and electrical and oxygen requirements in-flight or on the ground, only if it limits aircraft operation. (MCD)
c. Obtain escape and evasion (E & E) briefing (as required). Identify armed crewmembers (as required).
d. Obtain briefing on weather, en route times, total number of crew, flight/cabin altitudes, refueling stops and possible delays.
e. Identify emergency and communication signals/methods with pilot and LM/BO.
f. Discuss enplaning/ERO requirements (time constraints, loading requirements, i.e., ramps, AMBUS, safety observer, etc.).
g. Identify Aeromedical Readiness Mission (ARM) requirements (as required).
h. Discuss emergency requirements (radio transmissions/use of headsets). (MCD)
i. Brief LM/BO on anticipated patient load, number of AEC, souls on board verification, and cabin secure prior to take-off. (MCD)
j. Coordinates egress plan, meal times, special diets, and mission unique items with LM/BO. (MCD)

Table A2.2. EXPANDED CREW DUTIES -- MEDICAL CREW DIRECTOR (MCD), FLIGHT NURSE (FN) CHECKLIST.

MCD/FN is required to use and refer directly to this publication when accomplishing their abbreviated flight crew checklist duties. The abbreviated flight crew checklist will be used during all phases of the mission. If the checklist is accomplished by one flight nurse, accomplish all MCD and FN duties. When aircraft preparation and loading are accomplished by a ground support crew, checklist items denoted by "*" WILL be briefed by ground support personnel (qualified AECM) prior to the flight crew assuming responsibility. Preflight inspection/enplaning duties and procedures may have to be modified as the situation dictates. **Items with an "!" WILL be accomplished prior to take-off for contingency/combat missions.** Resume the applicable section of the checklist, once in-flight.

PREFLIGHT INSPECTION.
The interior inspection will be accomplished by using the abbreviated flight crew checklist.
!1. Rollers - stowed (as required).
!2. Oxygen Mask/MA-1 Bottle/Goggles/LPU/EPOS/PBE - Checked. (AEC)
a. MA-1 bottle serviced.
b. Attach mask to MA-1 bottle and check operation via PRICE check (as required).
c. Ensure unit is properly secured at duty station.
d. Secure all personal equipment and set up work area.
!3. Headset and extension connected, (MCD)
4. Cabin Preparation - Checked/completed. (AEC)

a. Configure aircraft for patient requirements per configuration plan, T.O. 1C-MDS-9, and AFI 11-2AE, Vol. 3, Addenda A. (AEC)
b. Litter stanchions/straps/brackets installed per mission requirements.
c. Seats properly secured to the aircraft and seat belts are attached.
d. Check and adjust litter brackets according to patient positioning plan.
e. Secure medications (patient, emergency, and narcotics). (FN)
f. Infection control/isolation area setup per established procedures. (FN)
*!5. Therapeutic Oxygen System - Checked/secured. (AEC)

WARNING: Do not position PTLOX near hydraulic reservoirs.

a. Check aircraft oxygen quantity and turn switches to “ON”. (C-17)

NOTE: Place the ON/OFF levers to ON one at a time and lift the levers slowly from OFF to ON to ensure stable output pressure.

b. Set-up/secure (as required) PTLOX and verify quantity/pressure.
c. Attach oxygen hose(s), flow control device(s), and flow meter(s) and check for proper operation.
!6. Electrical System(s) - Connected/secured. (AEC)

WARNING: Estimate total equipment draw from electrical system prior to connecting any electrical equipment to prevent overload of the aircraft electrical system and the frequency converter(s).

CAUTION: Assess aircraft amperage capacity.

a. Connect electrical frequency converter(s) to aircraft IAW established procedures (as required).
b. Connect Electrical Cable Assembly Set (ECAS) to aircraft following established procedures, ensuring cord(s) are attached to appropriate outlet(s).
c. Medical equipment plugged in (as required).
*!7. Suction/Bag-Valve-Mask (BVM) - Operable/secured. (AEC)
a. Ensure suction equipment is set up and available.
b. Ensure (BVM) manual resuscitator is available.
*!8. Medical Supplies/Equipment - Checked/secured. (AEC)
a. Ensure medical equipment is accessible and complete functional check.
b. Ensure supplies are accessible and secured, including special supplies/equipment.
9. Aircraft Acceptability/Discrepancies - Reported. (AEC)
a. Report duties accomplished/discrepancy to CMT. (MCD/FN)

LOADING.
! 1. (ERO) Preparations (as required) - Completed. (AEC)
a. Coordinate ERO activities with LM. (N/A for KC-135, KC-10 and C-21).
b. At en route stops, prepare cabin for ERO operations after departing the active runway (as required).
2. Aircraft Ready for Enplaning - Coordinated. (AEC)

a. Crew stations assumed for enplaning. (AEC)
! 3. Patient Report/Records/Medications/Supplies/Anti-hijacking Statement - Received. (MCD/FN)
a. Receive patient clinical update, medical records, X-rays, medications, passports, anti-hijacking statement, etc., from Medical Treatment Facility (MTF)/Aeromedical Staging Facility (ASF)/Mobile Air Staging Facility (MASF) personnel.
4. Anti-hijacking Procedures (as required).
a. Verify anti-hijacking procedures were accomplished by MTF/ASF/MASF personnel.
5. Patients - Enplaned. (AEC)
a. Coordinate/direct patient enplaning procedures with CMT and MTF/MASF personnel per patient positioning plan. (MCD)
b. Assist with enplaning litter patients.
c. Supervise/assist with enplaning of ambulatory patients/attendants.
d. Notify MCD of any changes in patient status.
e. Correct manifest(s) and revise patient positioning plan to reflect cancellations/add-on patients and number of correct souls on board. (MCD)
f. Coordinate cardiac arrest plan with CCATT/medical attendants, as applicable.
g. Load patient baggage and assist with hand-carried items. (AEC)
6. Patient/Passenger briefing - Completed. (AEC)

BEFORE TAXI.
! 1. Patients - Secured. (AEC)
a. Assist LM/BO with demonstration of LPUs, EPOS, and emergency exits to patients.
b. Provide individual briefings to litter patients and other individual patients (as required).

WARNING: As a minimum, outside litter brackets will be secured before taxi.

WARNING: If the AEC is not ready for taxi, the MCD will immediately notify the PIC.

!2. Souls On Board - Reported to MCD. (FN)
a. FN will physically obtain Souls on Board.
!3. Souls On Board - Reported to AEC/LM/BO. (MCD)

BEFORE TAKE-OFF.
1. Patient Care - Completed. (AEC)
a. Direct/perform pre-departure patient care.
b. Check condition/comfort of patients.
c. Notify the MCD if a potential delay will occur due to patient needs.
2. Cabin Secure - Completed. (AEC)
a. Ensure all patients/equipment/baggage are secured.
b. Take assigned seat and report cabin secure to MCD/CMT. (AEC)

WARNING: Ensure all litter stanchion brackets/patients are secured prior to takeoff. MCD will immediately notify PIC if the cabin is not secure for take-off.

NOTE: MCD will notify PIC/LM/BO if AECMs or medical attendants must stand during take-off.

ASCENT.
1. Observe for unusual occurrences/emergency situations.
2. Observe patients during ascent.
3. Review patient records and develop patient care plan.

NOTE: MCD will notify LM/BO if AECMs must attend to patient during ascent.

CRUISE (When safe to move about the cabin).
1. Patient Check - Completed. (AEC)
a. Check patient's pain level/condition.
2. Patient Care - Administered. (AEC)
a. Assess patient; perform patient care.
b. Document patient medications and treatments.
c. Distribute comfort items and provide fluids every two hours if not contraindicated.
d. Direct AEC in management/performance of patient care requirements. (MCD)
e. Administer/document patient medications and treatments. (FN)
f. Direct and supervise AEC in their duties. (MCD)
3. In-Flight Meal Service - Completed. (AEC)
a. Coordinate meal service with CMT. (MCD/FN)
b. Assist in distribution of meals.
c. Assist patients who cannot feed themselves and/or require help to eat.

NOTE: Recommend meal service in the following order: special diets, litter patients, ambulatory patients.

4. Administrative Duties. (AEC)
a. Complete all patient records. Ensure all vital signs and intake/output results are documented. (AEC)
b. Separate patient paperwork and medications according to destination medical facility (as required). (MCD/FN)
c. Ensure AFTO Form 781 information is correct, and provide to flight Engineer/LM/BO. (MCD/FN)
d. Provide pilot written offload message indicating any special ground support requirements a minimum of 45 minutes prior to estimated time of arrival. (MCD)
e. Co-Sign AET patient documentation records. (FN)
5. Cabin Cleanliness - Maintained. (AEC)
a. Collect garbage after meals and prior to descent. (AEC)
6. Medical/Supply Inventory - Tracked. (AEC)

DESCENT.
1. Enplaning/Deplaning - Coordinated. (AEC)
a. Discuss tentative enplaning/deplaning procedures and any special procedures at en route stop and/or final destination - Prepare for Landing. (AEC)

b. Provide individual briefings to litter patients and other individual patients.
c. Consolidate patient report information.
2. Patients and Equipment - Secured. (AEC)
a. Ensure all litter/ambulatory patients in assigned area are secured. (MCD/FN)
b. Ensure all medical equipment and supplies are secured. (AEC).
3. Take assigned seat and report cabin secure to MCD/CMT. (AEC).
4. Observe patients during descent.

WARNING: MCD will immediately notify LM/BO if the cabin is not secure for landing.

NOTE: MCD will notify LM/BO if AECMs or medical attendants must stand during landing.

OFFLOADING.
1. ERO Preparations (as required) - Completed. (AEC)
a. Coordinate ERO activities with LM. (N/A for KC-135, KC-10 and C-21)
b. At en route stops, prepare cabin for ERO operations after departing the active runway (as required).
2. Coordinate deplaning sequence with ground support.(MCD).
3. Provide ground support personnel with paperwork (as required). (MCD/FN)
4. Ensure patients have supplies/equipment/personal belongings.
5. Remove EPOS/LPUs from patient litters.
6. Identify patients requiring assistance. (AEC)
7. Provide clinical update to MTF/ASF/MASF personnel. (MCD/FN)
8. Obtain signature for patient records, X-rays, medications, supplies, and equipment being offloaded. (MCD/FN)

NOTE: Deplaning during patient report is highly encouraged but final approval is at the discretion of the MCD.

9. Patients - Deplaned. (AEC)
a. Confirm AEC/aircraft ready for deplaning and ground medical facility ready to receive patients. (CMT)
b. Deplane patients. (AEC)
c. Off-load baggage and assist with hand carried items. (AEC)
10. Contaminated Waste/Linens - Offloaded. (AEC)

NOTE: Medical equipment remains on board and operationally ready for use until all patients have deplaned. Individual oxygen masks will not be disconnected until all patients and attendants have been deplaned.

BEFORE LEAVING AIRCRAFT.
1. Discrepancies - Reported. (AEC)
a. Receive mission/aircraft discrepancy report from FN/CMT. (MCD)
b. Report patient care related discrepancies to MCD. (FN)
c. Report aircraft discrepancies to LM/BO for documentation on aircraft forms. (MCD)
2. Aircraft Flying Time Forms - Obtained. (MCD)

a. Obtain certified, “extract” copy of AFTO Form 781 (as required).
3. Equipment/Supplies - Removed/Stowed. (AEC)
a. Identify and tag all inoperable AE equipment.
b. Properly repack all medical equipment/supplies.
c. Remove all medical equipment/supply kits.
d. Remove all professional gear and personal bags per local policy.
4. Deconfigure aircraft (as required). (AEC)
a. Inspect/package LSAS/PSP.

POST MISSION.
1. Post Flight Debriefings - Attended. (AEC)
a. Attend applicable debrief(s) (pilot's, intelligence, crew, etc.)
2. Discuss mission discrepancies, positive mission outcomes, etc. (AEC)
3. Properly store all medical equipment/supply kits per local policy. (AEC).
a. Turn in medical supply inventory (as required).
4. Brief/Update C2 agency of patient status changes. (MCD)
5. Calculate crew rest. (MCD/CMT)
6. Coordination with Command Post, Squadron, etc. (AEC)
7. FAX mission paperwork to AE C2 agency. (MCD)
8. Arrange for flight home (as required). (MCD/CMT)
9. Coordinate billeting arrangements with pilot (as required). (MCD)
10.Notify tasking AE command element of crew's status, billeting arrangements and ACM plans. (MCD)

Table A2.3. EXPANDED CREW DUTIES -- CHARGE MEDICAL TECHNICIAN (CMT), AEROMEDICAL EVACUATION TECHNICIANS (2AET/3AET) CHECKLIST.

AETs are required to use and refer directly to this publication when accomplishing their abbreviated flight crew checklist duties. The abbreviated flight crew checklist will be used during all phases of the mission. If the checklist is accomplished by one or two aeromedical evacuation technicians (AET), accomplish all CMT/2AET/3AET duties. Duties may be delegated by the CMT. When aircraft preparation and loading are accomplished by a ground support crew, checklist items denoted by “*” WILL be briefed by ground support personnel (qualified AECM) prior to the flight crew assuming responsibility. Preflight inspection/enplaning duties and procedures may have to be modified as the situation dictates. **Items with an “!” WILL be accomplished prior to take-off for contingency/combat missions.** Resume the applicable section of the checklist, once in-flight.

PREFLIGHT INSPECTION.
The interior inspection will be accomplished by using the abbreviated flight crew checklist.
! 1. Loadmaster/BO Coordination. (CMT)
a. AFTO Form 781A - Checked.
b. Verify numbers and types of survival equipment (LPUs, EPOS) available for patients.
c. Notify LM/BO of total equipment weight and when applicable total estimated PSP weight

including patient weights.
d. Coordinate vehicle movement/positioning.
2. Rollers stowed (as required).
! 3. Oxygen Mask/MA-1 Bottle/Goggles/PBE/LPU/EPOS - Checked. (AEC)
a. Attach mask to MA-1 bottle and check operation via PRICE check.
b. Ensure unit is properly secured at duty station.
c. Check for currency of PBE/LPU/EPOS.
d. Secure all personal equipment and set up work area.
*! 4. Cabin Preparation - Checked/Completed. (AEC)
a. Configure aircraft for patient requirements per configuration plan, T.O. 1C-MDS-9, and AFI 11-2AE, Vol. 3, Addenda A. (AEC)
b. Litter stanchions/straps/brackets installed per mission requirements.
c. Seats properly secured to the aircraft and seat belts are attached.
d. Check and adjust litter brackets according to patient positioning plan.
e. Inspect LSAS/PSP. (CMT)
(1) Annotate discrepancies on AFTO Form 350/AFTO Form 244.
*! 5. Therapeutic Oxygen System - Checked/Secured. (AEC)

WARNING: Do not position PTLOX near hydraulic reservoirs.

a. Check aircraft oxygen quantity and ensure system is “ON”. (C-17)

NOTE: Place the ON/OFF levers to ON one at a time and lift the levers slowly from OFF to ON to ensure stable output pressure.

b. Set-up/secure (as required) PT LOX and verify quantity/pressure.
c. Attach oxygen hose(s), flow control device(s), and flow meter(s) and check for proper operation.
! 6. Electrical System(s) - Connected/Secured. (AEC)

WARNING: Estimate total equipment draw from electrical system prior to connecting any electrical equipment to prevent overload of the aircraft electrical system and the frequency converter(s).

CAUTION: Assess aircraft amperage capacity.

a. Connect electrical frequency converter(s) to aircraft.
b. Connect Electrical Cable Assembly Set (ECAS) to aircraft following established procedures, ensuring cord(s) are attached to appropriate outlet(s).
c. Medical equipment plugged in.
*!7. Suction/Bag-Valve-Mask (BVM) - Operable/Secured. (AEC)
a. Ensure suction equipment is set up and available.
b. Ensure (BVM) manual resuscitator is available.
*!8. Medical Supplies/Equipment - Checked/Secured. (AEC)
a. Ensure medical equipment is accessible and complete functional check.
b. Ensure supplies are accessible and secured, including special supplies/equipment.

*9. Meals/Service Items - Available/Received. (CMT/3AET)
a. Verify number of regular/special diets required for the mission.
b. Ensure aircraft lavatory is stocked with service items.
10. Aircraft Acceptability/Discrepancies - Reported. (AEC)
a. Report duties accomplished/discrepancy to CMT. (2AET/3AET)
b. Report discrepancies to MCD. (CMT)
11. Emergency Egress Passageways - Clear (CMT)

LOADING.
!1. ERO Preparations (as required) - Completed. (AEC)
a. Coordinate ERO activities with LM. (N/A for KC-135, KC-10 and C-21)
b. At en route stops, prepare cabin for ERO operations after departing the active runway (as required).
2. Auxiliary Ground Loading Ramps (as required) - Installed. (CMT)
a. Ensure auxiliary ground loading ramps are installed when enplaning patients via the cargo ramp (as required).
3. Vehicle positioning - Completed. (CMT)
4. Coordinate enplaning procedures with ground support - Accomplished. (CMT)
5. Confirm anti-hijacking procedures have been completed - Accomplished. (CMT)
a. Perform anti-hijacking procedures if not already accomplished by MTF/ASF/MASF personnel.
6. Identify patients requiring assistance - Accomplished. (CMT)
7. Distribute hearing protection - Completed. (CMT)
8. Check psychiatric litter patients for sharp objects - Completed. (CMT)
9. Check litter patients for security, approved litters, strap placement, and backrest placement - Completed. (CMT)

NOTE: If any patient condition is questionable or exceeds the capabilities of the AEC, notify the MCD.

NOTE: Enplaning during patient report is highly encouraged but final approval is at the discretion of the MCD.

10. Patients Enplaned. (AEC)
a. Confirm AEC/aircraft ready for patient enplaning. (CMT)
b. Assume enplaning positions. (AEC)
11. Baggage Procedures - Completed/Secured. (3AET)
a. Validate patient baggage manifest.
b. Sign for baggage on appropriate forms.
c. Assist LM/BO with loading/securing of patient/crew baggage.

BEFORE TAXI.
1. Patient Briefing - Completed. (AEC)
a. Assist LM/BO with demonstration of LPUs, EPOS, and emergency exits to patients.
b. Provide individual briefings to litter patients and other individual patients (as required).
c. Ensure litter/ambulatory patients have emergency oxygen/LPU.

!2. Patients and Equipment - Secured. (AET)
a. Ensure all litter/ambulatory patients in assigned area are secured.(AET)
b. Ensure all medical equipment and supplies are secured. (AET)

WARNING: As a minimum, outside litter brackets will be secured before taxi.

WARNING: If the AEC is not ready for taxi, the MCD will immediately notify the PIC.

!3. Souls on Board Report - Received. (AEC)

BEFORE TAKE-OFF.
!1. Patient Care - Completed. (AEC)
a. Perform pre-departure patient care as directed by MCD/FN.
b. Check condition/comfort/pain of patients.
c. Notify MCD if a potential delay will occur due to patient needs. (AEC)
! 2. Cabin Secure - Completed. (AEC)
a. Ensure all patients/equipment/baggage are secured.
b. Take assigned seat and report cabin secure to MCD/CMT. (AET)

WARNING: Ensure all litter stanchion brackets/patients are secured prior to takeoff. MCD will immediately notify PIC if the cabin is not secure for take-off.

NOTE: MCD will notify PIC/LM/BO if AECMs or medical attendants must stand during take-off.

ASCENT
1. Observe for unusual occurrences/emergency situations. (AEC)
2. Observe patients during ascent. (AEC)
3. Review patient records and develop patient care plan. (AEC)

NOTE: MCD will notify LM/BO if AECMs must attend to patient during ascent.

CRUISE (When safe to move about the cabin).
1. Patient Check - Completed. (AEC)
a. Check patient's pain level/condition.
2. Patient Care - Administered. (AEC)
a. Assess patient; perform patient care.
b. Document patient medications and treatments.
c. Distribute comfort items and provide fluids every two hours if not contraindicated.
3. In-Flight Oxygen - Checked. (CMT)
a. Verify therapeutic oxygen quantities.
4. In-Flight Meal Service - Completed. (AEC)
a. Coordinate meal service with MCD. (CMT)
b. Assist LM/BO with meal briefing (crew duties permitting). (3AET)

c. Assist in distribution of meals.
d. Assist patients who cannot feed themselves and/or require help to eat.

NOTE: Recommend meal service in the following order: special diets, litter patients, ambulatory patients.

5. Administrative Duties - Completed. (AEC)
a. Complete all patient records. Ensure all vital signs and intake/output results are documented. (AEC)
b. Obtain flight nurse signature on patient records after last entry. (AET)
c. Complete baggage manifest for off load station. (3AET)
d. Coordinate agriculture, border clearance, customs, and immigration requirements with LM/BO (as required). (3AET)
6. Cabin Cleanliness - Maintained. (AEC)
a. Collect garbage after meals and prior to descent. (AET)
7. Medical/Supply Inventory - Tracked. (AEC)
a. Document supplies used during the mission.

DESCENT.
1. Enplaning/Deplaning - Coordinated. (AEC)
a. Discuss tentative enplaning/deplaning procedures and any special procedures at en route stop and/or final destination. (CMT)
2. Prepare Patients for Landing. (AEC)
a. Wake patients and provide individual briefings to litter patients and other individual patients.
3. Patients and Equipment - Secured. (AEC)
a. Ensure all litter/ambulatory patients in assigned area are secured. (AET)
b. Ensure all medical equipment and supplies are secured. (AEC)
4. Take assigned seat and report cabin secure to MCD/CMT. (AEC)
5. Observe patients during descent.

WARNING: MCD will immediately notify LM/BO if the cabin is not secure for landing.

NOTE: MCD will notify LM/BO if AECMs or medical attendants must stand during landing.

OFFLOADING.
1. ERO Preparations (as required) - Completed. (AEC)
a. Coordinate ERO activities with LM. (N/A for KC-135, KC-10 and C-21)
b. At en route stops, prepare cabin for ERO operations after departing the active runway (as required).
2. Auxiliary Ground Loading Ramps (as required) - Installed. (CMT)
a. Ensure auxiliary ground loading ramps are installed when enplaning patients via the cargo ramp (as required).
3. Vehicle positioning - Completed. (CMT)
4. Coordinate deplaning procedures with ground support. (CMT)
5. Check litter patients for security, strap placement, and backrest placement. (2AET)
6. Ensure patients have supplies/equipment/personal belongings. (2AET)

7. Remove EPOS/LPUs from patient litters. (2AET)
8. Identify patients requiring assistance - Accomplished. (AEC)

NOTE: Deplaning during patient report is highly encouraged but final approval is at the discretion of the MCD.

9. Patients - Deplaned. (AEC)
a. Confirm AEC/aircraft ready for deplaning and ground medical facility ready to receive patients. (CMT)
b. Deplane patients. (AEC)
10. Contaminated Waste/Linens - Offloaded. (AEC)
11. Baggage Procedures - Completed. (3AET)
a. Validate patient baggage manifest.
b. Obtain signature on appropriate forms.
c. Assist with offloading patient/crew baggage.

NOTE: Medical equipment remains on board and operationally ready for use until all patients have deplaned. Individual oxygen masks will not be disconnected until all patients and attendants have been deplaned.

BEFORE LEAVING AIRCRAFT.
1. Discrepancies - Reported. (AEC)
a. Report aircraft discrepancies to BO/LM.
2. Equipment/Supplies - Removed/Stowed. (AEC)
a. Identify and tag all inoperable AE equipment.
b. Properly repack all medical equipment/supplies.
c. Remove all medical equipment/supply kits.
d. Remove all professional gear and personal bags per local policy.
3. Deconfigure aircraft (as required). (AEC)
a. Inspect/package LSAS/PSP.
(1) Annotate discrepancies on AFTO Form 350/AFTO Form 244.
4. Cargo Compartment in order. (CMT)

POST MISSION
1. Post Flight Debriefings - Attended. (AEC)
a. Attend applicable debrief(s) (pilots, intelligence, crew, etc.)
2. Discuss mission discrepancies, positive mission outcomes, etc. (AEC)
3. Properly store all medical equipment/supply kits per local policy. (AEC).
a. Turn in medical supply inventory (as required).
4. Brief/Update C2 agency of patient status changes. (MCD)
5. Coordination with Command Post, Squadron, etc. (AEC)
6. FAX mission paperwork to AE C2 agency. (MCD)
7. Arrange for flight home (as required). (MCD/CMT)
8. Coordinate billeting arrangements with pilot (as required). (MCD)
9. Calculate crew rest. (MCD/CMT)
10.Coordinate with tasking AE command element of crew's status, billeting arrangements and

ACM plans. (MCD)

FUSELAGE FIRE/SMOKE AND FUMES ELIMINATION
1. **OXYGEN - ON, 100% (ALL)**

NOTE: Protective Breathing Equipment (PBE) or Emergency Passenger Oxygen System (EPOS) may be used if oxygen mask/eye protection are not available.

NOTE: The MA-1 portable oxygen bottle delivers 100% oxygen at all settings. The regulator does not have to be turned to "emergency" to provide 100% oxygen.

WARNING: Removal of oxygen masks when smoke or fumes are present can result in personal injury or death.

2. Crew Alerted (AEC)
a. Notify loadmaster/boom operator/pilot (if origin of fire is in cabin) and aeromedical evacuation crew of nature of emergency.
3. Fire combat as directed (AEC)

NOTE: The pilot/LM/BO will direct crewmembers to fight the fire as required. Crewmembers not directly involved with combating the fire will proceed with their emergency procedures checklist.

WARNING: Although Halon 1211 vapor has a low toxicity, its decomposition products can be hazardous. On decomposition, Halon 1211 has a characteristic sharp, acrid odor, even in concentrations of only a few parts per million. The odor provides a built-in warning system for the agent and at the same time creates a noxious, irritating atmosphere for those who are in the hazard area during and following a fire. Leave and/or ventilate area after fighting a fire.

NOTE: To use the Halon 1211 fire extinguisher, hold a vertical position, about eight feet from the fire. Remove the pull-ring pin and aim nozzle at base of the fire. Squeeze lever and sweep agent across base of fire.

4. Patients. Assist as necessary (AEC)
a. Assist patients in donning emergency oxygen equipment.
b. Relocate patients out of the vicinity of the fire.
c. Secure patients in preparation for Smoke and Fumes Removal procedures.

NOTE: Placing a wet towel or handkerchief over the nose and mouth or over the mask, when utilized, affords better protection from smoke and fumes. Relocate the patients as necessary.

EMERGENCY SIGNALS
1. **Ground Evacuation**
a. Prepare to abandon airplane – three short rings. (KC-135 only)
b. Abandon airplane – one long sustained ring/horn blast.

2. **Ditching or Crash Landing**
a. Prepare for ditching or crash landing – six short rings/horn blasts.
b. Brace for impact – one long sustained ring/horn blast.

IN-FLIGHT DOOR WARNING
1. Oxygen As required (AEC)
a. The pilot will direct all crewmembers to don oxygen (as appropriate)
2. Crew Notified (AEC)
3. Patients/Passengers Secured (AEC)
4. Crewmembers Secured (AEC)

RAPID DECOMPRESSION
1. **OXYGEN - ON, 100 % (ALL)**

NOTE: The MA-1 portable oxygen bottle delivers 100% oxygen at all settings. The regulator does not have to be turned to "Emergency" to provide 100% oxygen.

2. Crewmember Secured (as required) (AEC)
a. If structural damage or aircraft flight maneuvers preclude personnel safety without a seat belt, aeromedical evacuation crewmembers will make every effort to secure themselves in any available seat until it is safe to move about the cabin.
b. If rapid decompression is not accompanied by unusual aircraft movements, AE crewmembers will continue with the checklist. If in the litter section, hold on to the nearest litter stanchion or aircraft structure.
3. Patients Assist (as required) (AEC)
a. When it is safe to move about, check patients and assist them with their oxygen source.
b. Ensure all patients are secured.

Table A2.4. Universal Procedures: Ditching Chart.

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
MEDICAL CREW DIRECTOR 1. Acknowledge pilot's order to prepare for ditching. Coordinate egress with PIC/ LM/BO. 2. Brief AEC. a. Any special instructions from pilot. b. Select able-bodied ambulatory patients to assist as required. c. Coordinate which litter patients will be moved to seats. 3. Don life preserver. 4. Inflate LPU 6/P (Infant Cot) life preservers prior to evacuating aircraft (as required). 5. Brief patients on assigned side of aircraft on evacuation procedures. a. Identify emergency exits to be used and order in which to evacuate. b. Position to assume at the "Brace for Impact" signal (one long sustained ring/horn blast on alarm bell/horn).	1. Check patients on assigned side of aircraft are properly secured and assuming "brace for impact position. 2. Take assigned seat. 3. Fasten seat belt. 4. Assume ditching position at "brace for Impact" signal.	1. Medical supplies, medications, equipment. 2. Flashlight 3. Patient manifest.	1. Assigned seat	1. Remain seated until aircraft has come to a complete stop. 2. Open exits. a. Open available exits and deploy life rafts as directed per egress plan or by PIC/ LM/BO. 3. Direct and assist patient egress per egress plan or as directed by PIC/ LM/BO; ambulatory followed by litters. **WARNING:** Brief patients to inflate life preservers after leaving the aircraft. 4. Evacuate aircraft 5. Board assigned life raft. (1) The first crewmember into the life raft will secure the clamp on the equalizer tube, as required. (2) Assist patients into the life rafts. (3) Group life rafts together (if possible).

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
(1) Side/forward facing seats - lean forward, place hands behind neck and pull head to knees; elbows should be outside of knees. (2) Aft facing seats – sit erect with head firmly against headrest, arms grasping armrests. (3) Litters - lie flat, grasp sides of litter tightly. 6. Prepare and secure litter and ambulatory patients on assigned side of aircraft. a. Assist CMT with positioning patients, checking litter straps and litter support systems on assigned side of aircraft. (1) Remove sharp objects, high heels, ties; loosen collars/tight fitting clothing. (2) Place sharp objects and loose items in large plastic bag and secure. Remove eyeglasses and dentures, pad, and secure on individual. (3) Position litter patients in seats and evacuate as ambulatory (if condition permits). b. Apply extra padding and litter straps to litter patients. c. Move litters to lower tier spaces.				

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
d. Remove IV lines, catheters, etc. that may impede egress. e. Assist patients in donning life preservers. **WARNING:** Brief patients to inflate life preservers after leaving the aircraft. **NOTE:** The LPU 6/P (Infant Cot) is the only life preserver that can be inflated inside the aircraft. 7. Distribute medical supplies, medications, and equipment to crewmembers for removal from aircraft upon evacuation. As a minimum collect narcotics, oral airways, BVM resuscitator , flashlight and patient manifest for removal from aircraft. 8. Secure cabin. a. Secure patients on assigned side of aircraft; check seat belts. b. Secure small children with extra litter straps and pad with pillows and blankets as required. c. Secure all loose articles and equipment. 9. Receive cabin secured report from FN/CMT. 10. Report cabin secured to PIC/LM/BO.				

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
FLIGHT NURSE 1. Don life preserver. 2. Inflate LPU 6/P (Infant Cot) life preservers prior to evacuating aircraft (as required). 3. Brief patients on assigned side of aircraft in evacuation procedures. a. Identify emergency exits to be used and order in which to evacuate. b. Position to assume at the "Brace for Impact" signal (one long sustained ring/horn blast on alarm bell/horn). (1) Side/forward facing seats - lean forward, place hands behind neck and pull head to knees; elbows should be outside of knees. (2) Aft facing seats – sit erect with head firmly against headrest, arms grasping armrests. (3) Litters - lie flat, grasp sides of litter tightly. 4. Prepare and secure litter and ambulatory patients on assigned side of aircraft.	1. Check patients on assigned side of aircraft are properly secured and assuming "Brace for Impact" position. 2. Take assigned seat. 3. Fasten seat belt. 4. Assume ditching position at "Brace for Impact" signal.	1. Medical supplies, medications, equipment 2. Flashlight	1. Assigned seat	1. Remain seated until aircraft has come to a complete stop. 2. Open exits. a. Open available exits and deploy life rafts as directed per egress plan or by PIC/ LM/BO. 3. Direct and assist patient egress per egress plan or as directed by PIC/ LM/BO; ambulatory followed by litters. **WARNING:** Brief patients to inflate life preservers after leaving the aircraft. 4. Evacuate aircraft 5. Board assigned life raft. (1) The first crewmember into the life raft will secure the clamp on the equalizer tube, as required. (2) Assist patients into the life rafts. (3) Group life rafts together (if possible).

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
a. Assist 2AET with positioning patients, checking litter straps and litter support systems on assigned side of aircraft. (1) Remove sharp objects, high heels, ties; loosen collars/tight fitting clothing. (2) Place sharp objects and loose items in large plastic bag and secure. Remove eyeglasses and dentures, pad, and secure on individual. (3) Position litter patients in seats and evacuate as ambulatory (if condition permits). b. Apply extra padding and litter straps to litter patients. c. Move litters to lower tier spaces. d. Remove IV lines, catheters, etc. that may impede egress. e. Assist patients in donning life preservers. **WARNING:** Brief patients to inflate life preservers after leaving the aircraft. **NOTE:** The LPU 6/P (Infant Cot) is the only life preserver that can be inflated inside the aircraft.				

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
5. Distribute medical supplies, medications, and equipment to crewmembers for removal from aircraft upon evacuation. At a minimum collect narcotics, oral airways, BVM resuscitator and flashlight for removal from aircraft. 6. Secure cabin. a. Secure patients on assigned side of aircraft; check seat belts. b. Secure small children with extra litter straps and pad with pillows and blankets as required. c. Secure all loose articles and equipment. 7. Report cabin secured to MCD.				

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
CHARGE MEDICAL TECHNICIAN 1. Don life preserver. 2. Brief assigned assistants to remain in aircraft to assist in evacuation of patients on assigned side of aircraft. Inflate LPU 6/P (Infant Cot) life preservers prior to evacuating aircraft (as required). 3. Brief patients on assigned side of aircraft in evacuation procedures. a. Identify emergency exits to be used and order in which to evacuate. b. Position to assume at the "Brace for Impact" signal (one long sustained ring/horn blast on alarm bell/horn). (1) Side/forward facing seats - lean forward, place hands behind neck and pull head to knees; elbows should be outside of knees. (2) Aft facing seats – Sit erect with head firmly against headrest, arms grasping armrests.	1. Check patients on assigned side of aircraft are properly secured and assuming "Brace for Impact" position. 2. Take assigned seat. 3. Fasten seat belt. 4. Assume ditching position at "Brace for Impact" signal.	1. Medical supplies, medications, equipment. 2. First aid kit. 3. Flashlight	1. Assigned seat.	1. Remain seated until aircraft has come to a complete stop. 2. Open exits. a. Open available exits and deploy life rafts as directed per egress plan or by PIC/ LM/BO. 3. Evacuate aircraft per egress plan or as directed by PIC/LM/ BO and inflate life preserver. **WARNING:** Brief patients to inflate life preservers after leaving the aircraft. 4. Board assigned life raft. a. The first crewmember into the life raft will secure the clamp on the equalizer tube, as required.

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
(3) Litters - lie flat, grasp sides of litter tightly. 4. Prepare and secure litter and ambulatory patients on assigned side of aircraft. a. Assist MCD with positioning patients, checking litter straps and litter support systems on assigned side of aircraft. (1) Remove sharp objects, high heels, ties; loosen collars/tight fitting clothing. (2) Place sharp objects and loose items in large plastic bag and secure. Remove eyeglasses and dentures; pad, and secure on individual. (3) Position litter patients in seats and evacuate as ambulatory (if condition permits). b. Apply extra padding and litter straps to litter patients. c. Move litters to lower tier spaces. d. Remove IV lines, catheters, etc. that may impede egress. e. Assist patients in donning life preservers.				b. Assist patients into the life rafts. c. Group life rafts together (if possible).

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
WARNING: Brief patients to inflate life preservers after leaving the aircraft. **NOTE:** The LPU 6/P (Infant Cot) is the only life preserver that can be inflated inside the aircraft. 5. Receive medical supplies, medications, and equipment from MCD for removal from aircraft upon evacuation. Collect first aid kit and flashlight. 6. Remove restraints from psychiatric patients a. Secure patients on assigned side of aircraft; check seat belts. b. Secure small children with extra litter straps and pad with pillows and blankets as required. c. Secure all loose articles and equipment. 7. Secure cabin. 8. Report cabin secured to MCD				

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
SECOND MEDICAL TECHNICIAN 1. Don life preserver. 2. Brief assigned assistants to remain in aircraft to assist in evacuation of patients on assigned side of aircraft and assist with launching life rafts. Inflate LPU 6/P (Infant Cot) life preservers prior to evacuating aircraft (as required). 3. Brief patients on assigned side of aircraft in evacuation procedures. a. Identify emergency exits to be used and order in which to evacuate. b. Position to assume at the "Brace for Impact" signal (one long sustained ring/horn blast on alarm bell/horn). (1) Side/forward facing seats - lean forward, place hands behind neck and pull head to knees; elbows should be outside of knees. (2) Aft facing seats – Sit erect with head firmly against headrest, arms grasping armrests.	1. Check patients on assigned side of aircraft are properly secured and assuming "Brace for Impact" position. 2. Take assigned seat. 3. Fasten seat belt. 4. Assume ditching position at "Brace for Impact" signal.	1. Medical supplies, medications, equipment. 2. First aid kit. 3. Flashlight	1. Assigned seat.	1. Remain seated until aircraft has come to a complete stop. 2. Open exits. a. Open available exits and deploy life rafts as directed per egress plan or by PIC/ LM/BO. 3. Evacuate aircraft per egress plan or as directed by PIC/LM/ BO and inflate life preserver. **WARNING:** Brief patients to inflate life preservers after leaving the aircraft. 4. Board assigned life raft. a. The first crewmember into the life raft will secure the clamp on the equalizer tube, as required.

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
(3) Litters - lie flat, grasp sides of litter tightly. 4. Prepare and secure litter and ambulatory patients on assigned side of aircraft. a. Assist MCD with positioning patients, checking litter straps and litter support systems on assigned side of aircraft. (1) Remove sharp objects, high heels, ties; loosen collars, tight fitting clothing. (2) Place sharp objects and loose items in large plastic bag and secure. Remove eyeglasses and dentures; pad, and secure on individual. (3) Position litter patients in seats and evacuate as ambulatory (if condition permits). b. Apply extra padding and litter straps to litter patients. c. Move litters to lower tier spaces. d. Remove IV lines, catheters, etc. that may impede egress. e. Assist patients in donning life preservers.				b. Assist patients into the life rafts. c. Group life rafts together (if possible).

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
WARNING: Brief patients to inflate life preservers after leaving the aircraft. **NOTE:** The LPU 6/P (Infant Cot) is the only life preserver that can be inflated inside the aircraft. 5. Receive medical supplies, medications, and equipment from MCD for removal from aircraft upon evacuation. Collect first aid kit and flashlight. 6. Remove restraints from psychiatric patients a. Secure patients on assigned side of aircraft; check seat belts. b. Secure small children with extra litter straps and pad with pillows and blankets as required. c. Secure all loose articles and equipment. 7. Secure cabin. 8. Report cabin secured to CMT.				

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
THIRD AEROMEDICAL EVACUATION TECHNICIAN 1. Don life preserver. 2. Brief assigned assistants to remain in aircraft to assist in evacuation of ambulatory patients in assigned portion of cargo compartment and assist with launching life rafts. Inflate LPU 6/P (Infant Cot) life preservers prior to evacuating aircraft (as required). 3. Brief ambulatory patients in assigned portion of cargo compartment on evacuation procedures. a. Identify emergency exits to be used and order in which to evacuate. b. Position to assume at the "Brace for Impact" signal (one long sustained ring/horn blast on alarm bell/horn). (1) Side/forward facing seats - lean forward, place hands behind neck and pull head to knees; elbows should be outside of knees.	1. Check ambulatory patients in assigned portion of aircraft are properly secured and assuming "Brace for Impact" position. 2. Take assigned seat. 3. Fasten seat belt. 4. Assume ditching position at "Brace for Impact" signal.	1. Medical supplies, medications, equipment. 2. First aid kit. 3. Flashlight	1. Assigned seat.	1. Remain seated until aircraft has come to a complete stop. 2. Open exits. a. Open available exits and deploy life rafts as directed per egress plan or by PIC/ LM/BO. 3. Evacuate aircraft per egress plan or as directed by PIC/LM/ BO and inflate life preserver. **WARNING:** Brief patients to inflate life preservers after leaving the aircraft. 4. Board assigned life raft. (1) The first crewmember into the life raft will secure the clamp on the equalizer tube, as required. (2) Assist patients into the life rafts. (3) Group life rafts together (if possible).

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
(2) Aft facing seats – Sit erect with head firmly against headrest, arms grasping armrests. 4. Prepare and secure ambulatory patients in assigned portion of cargo compartment. a. Remove sharp objects, high heels, ties; loosen collars/tight fitting clothing. b. Place sharp objects and loose items in large plastic bag and secure. Remove eyeglasses and dentures; pad, and secure on individual. c. Assist ambulatory patients in donning life preservers. **WARNING:** Brief patients to inflate life preservers after leaving the aircraft. **NOTE:** The LPU 6/P (Infant Cot) is the only life preserver that can be inflated inside the aircraft. 5. Receive medical supplies, medications, and equipment from FN for removal from aircraft upon evacuation. Collect first aid kit and flashlight. 6. Remove restraints from psychiatric patients. 7. Secure cabin.				

FIRST ACTION	DITCHING IMMINENT (10 Minutes Left)	PROVIDE	POSITION	AFTER DITCHING
a. Secure ambulatory patients in assigned portion of cargo compartment; check seat belts. b. Secure small children with extra litter straps and pad with pillows and blankets as required. c. Secure all loose articles and equipment. 8. Report cabin secured to CMT.				

Table A2.5. Universal Procedures: Emergency Landing.

FIRST ACTION	EMERGENCY LANDING (10 Minutes Left)	PROVIDE	POSITION	AFTER LANDING
MEDICAL CREW DIRECTOR 1. Acknowledge pilot's order to prepare for emergency landing. Coordinate egress with PIC/ LM/BO. 2. Brief AEC. a. Any special instructions from pilot. b. Select able-bodied ambulatory patients to assist as required. c. Coordinate which litter patients will be moved to seats. 3. Brief assigned assistants to remain in aircraft to assist in evacuation of patients on assigned side of aircraft. 4. Brief patients on assigned side of aircraft on evacuation procedures. a. Identify emergency exits to be used and order in which to evacuate. b. Position to assume at the "Brace for Impact" signal (one long sustained ring/horn blast on alarm bell/horn). (1) Side/forward facing seats - lean forward, place hands behind neck and pull head to knees; elbows should be outside of knees.	1. Check patients on assigned side of aircraft are properly secured and assuming "Brace for Impact" position. 2. Take assigned seat. 3. Fasten seat belt. 4. Assume ditching position at "Brace for Impact" signal.	1. Medical supplies, medications, equipment. 2. Flashlight 3. Patient manifest.	1. Assigned seat.	1. Remain seated until aircraft has come to a complete stop. 2. Open exits. a. Open available exits as directed per egress plan or by PIC/LM/ BO. 3. Direct and assist patient and passenger egress per egress plan or as directed by PIC/ LM/BO; ambulatory followed by litters. 4. Evacuate aircraft through designated exit. 5. Direct patients away from aircraft. a. Direct patients to meet upwind of the aircraft or as directed by the pilot. b. Accomplish a head count and provide numbers to pilot or senior ranking survivor.

FIRST ACTION	EMERGENCY LANDING (10 Minutes Left)	PROVIDE	POSITION	AFTER LANDING
(2) Aft facing seats – sit erect with head firmly against headrest, arms grasping armrests. (3) Litters - lie flat, grasp sides of litter tightly. 5. Prepare and secure litter and ambulatory patients on assigned side of aircraft. a. Assist CMT with positioning patients, checking litter straps and litter support systems on assigned side of aircraft. (1) Remove sharp objects, high heels, ties; loosen collars/tight fitting clothing. (2) Place sharp objects and loose items in large plastic bag and secure. Remove eyeglasses and dentures, pad, and secure on individual. (3) Position litter patients in seats and evacuate as ambulatory (if condition permits). b. Apply extra padding and litter straps to litter patients. c. Move litters to lower tier spaces. d. Remove IV lines, catheters, etc. that may impede egress. 6. Distribute medical supplies, medications, and equipment to crewmembers for removal from aircraft upon evacuation. As a minimum, collect narcotics, oral airways, and BVM resuscitator, flashlight and patient manifest for removal from aircraft.				

FIRST ACTION	EMERGENCY LANDING (10 Minutes Left)	PROVIDE	POSITION	AFTER LANDING
7. Secure cabin. a. Secure patients on assigned side of aircraft; check seat belts. b. Secure small children with extra litter straps and pad with pillows and blankets as required. c. Secure all loose articles and equipment. 8. Receive cabin secured report from FN/CMT. 9. Report cabin secured to LM/BO.				

FIRST ACTION	EMERGENCY LANDING (10 Minutes Left)	PROVIDE	POSITION	AFTER LANDING
FLIGHT NURSE 1. Brief assigned assistants to remain in aircraft to assist in evacuation of patients on assigned side of aircraft. 2. Brief patients on assigned side of aircraft on evacuation procedures. a. Identify emergency exits to be used and order in which to evacuate. b. Position to assume at the "Brace for Impact" signal (one long sustained ring/horn blast on alarm bell/horn). (1) Side/forward facing seats - lean forward, place hands behind neck and pull head to knees; elbows should be outside of knees. (2) Aft facing seats – Sit erect with head firmly against headrest, arms grasping armrests. (3) Litters - lie flat, grasp sides of litter tightly. 3. Prepare and secure litter and ambulatory patients on assigned side of aircraft. a. Assist 2AET with positioning patients, checking litter straps and litter support systems on assigned side of aircraft. (1) Remove sharp objects, high heels, ties; loosen collars/tight fitting clothing.	1. Check patients on assigned side of aircraft are properly secured and assuming "Brace for Impact" position. 2. Take assigned seat. 3. Fasten seat belt. 4. Assume ditching position at "Brace for Impact" signal.	1. Medical supplies, medications, equipment 2. First aid kit 3. Flashlight	1. Assigned seat	1. Remain seated until aircraft has come to a complete stop. 2. Open exits. a. Open available exits as directed per egress plan or by PIC/LM/ BO. 3. Direct and assist patient and passenger egress per egress plan or as directed by PIC/ LM/BO: ambulatory followed by litters. 4. Evacuate aircraft through designated exit. 5. Direct patients away from aircraft. a. Direct patients to meet upwind of the aircraft or as directed by the pilot. b. Accomplish a head count and provide numbers to pilot / MCD/or senior ranking survivor.

FIRST ACTION	EMERGENCY LANDING (10 Minutes Left)	PROVIDE	POSITION	AFTER LANDING
(2) Place sharp objects and loose items in large plastic bag and secure. Remove eyeglasses and dentures, pad, and secure on individual. (3) Position litter patients in seats and evacuate as ambulatory (if condition permits). b. Apply extra padding and litter straps to litter patients. c. Move litters to lower tier spaces. d. Remove IV lines, catheters, etc. that may impede egress. 4. Distribute medical supplies, medications, and equipment to crewmembers for removal from aircraft upon evacuation. As a minimum, collect narcotics, oral airways, and BVM resuscitator and flashlight for removal from aircraft. 5. Secure cabin. a. Secure patients on assigned side of aircraft; check seat belts. b. Secure small children with extra litter straps and pad with pillows and blankets as required. c. Secure all loose articles and equipment. 6. Report cabin secured to MCD.				

FIRST ACTION	EMERGENCY LANDING (10 Minutes Left)	PROVIDE	POSITION	AFTER LANDING
CHARGE MEDICAL TECHNICIAN 1. Brief assigned assistants to remain in aircraft to assist in evacuation of patients on assigned side of aircraft. 2. Brief patients on assigned side of aircraft on evacuation procedures. a. Identify emergency exits to be used and order in which to evacuate. b. Position to assume at the "Brace for Impact" signal (one long sustained ring/horn blast on alarm bell/horn). (1) Side/forward facing seats - lean forward, place hands behind neck and pull head to knees; elbows should be outside of knees. (2) Aft facing seats – Sit erect with head firmly against headrest, arms grasping armrests. (3) Litters - lie flat, grasp sides of litter tightly. 3. Prepare and secure litter and ambulatory patients on assigned side of aircraft. a. Assist MCD with positioning patients, checking litter straps and litter support systems on assigned side of aircraft. (1) Remove sharp objects, high heels, ties; loosen collars/tight fitting clothing.	1. Check patients on assigned side of aircraft are properly secured and assuming "Brace for Impact" position. 2. Take assigned seat. 3. Fasten seat belt. 4. Assume ditching position at "Brace for Impact" signal.	1. Medical supplies, medications, equipment. 2. First aid kit. 3. Flashlight	1. Assigned seat.	1. Remain seated until aircraft has come to a complete stop. 2. Open exits. a. Open available exits as directed per egress plan or by PIC /LM/BO. 3. Direct and assist patient and passenger egress per egress plan or as directed by PIC/ LM/BO: ambulatory followed by litters. 4. Evacuate aircraft. 5. Direct patients away from aircraft. a. Direct patients to meet upwind of the aircraft or as directed by the pilot. b. Accomplish a head count and provide numbers to pilot /MCD/or senior ranking survivor.

FIRST ACTION	EMERGENCY LANDING (10 Minutes Left)	PROVIDE	POSITION	AFTER LANDING
(2) Place sharp objects and loose items in large plastic bag and secure. Remove eyeglasses and dentures, pad, and secure on individual. (3) Position litter patients in seats and evacuate as ambulatory (if condition permits). b. Apply extra padding and litter straps to litter patients. c. Move litters to lower tier spaces. d. Remove IV lines, catheters, etc. that may impede egress. 4. Receive medical supplies, medications, and equipment from MCD for removal from aircraft upon evacuation. Collect first aid kit and flashlight. 5. Remove restraints from psychiatric patients . 6. Secure cabin. a. Secure patients on assigned side of aircraft; check seat belts. b. Secure small children with extra litter straps and pad with pillows and blankets as required. c. Secure all loose articles and equipment. 7. Report cabin secured to MCD.				

FIRST ACTION	EMERGENCY LANDING (10 Minutes Left)	PROVIDE	POSITION	AFTER LANDING
SECOND MEDICAL TECHNICIAN 1. Brief assigned assistants to remain in aircraft to assist in evacuation of patients on assigned side of aircraft. 2. Brief patients on assigned side of aircraft on evacuation procedures. a. Identify emergency exits to be used and order in which to evacuate. b. Position to assume at the "Brace for Impact" signal (one long sustained ring/horn blast on alarm bell/horn). (1) Side/forward facing seats - lean forward, place hands behind neck and pull head to knees; elbows should be outside of knees. 2) Aft facing seats – Sit erect with head firmly against headrest, arms grasping armrests. (3) Litters - lie flat, grasp sides of litter tightly. 3. Prepare and secure litter and ambulatory patients on assigned side of aircraft. a. Assist FN with positioning patients, checking litter straps and litter support systems on assigned side of aircraft. (1) Remove sharp objects, high heels, ties; loosen collars/tight fitting clothing. (2) Place sharp objects and loose items in large plastic bag	1. Check patients on assigned side of aircraft are properly secured and assuming "Brace for Impact" position. 2. Take assigned seat. 3. Fasten seat belt. 4. Assume ditching position at "Brace for Impact" signal.	1. Medical supplies, medications, equipment. 2. First aid kit. 3. Flashlight	1. Assigned seat.	1. Remain seated until aircraft has come to a complete stop. 2. Open exits. a. Open available exits as directed per egress plan or by PIC /LM/BO. 3. Direct and assist patient and passenger egress per egress plan or as directed by PIC/ LM/BO: ambulatory followed by litters. 4. Evacuate aircraft. 5. Direct patients away from aircraft. a. Direct patients to meet upwind of the aircraft or as directed by the pilot. b. Accomplish a head count and provide numbers to pilot /MCD/or senior ranking survivor.

FIRST ACTION	EMERGENCY LANDING (10 Minutes Left)	PROVIDE	POSITION	AFTER LANDING
and secure. Remove eyeglasses and dentures, pad, and secure on individual. (3) Position litter patients in seats and evacuate as ambulatory. b. Apply extra padding and litter straps to litter patients. c. Move litters to lower tier spaces. d. Remove IV lines, catheters, etc. that may impede egress. 4. Receive medical supplies, medications, and equipment from FN. Collect first aid kit and flashlight. 5. Remove restraints from psychiatric patients. 6. Secure cabin. a. Secure patients on assigned side of aircraft; check seat belts. b. Secure small children with extra litter straps and pad with pillows and blankets as required. c. Secure all loose articles and equipment. 7. Report cabin secured to CMT.				

FIRST ACTION	EMERGENCY LANDING (10 Minutes Left)	PROVIDE	POSITION	AFTER LANDING
THIRD AEROMEDICAL EVACUATION TECHNICIAN 1. Brief assigned assistants to remain in aircraft to assist in evacuation of ambulatory patients in assigned portion of cargo compartment. 2. Brief ambulatory patients in assigned portion of cargo compartment in evacuation procedures. a. Identify emergency exits to be used and order in which to evacuate. b. Position to assume at the "Brace for Impact" signal (one long sustained ring/horn blast on alarm bell/horn). (1) Side/forward facing seats - lean forward, place hands behind neck and pull head to knees; elbows should be outside of knees. (2) Aft facing seats – Sit erect with head firmly against headrest, arms grasping armrests. 3. Prepare and secure ambulatory patients in assigned portion of cargo compartment.	1. Check ambulatory patients in assigned portion of aircraft are properly secured and assuming "Brace for Impact" position. 2. Take assigned seat. 3. Fasten seat belt. 4. Assume ditching position at "Brace for Impact" signal.	1. Medical supplies, medications, equipment. 2. First aid kit. 3. Flashlight.	1. Assigned seat.	1. Remain seated until aircraft has come to a complete stop. 2. Open exits. a. Open available exits as directed per egress plan or by PIC /LM/BO. 3. Direct and assist patient and passenger egress per egress plan or as directed by PIC/ LM/BO: ambulatory followed by litters. 4. Evacuate aircraft. 5. Direct patients away from aircraft. a. Direct patients to meet upwind of the aircraft or as directed by the pilot. b. Accomplish a head count and provide numbers to pilot /MCD/or senior ranking survivor.

FIRST ACTION	EMERGENCY LANDING (10 Minutes Left)	PROVIDE	POSITION	AFTER LANDING
a. Remove sharp objects, high heels, ties; loosen collars/tight fitting clothing. b. Place sharp objects and loose items in large plastic bag and secure. Remove eyeglasses and dentures, pad, and secure on individual. (3) Position litter patients in seats and evacuate as ambulatory. 4. Receive medical supplies, medications, and equipment from FN for removal from aircraft upon evacuation. Collect first aid kit and flashlight. 5. Remove restraints from psychiatric patients. 6. Secure cabin. a. Secure ambulatory patients in assigned portion of cargo compartment; check seat belts. b. Secure small children with extra litter straps and pad with pillows and blankets as required. c. Secure all loose articles and equipment. 7. Report cabin secured to CMT.				