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*SECRETARY OF THE AIR FORCE*

*AIR FORCE INSTRUCTION 41-106*

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*Health Services*

# *UNIT LEVEL MANAGEMENT OF MEDICAL READINESS PROGRAMS*

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This instruction implements Air Force Policy Directive (AFPD) 41-1, *Health Care Programs and Resources* and DOD Instruction (DODI) 1322.24, *Medical Readiness Training*. It sets procedures for medical readiness planning, training, exercising and reporting expeditionary and installation response operations. This instruction applies to Active Component (AC) and Air Reserve Component (ARC) units and may be supplemented by headquarters (HQ) ARC and major command (MAJCOM) specific guidance as necessary. Specific requirements for aeromedical evacuation (AE) units in this instruction will be superseded by guidance in AFI 10-2912 when published. Throughout this AFI references to AEF cycle and AEF window are to be interpreted as the new AEF Tempo Band Construct and the 24 month AEF schedule. ***NOTE:*** ANG is considered a MAJCOM throughout this instruction.

## *SUMMARY OF CHANGES*

This interim change updates Medical Readiness Training (MRT) and Medical Counter-Chemical, Biological, Radiological, and Nuclear (MC-CBRN) guidance in **Chapter 2** and **Chapter 3**. The CBRN Medical Defense Officer (MDO) appointed position has been deleted. References to the Exercise Oversight Committee have been changed to reflect the recent merge of this committee with the Readiness Training Oversight Committee (RTOC). Medical Readiness Training categories in **Chapter 5** and **Attachment 3** have been restructured to more closely match unit medical readiness training scheduling and tracking processes. Medical Readiness Training schedules and minimum frequencies, or recurrences, have been updated to conform to the 24 month Air and Space Expeditionary Force (AEF) schedule, as defined by the new AEF Tempo Band construct. **Table 8.1.**, Reportable Medical Readiness Training, has been updated.

## Chapter 1

## THE AIR FORCE MEDICAL SERVICE READINESS MISSION

**1.1. Mission Overview.** The Air Force Medical Service (AFMS) provides seamless health service support to USAF and combatant commanders and assists in sustaining the performance, health and fitness of every Airman in-garrison and while deployed within the Continental United States (CONUS) or overseas. This capability is summarized by the phrase "global medical readiness" which includes the full spectrum of medical operations (expeditionary deployment operations and installation contingency response), planning, training, and readiness support functions (reports, disaster management, and others). Components of this global system are fully integrated, with forward-deployed medical support, and en route care to facilities providing comprehensive definitive medical specialty care. The foundational emphasis is on prevention of illness and injury. When illness or injury does occur, the AFMS provides a rapidly responding modular medical capability which can be tailored to the contingency requirement. If more definitive care is required, the AFMS supports an effective "evacuate and replace" policy through aeromedical evacuation (AE) of joint and combined forces. With this focus on preventive medicine, superior health care, and aeromedical evacuation, the AFMS promotes and advocates the optimization of human performance sustainment and enhancement, including the optimal integration of human capabilities with operational systems.

1.1.1. **Modular Capabilities.** The AFMS provides a light, lean modularized medical capability that can be deployed rapidly to support operations overseas and at home.

1.1.1.1. Most initial medical support begins with either the Global Reach Laydown (FFGRL) team or the Squadron Medical Element (SME). The FFGRL consists of four personnel and is assigned to the Contingency Response Group (CRG) to provide medical support during rapid opening of contingency airfields. The purpose of the CRG is to bring significant order, foresight, speed and safety during the critical opening days of a contingency. The SME is a small team consisting of a Flight Surgeon and two Medical Technicians attached to an AF flying squadron. This team deploys with the squadron and provides care and initial preventive medicine surveillance. As support to the expeditionary squadron grows, the SME can be augmented with additional Independent Duty Medical Technicians (IDMTs) and a Preventive Aerospace Medicine (PAM) team. The PAM team provides aerospace medicine support during the opening of a contingency airbase. If the beddown site becomes a more permanent operating site or the population at risk (PAR) increases, the AFMS can deploy the Expeditionary Medical Support (EMEDS) system. The scalable nature of EMEDS allows the AF to deploy a team as small as the Small Portable Expeditionary Aeromedical Rapid Response (SPEARR) team that can provide highly capable medical care for a limited number of casualties, to a medical system as large as an Air Force Theater Hospital (AFTH) that can provide specialized medical care to a PAR of several thousand.

1.1.1.2. For casualties requiring more definitive care than that provided by the EMEDS, the Global Patient Movement System can provide rapid AE of patients to the appropriate level of care. Using USAF Mobility Air Forces (MAF) aircraft, AE teams provide medical care during transportation of patients. Critical Care Air Transport Teams (CCATTs) work with AE teams to support patients requiring more intensive en route care.

1.1.1.3. These modular capabilities, including ground assets and AE assets, are organized by force modules to complement increases in combat capability. As a beddown grows, predetermined sup-

port assets, including medical assets, are deployed to that beddown. These predetermined modules provide an organized expansion capability, offer predictability to the supporting units, and simplify the planning process.

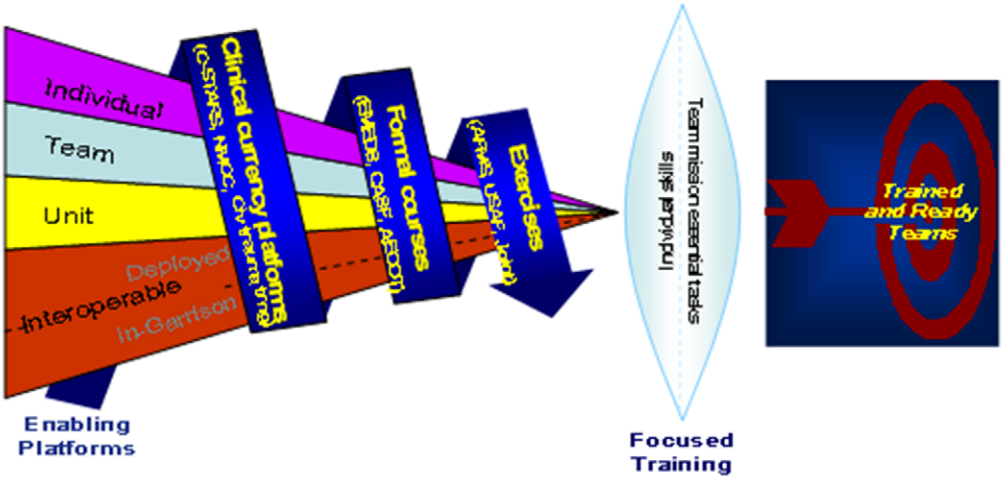
1.1.1.4. In addition to missions associated with aircraft beddown locations, AFMS forces may deploy to support humanitarian missions where medical, civil engineering, and security missions are the primary focus.

1.1.2. **Emergency Management.** Fixed facilities worldwide are postured to provide medical support during peacetime and wartime contingencies with their in- place generation missions. These missions include facility expansion, which can increase the bed capacity of many of our medical treatment facilities (MTFs) to receive and care for large numbers of casualties; in-place patient decontamination; and medical response/support to contingencies confined to the installation or involving Federal, State, Local, and Tribal agencies. The AFMS also participates in the National Disaster Medical System (NDMS) with the capability to treat military casualties resulting from a military conflict or civilian casualties resulting from a homeland contingency, including a terrorist attack, major accident, or natural disaster. Designated AF MTFs serve as Federal Coordinating Centers (FCCs) within the NDMS, providing support and leadership to the local hospitals contributing to the NDMS bed capability. To maintain this capability to respond to all contingencies, the AFMS relies on highly trained medical warriors and state-of-the-art, light, ruggedized medical equipment. Comprehensive planning and realistic exercises ensure personnel are prepared to support expeditionary operations and installation contingency response.

**1.2. Medical Readiness Training.** AFMS personnel require highly specialized initial, sustainment, and theater-specific training to respond to varied missions and environments. A continual assessment process ensures this training remains relevant and effective.

1.2.1. **Current Training System.** Training is provided for individuals, teams (collective training), and leaders, and prepares personnel to integrate themselves into joint medical platforms and situations. The training system includes AFSC-awarding training courses, clinical currency platforms, formal courses for deployment platforms, local courses and briefings, and exercises. See **Figure 1.1.**

**Figure 1.1. Medical Readiness Training and Assessment System.**




1.2.2. **Future Training System.** The current training system will be transformed over the next several years to comply with Line of the Air Force (LAF) and Joint Staff mission essential task-based training and assessment. The transformation is previewed in **Chapter 9**.

**1.3. Medical Readiness Resourcing.** To maintain a robust medical readiness capability, the AFMS manages the funding for training, exercises, personnel and equipment through an internal planning, programming and budgeting system. Specifically, the Medical Readiness (MR) Panel ensures resources are provided across the AFMS to create and maintain global response initiatives. The Readiness Training and Oversight Committee (RTOC), Exercise Oversight Committee (EOC), and Medical Readiness Decision Support System (MRDSS) Configuration Control Board (CCB) serve as sub-panels to the MR panel. Medical readiness resources are provided by Defense Health Programs (DHP) funding for operations and maintenance and LAF funding for War Reserve Materiel (WRM) and contingency response where CBRN aspects are present.

1.3.1. **Manpower and Equipment Force Packaging (MEFPAK) Resourcing.** To maintain the viability and effectiveness of its deployable medical capabilities, the AFMS has assigned MEFPAK responsibilities to MAJCOMs. Air Combat Command is the MEFPAK Responsible Agency (MRA) for medical ground-based unit type codes (UTCs) and MC-CBRN Allowance Standards; Air Mobility Command is the MRA for aeromedical evacuation and aeromedical enroute care support personnel and equipment UTCs; and, Air Force Special Operations Command is the MRA for special operations medical UTCs. PACAF and USAFE may maintain responsibility for theater-unique capabilities with Air Staff approval. Pilot units work closely with the MRAs to construct UTCs, associated mission capability statements (MISCAPs), and manpower details. MRAs request funding for the modernization and sustainment of their UTCs through both Line of the Air Force (LAF) and medical programming channels.

1.3.2. **Medical Counter-CBRN (MC-CBRN) Resources.** The AFMS utilizes LAF funds to provide critical capabilities to the Air Force in countering CBRN threats and the impact of CBRN attacks on

personnel and the mission. AF MTFs will maintain the capabilities described in this AFI organically within the medical organization, by establishing written mutual aid agreements (MAAs) with local medical and emergency response organizations, other MTFs in the local area or through a combination of these methods. MC-CBRN resources (also referred to as Home Station Medical Response, HSMR, in unrevised documents) are programmed at the AF/SG level, consolidating input from MAJCOMS and direct reporting units (DRUs), and advocating for MC-CBRN requirements through the AF Installation Support Panel.

1.3.3. **Unit Medical Operations Resourcing.** The unit Medical Readiness Staff Function (MRSF), or Executive Management Committee (EMC) for ARC units, identifies unit readiness training and resource requirements and provides a consolidated requirements document to their respective MAJCOM. For a full discussion of medical resource processes and procedures see AFI 41-120, *Medical Resource Operations.*

**1.4. Aeromedical Evacuation Guidance.** The AFMS partners with the Operations (A3) community to provide aeromedical evacuation capability for contingency and peacetime operations. The A3 staff provides comprehensive guidance for operational AE issues, while the AFMS is responsible for clinical guidance for AE medical crews and medical/training guidance for ground AE medical UTCs. Training, plans, and reporting requirements listed in this AFI for fixed medical facilities (medical units) do not apply to AE units except as noted.

**1.5. Global Medical Operations Plans and Reporting.** Realistic, comprehensive plans that describe responsibilities and procedures to perform the unit's mission are critical in building and maintaining highly effective medical response. Reporting systems, such as Status of Resources and Training System (SORTS), Defense Readiness Reporting System (DRRS) Enhanced Status of Resources and Training System (ESORTS), AEF Reporting Tool (ART), and the Medical Report for Emergencies, Disasters and Contingencies (MEDRED-C), provide planners at Combatant Commands, MAJCOMs, and the Air Staff valuable data with which to make planning and resourcing decisions relevant to myriad of AF taskings. Unit planning for global medical operations is discussed in **Chapter 4**, and medical readiness reports are discussed in **Chapter 8**.

**1.6. AEF Tempo Band Construct.** The AEF Tempo Band construct, also referred to as "Global AEF," was designed to accommodate high operations tempo and ongoing sustainment operations, while continuing to provide AF personnel a high level of deployment predictability and force stability.

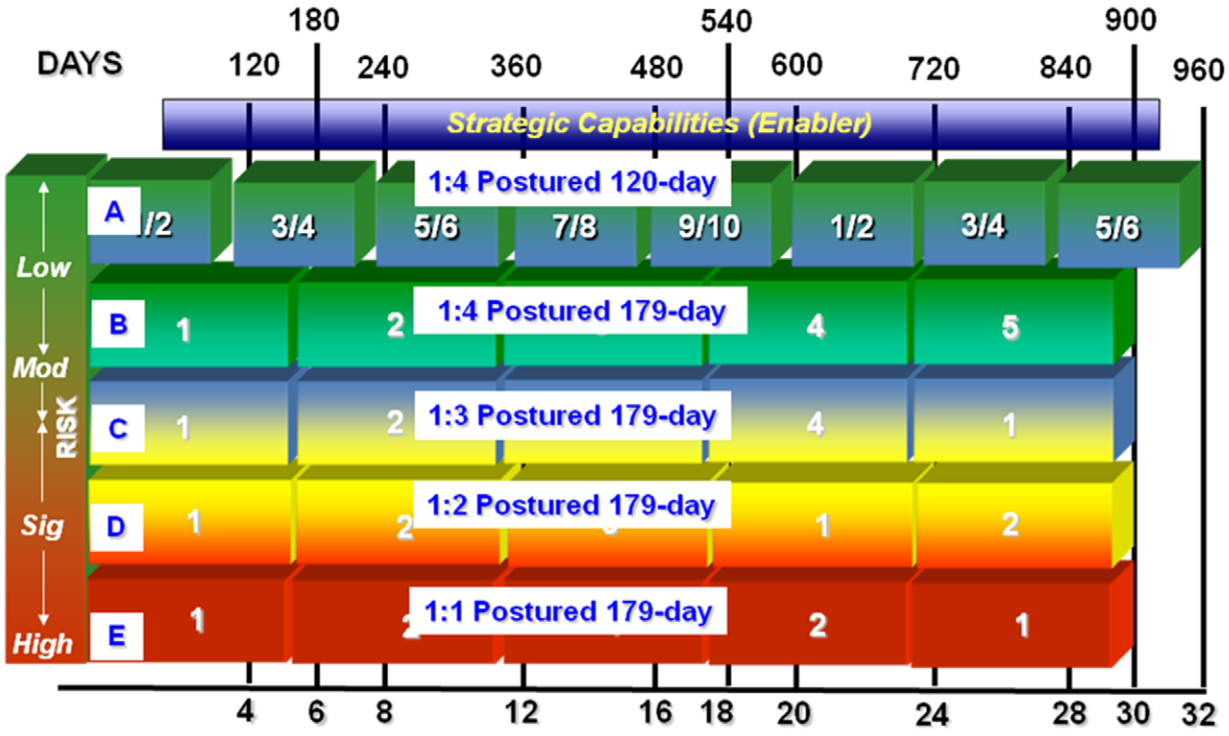
1.6.1. **Bands.** The AEF Tempo Band Construct modifies the current AEF construct by assigning the existing 20 month AEF cycle (five pairs of 4-month blocks) to Band "A" and adding six new AEF Tempo Bands, with four Tempo Bands supporting the active component (AC) and two Tempo Bands supporting the ARC. The four new AC Tempo Bands consist of five 6-month blocks (Band "B"), four 6-month blocks (Band "C"), three 6-month blocks (Band "D"), and two 6-month blocks (Band "E"). The two ARC mobilization Tempo Bands consist of nine 6-month blocks (Band "M") and eight 6-month blocks (Band "N") respectively. The blocks in Bands "M" and "N" are predicated on a 6-month employment period within a 9-month mobilization period. **Note:** At execution, mobilization periods may be other than 9 months.

1.6.2. **Deployment to Dwell Ratios.** The tempo bands represented deployment to dwell ratios, with Band A and B at a 1:4 ratio; Band C at 1:3; Band D at 1:2; and Band E at a 1:1 ratio, with risk increasing as the deployment to dwell ratio decreases. Additional guidance and information may be found in

AFI 10-401, *Air Force Operations Planning and Execution*. Figure 1.2. illustrates the AEF Tempo Bands concept.

1.6.3. **Aeromedical Evacuation.** Due to the nature of the AE system, all active duty AE unit-assigned forces are considered enablers. As such they are not included in the AEF Tempo Band construct.

**Figure 1.2. AEF Tempo Bands**



## Chapter 2

## ROLES AND RESPONSIBILITIES

**2.1. Purpose.** This chapter provides the responsibilities for Air Force Medical Readiness programs, including responsibilities at the Air Force, MAJCOM, installation and unit levels. It also provides responsibilities of supported and supporting organizations such as the Air Force Inspection Agency, Air Force Expeditionary Medical Skills Institute, and others.

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

2.1.1.1. Establish medical policy.

2.1.1.2. Advocate for, obtain and allocate resources for medical activities.

2.1.1.3. Continually evaluate AFMS ability to support the AF mission.

2.1.1.4. Establish and disseminate training and assessment policy.

2.1.1.5. Establish the Readiness Training Oversight Committee (RTOC) by charter to review AFMS medical readiness training programs to ensure such programs are adequately designed to fulfill defined medical readiness training requirements. The RTOC will also plan, coordinate and oversee medical exercise management and participation. Units with unique or extensive exercise proposals beyond the scope of unit funding may submit their proposals through their MAJCOMs to the RTOC for consideration.

2.1.1.6. DELETE

2.1.1.7. Establish the Medical Readiness Decision Support System (MRDSS) Configuration Control Board (CCB) by charter to manage ongoing development of MRDSS. The MRDSS CCB recommends approval or disapproval and prioritization of all proposed baseline hardware or software changes.

2.1.1.8. Through the respective MAJCOMs, designate Medical Treatment Facilities (MTFs) to operate as Laboratory Response Network (LRN) laboratories.

2.1.2. **The Assistant Surgeon General for Health Care Operations (HQ USAF/SG3).** This individual will:

2.1.2.1. Establish doctrine and policy to support medical readiness programs.

2.1.2.2. Advocate for, obtain and allocate resources for medical readiness activities, including training.

2.1.2.3. Recommend medical readiness strategies to the USAF/SG.

2.1.3. **Air Force Medical Support Agency/Medical Readiness Directorate (AFMSA/SGX).** This directorate will:

2.1.3.1. Support the development of medical readiness doctrine, policy, and programming. Provide daily oversight and accountability for medical readiness policy and processes.

2.1.3.2. Provide functional guidance and assistance to MAJCOMs on all aspects of medical readiness, to include policy decisions, procedures, and publications; deployment and operational infor-

mation and taskings; training development and opportunities; installation medical response guidance; and resource allocation, to include equipment funding.

2.1.3.3. Develop, publish and maintain this AFI in accordance with applicable directives and AF policy guidance.

2.1.3.3.1. Publish and maintain supplemental AFI 41- 106 guidance on the AFMSA/SGX Knowledge Exchange (Kx) website, to include training equivalency information, a consolidated list of UTC weapons requirements, sample training schedules, outlines and plans. The website is: **https://kx.afms.mil/sg3xp**.

2.1.3.3.2. Collect, track and evaluate AFI and supplemental guidance change requests submitted by the MAJCOMs, FOAs and DRUs. Publish changes as mission dictates.

2.1.3.4. Publish and maintain the Medical Resource Letter (MRL), identifying AFMS UTC apportionment.

2.1.3.5. Ensure Medical Readiness Decision Support System Unit Level Tracking and Reporting Application (MRDSS ULTRA) is maintained and funded, and continues to be enhanced as AFMS mission requirements evolve.

2.1.3.6. Establish a Medical Readiness (MR) Panel that will plan, program and budget for readiness resources.

2.1.3.7. Provide funding, management direction and oversight in support of War Reserve Materiel (WRM) Consolidated Storage and Deployment Center (CSDC) operations, IAW established Memorandums of Agreement (MOA).

2.1.3.8. Provide guidance and recommendations to AFMSA/SG3SL on procuring, storing, sustaining, reporting, and updating Medical Readiness program equipment and supplies.

2.1.3.9. Coordinate on proposed medical readiness program elements in the HSI Guide prior to publication.

2.1.3.10. Appoint a member of the AFMSA/SGX staff as the Program Element Manager (PEM) for the following Defense Health Program (DHP), Program Elements (PE): 87700 - Defense Medical Centers, Station Hospitals and Medical Centers – CONUS; 87714 - Other Health Activities; 87724 - Military Unique Requirements - Other Medical - Health Care; 87725 - Aeromedical Evacuation System - Health Care; 87900 - Defense Medical Centers, Station Hospitals and Medical Centers – OCONUS. The MR PEM is the primary advocate for medical readiness funding and supports the EOC, RTOC and MRDSS CCB.

2.1.3.11. Appoint a member of the AFMSA/SGX staff as the PEM for LAF PE 28036F, Medical Counter-CBRN (MC-CBRN) program. The MC-CBRN PEM is the primary advocate the Installation Support Panel on behalf of the AFMS for MC-CBRN program funding throughout all aspects of the AF Planning, Programming, Budgeting, and Execution System (PPBES) process.

2.1.4. **Air Force Medical Support Agency/Medical Modernization Directorate (AFMSA/SGR):** AFMSA/SGR oversees AF Medical Readiness program modernization requests and tracks Research, Development, Testing, and Evaluation (RDT&E) of AFMS initiated modernization requests.

2.1.5. **Medical Inspection Directorate, Air Force Inspection Agency (HQ AFIA/SG).** This agency will:

2.1.5.1. Assess medical unit capability to respond to the full spectrum of medical wartime and installation response missions.

2.1.5.2. Evaluate medical unit implementation of HQ USAF/SG and MAJCOM medical readiness policies and procedures.

2.1.5.3. Provide oversight and guidance to MAJCOMs that inspect using AFIA standards.

2.1.5.4. Coordinate MR- related inspection criteria with the OPR of this AFI prior to publication of AFIA inspection standards. Resolve disconnects or questions regarding the intent of guidance provided in this AFI in advance of publication of AFIA inspection standards.

2.1.6. **Air Force Expeditionary Medical Skills Institute (AFEMSI).** This agency will:

2.1.6.1. Administer/manage Centers for Sustainment of Trauma and Readiness Skills (C- STARS) operating locations to maximize efficiency and effectiveness.

2.1.6.1.1. Collaborate with similar Joint sustainment programs for benchmarking purposes.

2.1.6.1.2. Develop new C-STARS locations as required by AF/SG3 to meet first responder, trauma care, critical care, and aeromedical evacuation personnel training requirements.

2.1.6.2. Provide broad oversight of all AFSC- specific training through the Readiness Skills Verification Program (RSVP). Work with SG Consultants and Career Field Managers (CFM) to ensure individual readiness skills are valid and RSVP checklists are current, adding new initiatives as required.

2.1.6.3. Review/evaluate new advanced clinical sustainment programs, as directed.

2.1.6.4. Serve as a consultant/advisor to the AFMS on use of patient simulators and distance learning for development and sustainment of expeditionary clinical skills.

2.1.6.5. Serve as consultant/advisor to AFMS MTFs on the development of memorandums of understanding (MOUs) and training affiliation agreements to standardize training opportunities for medical-surgical services, medical support, or force enhancement personnel at local/civilian/Veterans Administration (VA)/Joint facilities.

2.1.6.6. Promote medical research, particularly with expeditionary impact, across the military/civilian spectrum.

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

2.1.7.1. Provide policy, guidance and assistance to all subordinate commands and medical unit commanders on all aspects of medical readiness.

2.1.7.1.1. Ensure that medical units are properly organized, trained, and equipped to carry out all aspects of their wartime and installation response missions IAW USAF War and Mobilization Plan, Vol 1 (USAF WMP 1) policy, Operation Plan (OPLAN) requirements and other applicable directives. For ARC units, this is additionally a gaining MAJCOM responsibility IAW AFI 10- 301, *Responsibilities of Air Reserve Component (ARC) Forces*.

2.1.7.1.2. Ensure each assigned medical unit's unit manning document (UMD) is postured to balance readiness, business case, and clinical currency requirements.

2.1.7.1.3. Provide supporting guidance to assist with the implementation of HQ USAF/SG policy on wartime and installation response operations, training, and assessment.

2.1.7.2. DELETE

2.1.7.3. Appoint a Public Health Officer (PHO) as the functional expert for Biological Warfare (BW) Disease Surveillance and Epidemiological response.

2.1.7.4. Appoint a Medical Corps officer with experience in preventive medicine and/or emergency response such as the assigned Chief of Aerospace Medicine (SGP) or Chief of Medical Services (SGH) as the MAJCOM Public Health Emergency Officer (PHEO). Reference AFI 10-2501, *Air Force Emergency Management (EM) Program Planning And Operations***,** AFI 10-2603, *Emergency Health Powers On Air Force Installations,* and AFI 10-2604, *Disease Containment Planning Guidance,* for additional policy direction.

2.1.7.5. Provide oversight to the MAJCOM/SGX office (or standing force headquarters equivalent) in the performance of the following tasks:

2.1.7.5.1. Assist medical readiness officers (MROs), medical readiness NCOs (MRNCOs), and civilian medical readiness managers (MRMs) in resolving issues with their units' readiness programs.

2.1.7.5.2. Ensure force health protection guidelines for each area of responsibility are available to subordinate units.

2.1.7.5.3. Review unit Medical Contingency Response Plans (MCRPs) prior to publication to ensure compliance with AF directives.

2.1.7.5.4. Review unit Medical Readiness Training and Exercise Plans (MRTEP) to ensure all individual, team, and leader training requirements are adequately addressed.

2.1.7.5.5. Collect and evaluate AFI and supplemental readiness guidance change requests from units and other subordinate organizations. Submit consolidated requests to AFMSA/SGX.

2.1.7.5.6. Manage the apportionment of MAJCOM UTCs in close coordination with AFMSA/SGX, utilizing the MRL in MRDSS.

2.1.7.5.7. Coordinate with MEFPAK responsible agencies (MRA) as necessary regarding input to UTC manning, equipment, and training requirements.

2.1.7.5.8. Review MRDSS data to identify personnel, training and equipment/supply trends, shortfalls and gaps. Refer to unit MRSF/EMC minutes to ensure the unit has identified requirements and established plans for resolution.

2.1.7.5.9. Identify MAJCOM MR program resource requirements for inclusion in the MAJCOM/SG POM and Execution Year budget submission. Additionally, notify the AF/SG MR Panel of MAJCOM MR program resource requirements, with the exception of formal Air Force Specialty Code (AFSC) awarding training.

2.1.7.5.9.1. Coordinate with other functional experts as required (Bioenvironmental Engineering, Public Health, Medical Logistics, CE, etc.) on MR resource requirements.

2.1.7.5.9.2. Advocate, in conjunction with the MAJCOM resource management office, to AFMSA/SGX and MAJCOM FM for resources associated with LAF funded MR programs.

2.1.7.5.10. Coordinate and submit consolidated SG and A3 exercise requirements to the RTOC. Provide representatives to the RTOC to provide MAJCOM input to training and exercise priorities and schedules, and ensure unit participation prior to AEF vulnerability periods.

2.1.7.5.11. Ensure war reserve materiel (WRM) assemblages required for Joint or RTOC-sanctioned exercises are requested using an exercise Time Phased Force Deployment List (TPFDL).

2.1.7.5.12. Coordinate ORI and other MAJCOM directed inspection activities with the MAJCOM inspection OPR.

2.1.7.5.13. Provide program oversight for MC-CBRN at the MAJCOM level.

2.1.7.5.14. Designate a MAJCOM/SGX representative to provide MRDSS ULTRA support to units. The MAJCOM MRDSS ULTRA representative will create MRDSS ULTRA Unit System Administrator user accounts, change passwords, review and drop/delete MRDSS ULTRA Unit System Administrators no longer requiring system access, and ensure positive control of sensitive information contained within MRDSS ULTRA. This individual will provide assistance and guidance to unit users with data entry, maintenance and reports, and contact the MRDSS Help Desk if technical assistance is required.

2.1.8. **MAJCOM Director of Operations (MAJCOM/A3).** In addition to responsibilities levied by 10-series AFIs and other directives, these individuals agree to:

2.1.8.1. Appoint aeromedical evacuation (AE) representatives to the RTOC for participation as directed by committee charter.

2.1.8.2. Coordinate with MAJCOM/SG to submit consolidated exercise requirements for AE to the RTOC.

2.1.8.3. Provide training and exercise priorities and schedules for AE to the RTOC and ensure unit participation.

2.1.9. **Manpower and Equipment Force Packaging (MEFPAK) Responsible Agencies.** MEFPAK Responsible Agencies (MRA) will comply with all MEFPAK requirements identified in AFI 10-401, *Air Force Operations Planning and Execution* and AFI 41-209*, Medical Logistics Support.* In addition, the MRAs will:

2.1.9.1. Appoint pilot units for each unit type code (UTC). These pilot units may be medical organizations outside the MRA with coordination of the gaining MAJCOM/SG.

2.1.9.2. Prepare a playbook for each UTC and installation response package aligned under the MRA. Incremental UTCs may be consolidated into a single playbook for each medical weapon system. This playbook will serve as a consolidated resource for all information regarding the UTC, to include personnel, equipment, mission capability, CONOPS or tactics, techniques and procedures (TTP), and individual UTC requirements for weapons, modernization, funding, other specific training, and mission essential task lists (METL). MRA playbooks will be posted as follows: ACC - **https://afkm.wpafb.af.mil/DocTax/Entry.aspx?Filter=MD-SG-00-15**; AMC -

https://afkm.wpafb.af.mil/DocTax/Entry.aspx?Filter=OO-LG-AM-50; AFSOC - https://afkm.wpafb.af.mil/DocTax/Entry.aspx?Filter=OO-SG-SO-02.

2.1.9.3. Each MRA Command Surgeon will prepare an annual status report on assigned UTCs. This report, prepared in a manner prescribed by the AF/SG should include current status of on-hand systems and personnel, modernization efforts and concerns, and is forwarded on a schedule established by the AF/SG.

2.1.9.4. Participate and support WRM Consolidated Storage and Deployment Center (CSDC) operations IAW established MOUs.

2.1.9.4.1. Verify CCDR requirements and task assets for deployment as necessary in coordination with the CSDC WRM managers and associated wing installation deployment officers. The Accountable Officer at the CSDC will be informed of any imminent deployment of assets from a CSDC.

2.1.9.4.2. Coordinate with AFMSA/SGX and AFMSA/SG3SL all requests to deploy a WRM UTC for training or exercise.

2.1.9.4.3. Coordinate requests to store and manage additional UTCs at CSDC locations with AFMSA/SG3SL.

2.1.9.4.4. Maintain control, oversight, configuration management, and tasking authority for WRM managed and maintained at the CSDCs.

2.1.9.4.5. Provide recommendations and input to the WRM spend plan process to ensure appropriate funding to support sustainment, reconstitution, and production requirements of consolidated WRM.

2.1.9.5. Develop training requirements for each UTC, force package or installation response capability, and identify funding requirements for training and exercises to the RTOC, EOC, and AFMSA/SGX as appropriate.

2.1.9.6. Plan and coordinate operational tests as necessary for the possible fielding of UTC, force package, or installation response equipment with pilot unit, other MAJCOMs, AFMSA/SGX, AFMSA/SGR, or operational test agencies, as appropriate. Identify procurement and sustainment lifecycle costs in coordination with AFMSA/SG3S and AFMSA/SGX.

2.1.9.7. Coordinate with appropriate joint training agencies, Air Force agencies, and MAJCOM/SG/A3 to ensure that AFMS and AE units participate in major training exercises, including Joint Chiefs of Staff (JCS) exercises, in accordance with AFMS policy.

2.1.10. **882nd Training Group (TRG) (AETC), Alpena Medical Readiness Training Site, and United States Air Force School of Aerospace Medicine (USAFSAM) (AFMC).** These organizations will:

2.1.10.1. Develop and conduct formal UTC courses. Include in these courses the training topics listed in **Attachment 7**.

2.1.10.2. Obtain approval of curriculum content for any formal medical readiness training course from the USAF/SG through the MRAs, RTOC, and the AF/SG3, with courtesy copy to HQ AETC/SGNU for technical training courses, prior to implementation.

2.1.11. **United States Air Force School of Aerospace Medicine (USAFSAM):** In addition to the responsibilities described in paragraph **2.1.10.** above, USAFSAM provides technical expertise and consultative reach back capability in the areas of bioenvironmental engineering, public health and epidemiology, clinical and environmental laboratory sciences, nuclear/radiological response and health physics support.

2.1.11.1. Manages the proficiency testing program for allowance standards requiring an advanced testing and monitoring program beyond initial training on equipment and supplies and provides monthly status reports, by unit/MAJCOM.

2.1.11.2. Monitors commercial off the shelf (COTS) equipment and supplies and provides recommendations to the pilot unit and MEFPAK on items that can be added to WRM and installation response packages.

2.1.12. **Air Force Personnel Center Medical Directorate (HQ AFPC/DPAM).** The Directorate of Personnel will:

2.1.12.1. Maintain published guidance outlining the process for submitting applications for Category I continuing medical education (CME) and other continuing education credit for medical readiness training courses.

2.1.12.2. Review and approve applications for Category I CME and continuing education credit when content meets the appropriate criteria.

2.1.13. **Medical Unit Commander.** The commander will:

2.1.13.1. Review UTCs apportioned to the unit in the medical resource letter (MRL) semiannually, or whenever there is a change, through MRDSS ULTRA, and document review in the next set of MRSF minutes.

2.1.13.2. In collaboration with MTF 3-letter functionals and senior enlisted functional managers, ensure qualified personnel are assigned to UTCs apportioned to the unit in the MRL and IAW AFI 10-401, *Air Force Operations Planning and Execution*, para. 11.18.2. Unit MRL Information - Current Year Taskings in the official approved MRL can be viewed in MRDSS ULTRA.

2.1.13.3. Ensure development and publication of a MCRP and provide medical input to base-level mission planning documents. AFRC medical and aeromedical evacuation (AE) units (active duty, AFRC and collocated ANG units) need not prepare the MCRP, but should be included as manpower resources in the MCRP of co-located active duty medical units. AE units should consult applicable operations guidance for local planning requirements.

2.1.13.4. Establish an effective medical readiness training program. Ensure assigned personnel meet mission training requirements and plan for deployment in accordance with AFI 10-401, paragraph 11.18.2, AFI 10-403 and this directive.

2.1.13.4.1. Direct the MR office to prepare a MRTEP annually and submit it to the Medical Readiness Staff Function (MRSF) for review and approval prior to the start of the next calendar year.

2.1.13.4.2. Ensure individuals, teams, and leaders assigned to their organization receive all training required to be mission ready in accordance with AF policy. Conduct training at the unit level when required.

2.1.13.4.3. Review and approve individual UTC Sustainment Training Equivalency Credit for Deployments or Exercises documentation, as appropriate. See paragraph **5.4.3.** for specific guidance. UTC Sustainment Training Equivalency for Deployments or Exercises matrices are located on the AFMSA/SGX Knowledge Exchange website at: **https://kx.afms.mil/sg3xp**.

2.1.13.5. Provide an assessment of the unit's readiness to perform its tasked missions, as applicable, in ART and DRRS ESORTS, upon implementation. Report unit readiness status in SORTS, as required.

2.1.13.6. Ensure AFRC unit capabilities (i.e. number of personnel by AFSC, UTCs available, etc.) is included in the collocated active duty unit MCRP. All AFRC units will document their wartime missions in the parent wing mobilization plan.

2.1.13.7. Chair the MRSF for Active Component (AC) or Executive Management Committee (EMC) for ARC. Approve agenda and meeting minutes. Ensure required attendance and determine additional participants.

2.1.13.7.1. Identify training and exercise funding requirements to wing commander and parent MAJCOM/SG (A3 for aeromedical evacuation (AE) units). Requirements for ARC units will be routed through appropriate Numbered Air Forces (NAFs).

Requirements for ARC units will be routed through appropriate Numbered Air Forces (NAFs).

2.1.13.7.2. Approve or disapprove individual requests for RSVP training credit for deployments or exercises, based on AFSC functional training managers' recommendation.

2.1.13.8. Appoint, in writing, a primary and alternate for each position below:

2.1.13.8.1. MRO, MRNCO, and/or MRM, as appropriate. See paragraph **2.1.14.** for additional guidance.

2.1.13.8.2. Unit Medical Readiness Training Manager. See paragraph **3.2.4.** for additional guidance.

2.1.13.8.3. AFSC Functional Training Manager for each assigned AFSC. See paragraph **2.1.20.** for additional guidance.

2.1.13.8.4. Public Health Emergency Officer (PHEO) (not applicable to AE units), IAW AFI 10- 2603. See paragraph **2.1.17.** for additional guidance.

2.1.13.8.5. Team Chiefs. See **2.1.19.** for additional guidance.

2.1.13.8.6. Medical Exercise Evaluation Team (EET) Chief and team members IAW local requirements. Select sufficient members to evaluate the full scope of unit medical operations. Members should serve for a minimum of one year. See paragraph **2.1.18.** for additional guidance.

2.1.13.8.7. Unit Reports Monitors, including unit SORTS monitor, ESORTS (when implemented) monitor, and ART monitor. See paragraph **3.2.3.** for additional guidance.

2.1.13.8.8. MRDSS ULTRA Unit System Administrator. See paragraph **3.2.5.** for additional guidance.

2.1.13.8.9. Medical representatives to the Installation Emergency Operations Center (EOC).

2.1.13.8.10. Unit Deployment Manager. See paragraph **3.2.1.** for additional guidance.

2.1.13.8.11. Unit Plans Officer/NCO. See paragraph **3.2.2.** for additional guidance.

2.1.13.8.12. WRM Project Officer. See AFI 41-209, Chapter 13 for additional guidance.

2.1.13.8.13. DELETE

2.1.13.8.14. PHO. See paragraph **2.1.15.** for additional guidance

2.1.13.8.15. For AFRC, an Education and Training office of responsibility.

2.1.13.9. Ensure a process is in place to verify predeployment medical screening and immunization requirements for all deploying forces (medical and non- medical) are identified and completed. This includes, but is not limited to, preventive health assessments (PHA), DNA sampling, HIV testing, tuberculin skin testing, and medical/dental screening.

2.1.13.10. Establish, evaluate and maintain the capability to provide and/or arrange for emergency care and transport of casualties resulting from medical contingencies consistent with the unit's mission taskings.

2.1.13.11. Establish home station capabilities IAW AF Tactics, Techniques, and Procedures (AFTTP), 3- 42.32, *Home Station Medical Response To Chemical, Biological, Radiological, Nuclear (CBRN) Events* and local requirements (not applicable to AE or AFRC medical units).

2.1.13.12. Approve medical emergency management support agreements with agencies on and/or off- base, military and/or civilian, as appropriate, in order to fully execute all installation plans, to include the MCRP. Ensure coordination of agreements through Base Legal Office, Wing Plans Office, and annual review by the MRSF.

2.1.13.13. Establish, organize, and maintain the Medical Control Center (MCC) as an operational location and team.

2.1.13.14. Ensure medical unit participation in development of the In-Garrison Expeditionary Site Plan (IGESP) and the Comprehensive Emergency Management Plan (CEMP) 10-2. See AFI 10-404, *Base Support and Expeditionary Site Planning, Attachment 17* and AFI 10-2501, *Air Force Emergency Management Program Planning and Operations* for additional information (not applicable to AFRC medical units).

2.1.13.15. Ensure the unit readiness planning process is linked to the MTF Business plan, maximizing effectiveness and optimization of resources for both the clinical mission and expeditionary/training requirements.

2.1.13.16. Manage and sustain critical capabilities to respond to contingencies with CBRN aspects by training, exercising, equipping, and budgeting to establish the following capabilities: AF MTFs will maintain the CBRN capabilities described in this AFI organically within the medical organization, by establishing written mutual aid agreements (MAAs) with other organizations in the local area, or through a combination of these methods.

2.1.13.16.1. Decontaminate patients prior to entry into a MTF. Each MTF, will maintain an in-place patient decontamination capability either organically, through MAAs with other organizations (fire department, for example), or a combination of both. At the beginning of an emerging incident, CBRN contamination screening of patients/casualties from an incident should be initiated to protect the medical capabilities of the medical facility and its staff. The

MTF may utilize the AFMS in-place patient decontamination (IPPD) or a fixed facility engineered decontamination capability. (Not applicable to AFRC medical units.)

2.1.13.16.2. Triage, stabilize, transport, and track casualties, to include behavioral casualties. To adequately treat patients in the event of a contingency with CBRN aspects, which may overwhelm local medical facilities, installations must plan for the capability to provide treatment for 300 casualties for 24 hours. Planning will include a collaborative community, or unified, response and necessary support from other military or civilian agencies through the use of MOU/MOA/MAA, as appropriate. (Not applicable to AFRC medical units.)

2.1.13.16.3. Conduct mass prophylaxis (vaccination, medications, etc.) based on credible threat or event, as directed by the installation commander or higher authority. Establish procedures to access the Strategic National Stockpile (SNS) and a plan to receive and distribute prophylaxis IAW Department of Health and Human Services (DHHS) and Department of Defense (DOD) Interagency Agreement of 5 May 2005, AFI 10-2603 and AFI 10-2604. NOTE: Installations outside the United States and its territories will coordinate through their respective MAJCOM/authority to determine an appropriate mass prophylaxis strategy. (Not applicable to AFRC medical units.)

2.1.13.16.4. Conduct threat-based health risk assessments to include CBRN sampling, testing, dose estimation and medical countermeasures. Conduct threat characterization and assessment to assist organizational commanders and incident commanders in operational risk management decision-making

2.1.13.16.5. Ensure the medical laboratory, if certified under the DOD Center for Clinical Laboratory Medicine (CCLM), participates in Centers for Disease Control (CDC) Laboratory Response Network (LRN) as a Basic Sentinel site. Those laboratories registered to perform high-complexity microbiology testing will serve as Advanced Sentinel sites and will be capable of ruling out the presence of *Bacillus anthracis, Brucella abortus, Fransciella tularensis, and Yersinia pestis* in clinical specimens adhering to CDC protocols.

2.1.13.16.6. Each MTF with the MC-CBRN Laboratory Response Team (LRT) capability must support environmental testing locally or have pre-existing formal agreements with other military or public health laboratories and ensure the medical laboratory has the ability to properly collect and ship clinical specimens for analysis.

2.1.14. **Medical Unit MRO, MRNCO, and MRM** (henceforth called the MR office unless a paragraph addresses one specifically). These individuals will:

2.1.14.1. Schedule and coordinate agenda for MRSF/EMC meetings IAW this AFI. ARC MRO/NCO will ensure required material is provided to the EMC at least quarterly.

2.1.14.2. Coordinate and publish the MCRP according to requirements outlined in **Chapter 4**. Provide medical input to other applicable base level plans.

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

2.1.14.4. Develop and coordinate medical readiness MOAs or Memorandums of Understanding (MOU) with the appropriate non- federal, civilian and DOD/Federal off-base agencies.

2.1.14.5. Develop a MRTEP IAW requirements outlined in **Chapter 4**. Include identification of training needs and frequency/type of exercises. Include unit developed readiness training programs under local purview.

2.1.14.6. Coordinate and schedule UTC- specific training for those personnel assigned to UTCs that have formal UTC training courses.

2.1.14.7. Collect UTC sustainment training equivalency credit for deployments or exercises documentation from individuals returning from a deployment or exercise and present them to the unit commander (via the MRSF/EMC) for review and approval. If approved, the deployment or exercise return date will be the new training completion date for the associated training requirements. UTC sustainment training equivalency credit for deployments or exercises matrices are located on the AFMSA/SGX Kx at: **https://kx.afms.mil/sg3xp**

2.1.14.8. Ensure medical readiness training is properly documented in MRDSS ULTRA.

2.1.14.9. Provide oversight and assist MCRP team chiefs in the management, training, planning and staffing functions of their teams.

2.1.14.10. Conduct all medical operational readiness reporting IAW AFI 10-201, *Status of Resources and Training System (SORTS)*, AFI 10-206, *Operational Reporting*, and AFI 10-244, *Reporting Status Of Aerospace Expeditionary Forces*.

2.1.14.11. Monitor the status of WRM and installation response assemblages through MRDSS ULTRA and obtain data from medical logistics staff, as necessary, to brief the unit commander and the MRSF/EMC.

2.1.14.12. Provide oversight for the MC-CBRN Program at the base level. See paragraph **3.3.11.** for additional guidance.

2.1.14.13. Identify unit MR program resource requirements for inclusion in the unit POM and Execution Year budget submission. Coordinate with other functional experts as required (BEE, PH, Medical Logistics, CE, etc.) on MR resource requirements.

2.1.14.14. Advocate, in conjunction with the resource management office, to the MAJCOM/SGX and installation FM for resources associated with LAF funded installation response programs.

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

2.1.14.16. Send copies of necessary documents/plans to the parent MAJCOM (at a minimum, the unit MRTEP, MCRP, and MRSF/EMC minutes).

2.1.14.17. Ensure all MR- related appointment letters are current, updated, and maintained as required.

2.1.14.18. Work with the EET Chief to design exercises that meet annual objectives.

2.1.14.19. Ensure the MRSF/EMC documents and tracks exercise discrepancies to resolution.

2.1.15. **Public Health Officer (PHO) (43HX)/Public Health NCO (PHNCO) (4E0XX) (not applicable to AE units).** This individual will:

2.1.15.1. Perform medical intelligence functions. For units without a PHO/PHNCO, contact the Command PHO for guidance. ***NOTE***: ARC units tasked with the Aerospace Medicine Function (FFDAF, FFDAG, FFDCC, FFDCD, and FFABC UTCs for AFRC and UTC FFGK1 for ANG) will be responsible for this duty. Provide a medical intelligence briefing to the MRSF upon request of the commander or receipt of a new deployment tasking. This briefing will include assessment of local threats, threats to potential deployment sites, current information on vaccines and antidotes, possible disease surveillance trends, and in coordination with the CBRN Medical Defense Officer/NCO (MDO), the capabilities to identify CBRN threats and the limitations to protective measures, if any. Utilize appropriate procedures for briefing and controlling classified information.

2.1.15.2. Attend Contingency Preventive Medicine (CPM) Course, #B3OZYCONOP-000, if not previously attended. Attend the Introduction to Medical Intelligence Course located at Armed Forces Medical Intelligence Center (AFMIC), Ft. Detrick, MD. The Public Health Apprentice, Officer, or AFMIC course may be attended in lieu of the CPM Course for ARC personnel performing medical intelligence functions.

2.1.15.3. In support of wing deployment operations, work with Line intelligence personnel and parent MAJCOM/SGPM personnel, to obtain a medical intelligence assessment to include disease risks, environmental health hazards, host nation medical capabilities/facilities, cultural- specific health issues unique to the host nation population, host nation CBRN warfare medical defense capabilities. Use all medical intelligence sources available to prepare the medical threat assessments at deployment locations. Use this data to provide medical intelligence briefings to all wing deploying forces during base deployment processing. During the post-deployment phase, provide input to the after-action report (AAR).

2.1.15.4. Collaborate with the PHEO regarding PH activities that identify and mitigate the consequences of a CBRN incident. Ensure medical surveillance, conducted IAW 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance*, includes baseline health surveillance to assist in detecting a CBRN event.

2.1.15.5. Collaborate with local off-base public health officials on CBRN threat response and epidemiological investigations.

2.1.15.6. Perform food vulnerability assessments to support planning and recommended corrective actions in anticipation of, and in response to, a CBRN event. Perform initial testing of foods suspected of deliberate bacterial contamination and collaborate with Office of Special Investigation (OSI), Security Forces Squadron (SFS), Laboratory Response Team (LRT) and PHEO to determine an appropriate course of action

2.1.15.7. Conduct medical surveillance and epidemiological investigations of the installation population and beneficiaries for sentinel events, diseases and adverse health effects due to CBRN events. (Not applicable to AFRC medical units.)

2.1.15.8. Conduct MC-CBRN risk communication to provide pre-, trans- and post-CBRN event health risk information to wing personnel and their families. Transmit, through the wing Public Affairs office, all risk communication information, intended for public release.

2.1.15.9. Provide medical intelligence, food vulnerability assessments, site assessments, and health risk assessment (HRA) information to the installation Threat Working Group and/or the Force Protection Working Group, as necessary.

2.1.16. **Bioenvironmental Engineer (BEE) (043E3) or a BEE Technician (4B071) (not applicable to AE units).** This individual will:

2.1.16.1. Provide hazard identification, evaluation, and control capabilities, and execute health risk assessment to recommend appropriate course of action to commanders pre-, trans-, and post-incident. Additionally, collaborates with public health personnel to conduct MC-CBRN risk communication to wing personnel and their families during all stages of the incident. Reference AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations* and AFI 10-2603, *Emergency Health Powers on Air Force Installations* for additional guidance.

2.1.16.2. Serve as a functional advisor to the MR office for planning, training, and execution of the unit installation contingency response program.

2.1.16.3. Attend the Medical Nuclear, Biological and Chemical (MNBC) Operations Course, #B3AZY4B0X1- 017, if not previously attended. Attendance priority is given to those personnel assigned as primary members to the FFGL1 UTC. BEEs who have graduated from the Bioenvironmental Engineering Officer Course (Full Course), #B3OBY43E1-015, or Bioenvironmental Engineering Officer Course (Increment 4), # B3OBY43E1-019, from January 2004 and later are already awarded credit for the MNBC course.

2.1.16.4. Serve as the medical unit POC to the installation Force Protection Working Group and Vulnerability Assessment Teams. The PHO and PHEO are additional POCs.

2.1.16.5. Conduct an annual assessment of local industrial facilities (on and off base) that may be of consequence to base operations if toxic industrial chemical/toxic industrial materials are released and report results to MRSF and Wing Force Protection Working Group. Provide the PHEO threat assessment information necessary for planning the clinical response to CBRN event. (Not applicable to AFRC units) Ensure classification of appropriate data where required. Utilize appropriate procedures for briefing and controlling classified information.

2.1.16.6. Evaluate CBRN aspects of the unit MCRP, the CEMP, and applicable MOUs/MOAs with local health care facilities (not applicable to AFRC units).

2.1.16.7. Provide subject matter expertise to medical and installation commanders and on CBRN effects, health-based risk assessment and operations in CBRN environments (not applicable to AE units.)

2.1.16.8. Ensure BE personnel are enrolled in the Respiratory Protection Program, participate in proficiency analytical testing for CBRN agents, and are trained on detection and response equipment.

2.1.16.9. Interact with OSI, Security Forces, and the installation Anti-Terrorism Officer (ATO) to ensure evidence is properly preserved and protected, and chain of custody requirements are met.

2.1.16.10. In a pre-attack posture, evaluate and advise on effectiveness of collective protection and appropriate MOPP posture in collaboration with base CE Readiness.

2.1.16.11. Advise the Incident Commander, as defined in AFI 10-2501, on the need for sheltering-in-place or evacuation of contaminated areas.

2.1.16.12. Implement water vulnerability assessment program IAW federal, state and local regulations and AFI 10-246. Review the Water Vulnerability assessment every year for currency and update assessment as needed."

2.1.17. **Public Health Emergency Officer (PHEO) (not applicable to AE units).** This individual will:

2.1.17.1. Assist the BEE with the assessment of the clinical capability and the impact of a CBRN threat, recommend appropriate actions to protect forces, and serve as the medical POC for the treatment portions of the MCRP Annex N.

2.1.17.2. Complete the Medical Management of Chemical and Biological Casualties (MMCBC) Course and CBRN Emergency Medical Preparedness and Response Course (EMPRC) Clinical Course prior to being appointed as the PHEO. For ARC, the PHEO may complete the training post-appointment and the MMCBC course at **http: ccc.apgea.army.mil** is recommended but not required.

2.1.17.3. Complete the Air Force Emergency Response Operations (ERO) Course (#ZZ133007) available under Emergency Management through Advanced Distributed Learning Service (ADLS) through the AF Portal within 90 days of appointment. Complete the Federal Emergency Management Agency (FEMA) Course IS-100.HC, *Introduction to the Incident Command System for Healthcare/Hospitals,* within 90 days of appointment. The ERO Course replaces the requirement for individually completing the FEMA Independent Study courses IS-100, 700, and 800. For ARC PHEOs, both in-residence and distance learning training requirements must be completed within one year of appointment as the PHEO. In addition, the following courses are recommended for AFRC PHEOs:

2.1.17.3.1. FEMA Course IS 100, Introduction to Incident Command System, **http://training.fema.gov/IS/crslist.asp**.

2.1.17.3.2. Hospital Management of CBRNE Incidents Course (HM-CBRNE), **http://ccc.apgea.army.mil**.

2.1.17.3.3. Terrorism, Preparedness and Public Health: An Introduction, **http://ualbanycphp.org/learning/**.

2.1.17.3.4. Epidemiology and Prevention of Vaccine-Preventable Disease, **http://www2a.cdc.gov/TCEOnline/**.

2.1.17.3.5. FEMA Course IS 700 National Incident Management System, An Introduction, **http://training.fema.gov/IS/crslist.asp**.

2.1.17.3.6. FEMA Course IS 800.B National Response Framework, An Introduction **http://training.fema.gov/IS/crslist.asp**.

2.1.17.4. In coordination with Public Health, ensure a process is in place to conduct daily medical surveillance to provide early detection of unusual disease trends that may suggest a suspected or confirmed CBRN attack.

2.1.17.5. Reference AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations* and AFI 10-2603, *Emergency Health Powers on Air Force Installations* and AFI-2604, *Disease Containment Planning Guidance,* for additional guidance, duties and responsibilities. AFRC PHEOs should have the following handbooks readily available for the home station medical response teams:

2.1.17.5.1. Medical Management of Biological Casualties Handbook, **http://www.usamriid.army.mil/education/instruct.htm**.

2.1.17.5.2. Defense Against Toxins Weapons Manual, **http://www.usamriid.army.mil/education/defensetox.htm**.

2.1.17.5.3. Medical Management of Chemical Casualties Handbook, **http://ccc.apgea.army.mil/products/info/products.htm**.

2.1.17.5.4. Medical Management of Radiological Casualties Handbook, **http://www.afrri.usuhs.mil/www/outreach/mmoresources.htm#MedManageHandbook** or the JANES Equivalent Books

2.1.17.5.5. Textbook of Military Medicine: Medical Aspects of Chemical & Biological Warfare, **https://ccc.apgea.army.mil/products/info/products.htm**.

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

2.1.18.1. Serve in the position for a minimum of 12 consecutive months. EET members will also serve for a minimum of 12 months.

2.1.18.2. Train medical EET members to assist in the evaluation of medical response during unit and wing exercises. Identify sufficient members to evaluate the full scope of unit medical operations.

2.1.18.3. Attend wing EET training as required by the wing plans and programs office.

2.1.18.4. Coordinate exercise goals and objectives with the MRO/MRNCO.

2.1.18.5. Develop medical portions of exercise scenarios that fully test medical response capability.

2.1.18.6. Direct medical portions of exercises according to the exercise schedule of events.

2.1.18.7. Evaluate medical aspects of exercises using established criteria, as appropriate.

2.1.18.8. Provide feedback to the MR office for inclusion in the medical unit Post- Incident/Exercise Summary.

2.1.18.9. IAW wing directives and time requirements, provide the medical unit commander and wing commander an exercise outcome report.

2.1.18.10. Brief Post-Incident/Exercise Summaries (PIES) and exercise results to the Medical Readiness Staff Function (MRSF) at the next meeting following the exercise.

2.1.19. **Team Chiefs.** This paragraph refers to UTC team chiefs, MCRP team chiefs, and Force Package team chiefs (such as EMEDS commanders or CASF commanders). Units are not expected to develop separate teams for MCRP and MC-CBRN operations. Therefore, unit MCRP teams must plan for all installation contingency response scenarios, including MC-CBRN operations. Team chiefs will:

2.1.19.1. Ensure team members receive all training required to be mission ready in accordance with AF policy and maintain proficiency standards. Conduct team training, when required. Establish a mechanism to identify individuals who require make-up training and ensure make-up training is conducted within the timeframe established by the unit commander. MCRP Team Chiefs are given MRDSS ULTRA accounts by the MRDSS ULTRA Unit System Administrator and will document/update team training for their team personnel in MRDSS ULTRA.

2.1.19.2. Report the status of team capabilities to the MRSF/EMC in accordance with unit requirements, but at least every other meeting. Included in this report should be the status of team training (using MRDSS ULTRA data), equipment/supplies, and exercise requirements, and an overall assessment of the team readiness to respond.

2.1.19.3. Maintain training and response resources and materials.

2.1.19.4. MCRP team chiefs will prepare MCRP checklists and procedures for responding to installation contingencies utilizing both DHP funded equipment and supplies, and LAF funded CBRN equipment and supplies (MC-CBRN allowance standards).

2.1.19.5. Ensure personnel assigned to the Laboratory Response Team (LRT), Immediate Medical Response (IMR), IPPD, and Threat Agent Surveillance (BE) Teams that are required to wear respiratory protection are enrolled in the Respiratory Protection Program and participate in proficiency testing for equipment listed on their respective MC-CBRN allowance standards.

2.1.19.6. MCRP team chiefs will identify team equipment and supplies requirements for inclusion in planning, programming, and budgetary submissions. For team equipment and supplies, develop a list to assess ongoing levels, and conduct an annual inventory. Ensure MC-CBRN allowance standards are operationally maintained IAW AFI 41-209, Chapter 14. Inventory team equipment and supplies after they are utilized for exercises or real world events.

2.1.19.7. Team chiefs of UTCs possessing WRM assemblages/equipment will annually set up, inventory, and exercise the assemblage(s). When the base is host to AFRC with similar UTCs, team chief will ensure that the tenant AFRC UTCs are given the opportunity to train with the host unit UTCs.

2.1.19.8. The Decontamination Team Chief and NCOIC will attend the Contingency/ Counter-Terrorism Casualty Decontamination Course, #B3AZYDECON-000, provided by the USAF School of Aerospace Medicine within six months of assignment.

2.1.20. **Unit AFSC Functional Training Managers.** These individuals will:

2.1.20.1. Develop, in coordination with the MR OFFICE, an AFSC functional binder containing the following information:

2.1.20.1.1. Appointment letter

2.1.20.1.2. Gap analysis (see para. **2.1.20.2.** below)

2.1.20.1.3. Make-up training policy

2.1.20.1.4. Lesson plans or reference to training materials maintained electronically

2.1.20.1.5. A copy of the unit MRTEP

2.1.20.2. Review pertinent RSVP checklists and identify AFSC training requirements. Conduct or oversee RSVP training, as appropriate, ensuring make-up training is conducted within 120 days for individuals who miss scheduled training events. Perform a gap analysis annually, or each time the RSVP checklist is updated, to determine which training is satisfied during daily practice; which tasks require special training events; and which cannot be accomplished at the unit level. Recommend training gap solutions to MRSF/EMC and document in the minutes.

2.1.20.2.1. Validate RSVP training that is accomplished during deployments, exercises or as part of upgrade training, and present recommendations to the unit commander. Update training

dates in MRDSS ULTRA. For training accomplished during deployments or exercises, utilize the deployment return or exercise termination date as the training completion date. If RSVP training credit is not granted for the deployment, conduct make-up training within 120 days.

2.1.20.2.2. Provide a comprehensive report on the status of RSVP training to the MRSF/EMC in accordance with unit requirements, but at least quarterly. The report format will be determined by the MRSF/EMC and will include a gap analysis of training elements which could not be met within unit capabilities/resources.

2.1.20.2.3. Coordinate with the MR office and /or Education and Training Office to determine an appropriate methodology and timeline for completion of all RSVP skills which require special training events.

2.1.20.2.4. Develop strategies, to include local training affiliation agreements or temporary duty (TDY) training, to fulfill training requirements that cannot be accomplished at the unit level. If unable to identify workable options, elevate requirement to MAJCOM/SGX for action. Actions and issues related to training outside the unit should be documented in MRSF/EMC minutes.

2.1.20.3. Obtain an MRDSS ULTRA account from the MRDSS ULTRA Unit System Administrator.

2.1.20.3.1. Maintain documentation on all AFSC-specific RSVP training in MRDSS ULTRA. Document currency by updating training data in MRDSS ULTRA within 48 hours of training completion or as soon as possible as mission allows.

2.1.20.3.2. Contact the MRDSS ULTRA Unit System Administrator for assistance with login, password updates, and system access.

2.1.20.4. Review personnel On-the-job training (OJT) records and independent duty medical technician (IDMT) folders, if applicable, prior to each deployment to ensure all required training has been completed and properly documented.

2.1.21. **First level supervisors.** These individuals will:

2.1.21.1. Schedule personnel and office activities to fully support all readiness requirements.

2.1.21.2. Ensure subordinates' ongoing competence in individual skills required by their UTC and MCRP team assignments and/or AFSC. Provide training to correct shortfalls at first opportunity.

2.1.21.3. Document training in MRDSS ULTRA and/or appropriate individual training record, as required. Contact the parent MAJCOM MRDSS ULTRA representative for guidance and assistance with managing, updating and using MRDSS ULTRA. Contact the MRDSS ULTRA Unit System Administrator for assistance with login, password updates, and system access.

**2.2. Additional Roles and Responsibilities.** This chapter captures most roles and responsibilities associated with the medical readiness programs addressed in this AFI. Additional responsibilities not mentioned here may be levied by other publications or directives.

## Chapter 3

## MEDICAL READINESS PROGRAM MANAGEMENT

**3.1. The Medical Readiness Office.** The MR office is the hub of readiness activities at the unit level. Personnel assigned to this office manage programs spanning the full range of global medical operations activities. To meet program requirements, there must be a minimum of two full- time personnel assigned to the MR office. Two primary positions in the MR office are the Medical Readiness Officer (MRO) and the Medical Readiness NCO (MRNCO). Depending on the size of the facility and the medical readiness program, the MRO may be appointed on a part- time basis. In this instance, a second enlisted member must be assigned to meet the two- person minimum staffing requirement. Other individuals should be added to the medical readiness staff as appropriate. A DOD civilian Medical Readiness Manager (MRM) may fill either the MRO or MRNCO position in a full-time capacity. (For AFRC, full-time refers to traditional reservists whose duties, in addition to their UTCs, are those of MRO and MRNCO with no other additional duties.)

3.1.1. **Tenure.** The MRO, MRNCO and MRM (if employed) must serve in their positions for a minimum of 24 months (not applicable to the ANG).

3.1.2. **Training.** Attend J3OZR4XXX- 00BC, Medical Readiness Planners' Course (MRPC) before or within six months of assignment to MRO/MRNCO/MRM duties. (Not applicable to the ANG).

**3.2. MR Roles Appointed in Writing.** MR office personnel must perform a variety of roles and functions. The following positions must be appointed by unit commander in writing:

3.2.1. **Unit Deployment Manager (UDM).** UDMs have primary responsibility for matching personnel to UTC positions and ensuring those personnel are trained and equipped to accomplish the missions of the UTCs to which they are assigned. Specific duties include:

3.2.1.1. Identify personnel to fill UTC positions, in coordination with the unit AFSC functional manager, using the Control AFSC (CAFSC) for enlisted personnel and Duty AFSC (DAFSC) for officers. Ensure the best AFSC and grade skill level match IAW AFI 10- 403, *Deployment Planning*; the UTC Mission Capability Statements (MISCAPs) (available in MRDSS ULTRA); the Medical Supplement to the AF War Mobilization Plan 1 (WMP 1), Enclosure G, Substitutions Policy and Guidelines, available on the AFMSA/SGX Knowledge Exchange at: **https://kx.afms.mil/sg3xp**; any other applicable supplemental processing guidance or reporting instructions. Assign personnel to UTCs using MRDSS ULTRA and enter and track deployment preparedness information.

3.2.1.2. Review monthly Duty Status reports prior to assigning personnel to UTC positions. These reports are available from the Commander's Support Staff (CSS). Before selecting individuals to deploy, UDMs and unit commanders must verify individual duty status and deployment availability (DAV) codes to verify that the individual is present for duty or can be recalled from TDY, and that there are no discriminating legal, security, medical, or administrative factors that may render a member ineligible to deploy.

3.2.1.3. Print out AF IMT 4005 from MRDSS ULTRA and prepare individual deployment folders for all personnel IAW Installation Deployment Plan.

3.2.1.4. Download and print an RSVP checklist for each deployer. Deploying individuals will track tasks performed during deployment and obtain the deployed unit commander's signature to request RSVP credit upon return to homestation (see para. **5.4.** for additional guidance).

3.2.1.5. Coordinate and manage medical deployment activities, to include deployers and deployment processing support teams.

3.2.1.5.1. Upon notification of a potential deployment, enter tasked members' anticipated deployment date and estimated tour length in MRDSS ULTRA. Update the data as necessary if the individual ultimately deploys on a different date or does not deploy.

3.2.1.5.2. Develop and maintain recall rosters for UTC personnel and MTF deployment processing support teams. The MRDSS ULTRA recall roster administration function may be used for this purpose. Develop procedures for recalling these key personnel during deployment activities and incorporate them into the MCRP.

3.2.1.5.3. Coordinate personnel predeployment processing activities, to include processing lines, notification of AFSC Functional Training Managers to ensure training certification, deployment folder reviews, personal deployment bag inventories, immunization reviews, country clearance requests, and passport verification.

3.2.1.5.4. Ensure personnel, mobility bags, weapons, and WRM requirements and timelines are met IAW the installation deployment plan.

3.2.1.6. Prepare and transmit deployment messages, including MEDRED-C part A, IAW AFI 10-206, *Operational Reporting*.

3.2.1.7. Individuals will report to the UDM upon return from deployment and provide documentation of training accomplished during the deployment. The UDM will:

3.2.1.7.1. Update MRDSS ULTRA to reflect that the individual has returned from deployment. Notify the appropriate AFSC functional training manager and MCRP team chief of the need to assess for make- up training. AFSC functional training managers will ensure make- up training is conducted within 120 days of return from deployment, if required.

3.2.1.7.2. Forward requests for RSVP deployment training credit to appropriate AFSC functional training manager for review and recommendations.

3.2.1.8. Contact the parent MAJCOM MRDSS ULTRA representative for guidance and assistance with managing, updating and using MRDSS ULTRA. Contact the MRDSS ULTRA Unit System Administrator for assistance with login, password updates, and system access.

3.2.1.9. Upon notification of a deployment tasking, review all line remarks, coordinate with the IDO, PRU, and Unit Medical Readiness Training Manager to schedule personnel to complete required training. Although minimum frequency for medical readiness training has been identified in **Attachment 3**, specific training events may occur more frequently for some personnel to ensure all required initial, sustainment, and recurring training remains current for the duration of the deployment.

3.2.2. **Unit Plans Officer/NCO.** Unit level planners assess the medical unit's capabilities to support wartime, humanitarian assistance, and installation response requirements. See **Chapter 4** for specific planning responsibilities, including publication of plans and coordination of memorandums of agreement (MOAs) and memorandums of understanding (MOUs). Response capabilities and procedures

are developed and implemented through publication of the MCRP and input to wing plans. Specific plans utilized and supported include but are not limited to:

3.2.2.1. MCRP. The MCRP details responsibilities and actions required to accomplish the unit's contingency response mission. See **Chapter 4** of this AFI for further details regarding the MCRP.

3.2.2.2. In-Garrison Expeditionary Site Plan (IGESP). IGESPs are primarily developed for forward operating locations with a permanent Air Force presence to provide deployment, beddown and operation guidance. They were formerly known as Base Support Plans. Additional information is provided in AFI 10-404, *Base Support and Expeditionary Site Planning*.

3.2.2.3. Comprehensive Emergency Management Plan (CEMP) 10-2. The Installation CEMP 10-2 is a base-level plan that aligns AF planning with the National Response Plan. Details are provided in AFI 10- 2501, *AF Emergency Management (EM) Program, Planning and Operations.*

3.2.2.4. Disease Containment Plan (DCP). The DCP addresses roles and procedures for responding to a disease outbreak. Details are provided in AFI 10-2604, *Disease Containment Planning Guidance.*

3.2.2.5. Installation Deployment Plan (IDP). The IDP provides details for deployment processing, tailored to a particular installation. AF-level guidance is provided in AFI 10-403, *Deployment Planning and Execution.*

3.2.2.6. Develop and Maintain Memorandums of Agreement. Develop and coordinate MR MOAs, MOUs, or Mutual Aid Agreements (MAAs) with appropriate state, local civilian, and federal off-base agencies as detailed in **Chapter 4**.

3.2.2.7. AE units will conduct planning IAW applicable operational directives and courses of action, which may not include plans listed above.

3.2.3. **Unit Reports Monitor.** The Unit Reports Monitor is responsible for determining the unit's mission preparedness and providing the information to the Unit Commander for his/her assessment and approval. MRDSS ULTRA is the primary tool used to track reportable data. Specific reporting responsibilities are detailed in **Chapter 8** of this AFI. Contact the parent MAJCOM MRDSS ULTRA representative for guidance and assistance with managing, updating and using MRDSS ULTRA. Contact the MRDSS ULTRA Unit System Administrator for assistance with login, password updates, and system access.

3.2.4. **Unit Medical Readiness Training Manager.** The Unit Medical Readiness Training Manager coordinates, schedules, tracks and documents medical readiness training, including combat arms training, CBRN defense, HAZMAT, and UTC-specific course attendance for assigned medical personnel. Reference **Chapter 5** for detailed training information. Duties include, but are not limited to:

3.2.4.1. Serve as an informational resource for AFSC Functional Training Managers managing the Readiness Skills Verification Program (RSVP).

3.2.4.2. Assist the MRO and MRNCO in preparing the Medical Readiness Training and Exercise Plan (MRTEP) and submit the plan to the MRSF for approval. Forward approved MRTEP to the MAJCOM/SGX/A3 for information only. MAJCOMs will provide feedback to the unit, ensuring that all required areas of training have been addressed. AFRC units submit MRTEP to NAF RSG/SG or DOA as appropriate. ANG will submit electronic copies only to ANGRC/SGX NLT 31 Oct of the next affected FY.

3.2.4.3. Plan and oversee the implementation of medical readiness training (MRT) events. Track individuals who did not participate and ensure they receive make-up training.

3.2.4.4. Ensure all medical readiness training is entered and tracked in MRDSS ULTRA. MRDSS ULTRA includes an automated tracking system that is utilized to document medical readiness training. Training documentation can be viewed for tracking, reporting and inspection purposes via the MRDSS ULTRA reports menu. **EXCEPTION:** AFSOC operational support medical (OSM) flights and all AE Squadrons track their own training in MRDSS ULTRA.

3.2.4.4.1. Enter and track all required medical readiness and deployment training for unit-attached IMAs in MRDSS ULTRA. Assign IMAs to the FFAZZ Associate UTC in MRDSS ULTRA for tracking purposes. They will not count against unit training statistics.

3.2.4.4.2. Print and file an AF Form 1098, *Special Task Certification and Recurring Training*, in the member's training folder only for individuals who are out- processing, deploying, separating, or retiring.

3.2.4.4.3. Contact the parent MAJCOM MRDSS ULTRA representative for guidance and assistance with managing, updating and using MRDSS ULTRA. Contact the MRDSS ULTRA Unit System Administrator for assistance with login, password updates, and system access.

3.2.4.4.4. Enter and track medical readiness and deployment training for other medical personnel on base, who may not work within the medical facility (e.g. Squadron Medical Element (SME) personnel), in MRDSS ULTRA. These individuals can be tracked by associating their unit with the medical unit within MRDSS ULTRA. Contact the MRDSS Help Desk for assistance and guidance with this process.

3.2.4.5. Schedule combat arms training in accordance with established guidance contained in AFPD 16-8, *Arming of Aircrew, Mobility, and Overseas Personnel*, AFI 31-207, *Arming and Use of Force by Air Force Personnel,* AFI 36-2226, *Combat Arms Program,* and this instruction. There must be a minimum of one qualified individual for each weapon required. See consolidated weapons requirements supplemental guidance for the number of weapons required for each UTC at: **https://kx.afms.mil/sg3xp**.

3.2.5. **MRDSS ULTRA Unit System Administrator.** The unit MRDSS ULTRA Unit System Administrator will create user accounts, change passwords, review and drop/delete unit-level users no longer requiring access, and ensure positive control of sensitive information contained within MRDSS ULTRA. This individual will provide assistance to unit users as necessary and will contact the parent MAJCOM MRDSS ULTRA representative for assistance or guidance. Contact the MRDSS Help Desk only if the MAJCOM representative is unable to provide assistance.

**3.3. Medical Readiness Program Management Functions.** The following functions are also managed by the MR office.

3.3.1. **In- and Out-processing.** Conduct medical readiness in- processing and out- processing for assigned personnel.

3.3.1.1. Establish standardized in-processing procedures for all newly assigned personnel. Develop an orientation checklist to include: in-processing in MRDSS ULTRA; Unit Mission Brief; MCRP review; UTC assignment and deployment requirements; MCRP team assignment;

training requirements; names and duty sections of team chiefs; and current deployability/training status. Assign training classes and provide a checklist of all items to be accomplished by member.

3.3.1.2. Establish standardized out-processing procedures for permanently changing station, or separating/retiring personnel, including out-processing in MRDSS ULTRA. Print out training data if necessary and provide the individual with their personnel readiness folder (deployment folder).

3.3.2. **Support MCRP Team Chiefs.** Register MCRP team chiefs using MRDSS ULTRA.

3.3.2.1. Provide oversight and assist Team Chiefs in the management, planning, training and staffing functions of their teams. Ensure team chiefs know their responsibilities, which include, but are not limited to: maintaining contact information for their team members; developing and maintaining team training lesson plans; ensuring their team members are trained and the training is documented; obtain, maintain and inventory team supplies and/or equipment; review and update the team's annex in the MCRP as well as supporting operational team checklists. Include MC-CBRN responsibilities and assets IAW AFI 41-209, Chapter 14, in all management activities.

3.3.2.2. Develop a standard format for unit MCRP team chief binders. Cross-reference sheets for binder documents, other than the MCRP and team checklists, are acceptable if the contents are maintained electronically or won't fit in one standard binder. Include as a minimum:

3.3.2.2.1. Current team roster and contact information.

3.3.2.2.2. A copy of the applicable MCRP annex with the team's annex tabbed for quick reference. A copy of the complete MCRP may be maintained electronically or in another binder.

3.3.2.2.3. A copy of the team's MCRP supporting checklist(s).

3.3.2.2.4. Team equipment and supply lists and inventories.

3.3.2.2.5. A copy of the unit's current MRTEP.

3.3.2.2.6. Team-unique lesson plans and training documentation (maintain for a minimum of two years).

3.3.2.2.7. Post-incident/exercise summary input forms or template.

3.3.3. **Support UTC Team Chiefs.** Unit commanders appoint UTC team chiefs (normally, the highest ranking individual assigned to the UTC). The MR office will:

3.3.3.1. Register the UTC Team Chief using MRDSS ULTRA.

3.3.3.2. Prepare UTC team chief appointment letters for commanders using MRDSS ULTRA.

3.3.3.3. Ensure UTC team chiefs know their responsibilities, which include, but are not limited to: maintaining contact information for their team members; ensuring their team members receive required training and the training is documented in MRDSS ULTRA; deployment recall procedures.

3.3.3.4. Provide each UTC team chief with the following, as a minimum:

3.3.3.4.1. A current UTC team roster with contact information.

3.3.3.4.2. A copy of the MEFPAK Playbook for their UTC, to include the UTC mission capability statement (MISCAP) and manpower force element (MANFOR) listing for their UTC.

3.3.3.4.3. A copy of the current MCRP and appropriate supporting checklists.

3.3.3.4.4. Copies of pertinent portions of the IDP and appropriate supporting checklists.

3.3.3.4.5. A copy of AFI 10-206, *Operational Reporting*, with Chapter 10, MEDRED-C, tabbed for quick reference.

3.3.3.4.6. Sample formats for the deployment after-action reports and PIES.

3.3.3.4.7. A sample format for UTC team training documentation for training that is conducted in-house.

3.3.4. **Coordinate with the Medical Representative to the Wing Exercise Evaluation Team (EET).** Provide exercise requirements to assist with exercise scenario development to ensure medical capabilities are adequately tested. Coordinate the MRTEP through the Medical EET representative to facilitate the integration of medical exercise requirements with planned wing exercises to the greatest extent possible.

3.3.5. **Manage deployment weapons and munitions requirements.** Weapons requirements and information are found at: **https://kx.afms.mil/sg3xp**. Munitions authorizations for internal security, protection, and personal defense are found in AFCAT 21-209, *Ground Munitions*.

3.3.6. **Establish and Augment the Medical Control Center (MCC)/Unit Control Center (UCC).**

3.3.6.1. Establish MCC/UCC operational capability, including sufficient operational space, equipment, and checklists/plans (except classified plans). Ensure access to classified materials, if required.

3.3.6.2. In accordance with local communications squadron policy, ensure the MCC/UCC equipment items include telephones, plus at least one secure terminal equipment (STE) or secure telephone unit (STU III), computer systems (secure/non-secure), land mobile radios (LMRs). All authorized communications items must be physically in the MCC/UCC. **EXCEPTION:** LMRs may be used for daily operations but must be identified for MCC use when needed.

3.3.6.3. Provide MCC/UCC manpower, either as team members or as augmentation, as specified by the unit MCRP. Be prepared to monitor and operate the MCC/UCC until activation of the MCC Team.

3.3.6.4. Provides command and control functions for the disaster teams within the medical treatment facility. Coordinates with the Emergency Support Functions (ESF) 8 and 11 representatives in the EOC, using the Air Force Incident Management System (see AFI 10-2501 for more information). **NOTE**: The incident commander has tactical control of medical personnel at the incident site.

3.3.7. **Interface with WRM Project Officer.** Maintain coordination with Medical Logistics Office to ascertain deployability of WRM assemblages, availability of antidotes for biological and chemical weapons; and serviceability of installation medical response assemblages, as applicable. Also coordinate availability of MCRP team equipment, including team boxes and natural disaster response resources.

3.3.8. **Maintain MR Office Documentation.** Maintain a copy of all annual unit readiness- related appointment/designation letters and monitor the currency of appointments quarterly. MCRP, MRSF/EMC minutes, appointment letters, training data, and team chief binders, can be maintained electronically without hard copy print-outs as long as all interested parties can access the information via a shared drive. At commander's discretion, properly formatted electronic signatures may be utilized for

appointment letters. Back-up of all documentation must be made at least monthly, and requests for hard copy information will be honored.

3.3.9. **Conduct MR Office Self-inspection.** Integrate the MR areas and elements of the AFIA/SG Health Services Inspection (HSI) Guide into the unit self-inspection program. Maintain an active self-inspection program with the goal of continuous improvement and compliance. Brief the status of the MR self-inspection program to the MRSF/EMC as required. AE Units will use only applicable portions of the HSI guide.

3.3.10. **Support Readiness-related Business Planning.** (Not applicable to AFRC or AE units) Provide input to the MTF Business Plan, particularly development of the readiness case analysis (RCA). Ensure MR training and exercise requirements are appropriately considered and incorporated. Ensure manpower and funding requirements needed to fulfill the unit's missions, to include deployments, installation medical response requirements, exercises and training, are captured in the program objectives memorandum (POM) submission each year.

3.3.10.1. The MR office, in consultation with the MRSF/EMC, must provide information to the Medical Resource Management Office to assist in preparing the business plan for MAJCOM submission. The RCA, combined with the currency case analysis (CCA) and a business case analysis (BCA), prepared by other MTF offices, determine the optimal capabilities of the facility and are incorporated in the business plan.

3.3.10.2. Medical units should consider all types of required resources, including manpower, funding for training and travel, contracted services, supplies and equipment (to include maintenance) and patient care hours when developing the RCA for consideration in the business plan.

3.3.11. **Medical Counter-Chemical, Biological, Radiological, and Nuclear (MC-CBRN) Program Oversight. (Not applicable to AE units.)** The Home Station Medical Response (HSMR) program is a subset of the MC-CBRN program.

3.3.11.1. Medical Contingency Response Plan (MCRP) team chiefs responsible for HSMR allowance standards (AS) will maintain, inventory, train and exercise with their equipment annually, at a minimum. Team chiefs will track this training in MRDSS ULTRA. HSMR/CBRNE materiel used during training or exercises must be replenished with MDG O&M funds.

3.3.11.2. The HSMR AS are listed in **Table 3.1.** below. OPRs for these AS will work with medical logistics to update and maintain AS inventory data in Defense Medical Logistics Standards Support (DMLSS). AS sustainment activities are further described in AFI 41-209, *Medical Logistics Support*, Chapter 14. **Note**: The 886A AS, In-Place Patient Decontamination, is an in-place asset to be utilized at the medical unit only.

**Table 3.1. HSMR Allowance Standard OPRs and Team Associations**

| AS | OPR | Associated MCRP Team | MCRP Annex |
|---|---|---|---|
| 886A, In-Place Patient Decontamination | Patient Decontamination Team Chief | Patient Decontamination Team | Annex N |
| 886 J, Field Response | Field Response Team Chief | Field Response Team | Annex D, Appendix 1, Tab 1 |
| 886K, Triage | Triage Team Chief | Triage Team | Annex D, Appendix 2 |
| 886L, Clinical | Immediate Team Chief | Casualty Management Teams (except Laboratory Team, Pharmacy Team, and Nursing Services Team) | Annex D |
| 886M, Medical Unit Security | Manpower/Security Team Chief | Manpower/Security | Annex H |
| 886D, In-patient Follow-on | Nursing Services Team Chief | Clinical Teams | Annex D, Appendix 2 |
| 886E, | Pharmacy Team Chief | Pharmacy Team | Annex D, Appendix 2, Tab 6 |
| 886H | Bioenvironmental Engineering Team Chief | Bioenvironmental Engineering Team | Annex F |
| 886I | Laboratory Team Chief | Laboratory Team | Annex D, Appendix 2, Tab 5 |

3.3.11.3. AS OPRs will project and submit AS requirements to the MR office. The MR office will manage utilization of local funds for the MC-CBRN program, in conjunction with the resource management office and in accordance with guidance in AFI 41-120, *Medical Resource Operations*. The MRO/MRNCO/MRM will brief MC-CBRN program funding and order submission status to the MRSF at least every other meeting.

**3.4. Medical Readiness Decision Support System Unit Level Tracking and Reporting Application (MRDSS ULTRA).** MRDSS ULTRA is the official system of record for the management of expeditionary medical personnel and resources for the AFMS and the single authoritative source of medical readiness training data for medical personnel. MRDSS ULTRA provides enhanced global visibility of medical materiel, personnel, and their training to allow for the efficient management and deployment of those assets. MRDSS ULTRA materiel data is updated automatically through the Defense Medical Logistics Standards Support (DMLSS) system. Personnel data is updated automatically through MILPDS and updated/maintained by the MTF. Training data is entered manually. The governing directive for MRDSS ULTRA is this AFI. The MRO/MRNCO/MRM should contact the MAJCOM SGX POC for an MRDSS ULTRA login and password, as well as specific MAJCOM guidance. Other unit personnel will contact the MRDSS ULTRA Unit System Administrator to obtain accounts. The MRDSS Help Desk can be reached at **mrdsshelp@caci.com** or 1-888-286-9238 for technical assistance.

3.4.1. **Access.** MRDSS ULTRA can be accessed at: **https://uim.mrdss.net/uim/sitaware**. Only authorized medical personnel and units, and others requiring access for official use only are granted

access to MRDSS and/or MRDSS ULTRA applications and data. Data it contains will not be released or provided outside the AFMS or supporting agencies. The data contained within MRDSS ULTRA is "Sensitive but unclassified." Although it contains the raw statistical data used to compile classified operational readiness reports, it does not contain, report, collect, or display all the data elements for a UTC, nor does it include supporting remarks or allow for unit commander assessments of the ability of each UTC to perform its specific mission. Furthermore, the "stoplight" color codes displayed in MRDSS ULTRA do not correlate to ART or DRRS ESORTS capability assessments.

3.4.2. **Capabilities.** The following capabilities are included in MRDSS ULTRA:

3.4.2.1. Capability Overview. The Capability Overview module provides a quick look at overall unit UTC personnel information, WRM, generation missions, and homeland defense/customer owned assemblages information.

3.4.2.2. MRDSS ULTRA Deployments. The deployments module provides multiple options for deploying and redeploying individuals, UTCs, or materiel, or for tracking unit deployment history data.

3.4.2.3. Personnel. The personnel module is utilized to inprocess and outprocess personnel and update personnel information, such as contact numbers, address, security clearance, and other vital medical readiness data. Individuals are assigned to standard or associate UTCs and MCRP teams from this screen as well. Recall rosters may also be designed and maintained from this location.

3.4.2.4. Training. Individual training records can be pulled from the training module by SSAN or last name. Training data can be updated for multiple individuals at once. AF Forms 4005 can be printed from individual training records found here. All training data can be exported into an Excel spreadsheet for presentation or tracking purposes, as necessary.

3.4.2.5. Readiness Skills Verification Program (RSVP). RSVP data is accessed, tracked and updated through this module.

3.4.2.6. Tools. The Tools module is used to update user information, add, edit, or create user accounts and passwords. Unit information located here must be validated monthly and updated as necessary. Standardized reports can be pulled from this location and exported to Excel spreadsheets if necessary; when doing so, remember to save the file to an easily identifiable location before exiting MRDSS ULTRA. MilPDS transactions can also be viewed from this module to facilitate personnel tracking.

3.4.2.6.1. The Forms tab provides access to AEF Cards, Employment Locator Forms, AF Forms 4005, as well as appointment letters for positions that are appointed through and tracked in MRDSS ULTRA. All of these documents can be exported and saved or printed as necessary.

3.4.2.6.2. The AF Forms tab provides access to an AEF Tempo Band chart, the list of authorized AFSC substitutions for AFMS UTCs from the AF WMP 1, and Manpower Force Element Listings for specific UTCs that are selected from a drop- down list. All of these documents can be exported and saved or printed as necessary.

3.4.2.7. Medical Resource Letter (MRL). The MRL module reflects all of the UTCs (personnel or equipment) apportioned to the unit, the AEF each UTC is assigned to, as well as the number of personnel each contains, if applicable. If the unit's SORTS Designed Operational Capability

(DOC) Statement references the MRL for a list of assigned UTCs, this is where they would be found. The list can be sorted and exported to an electronic spreadsheet as necessary for presentation or reporting purposes.

3.4.2.8. Situational Awareness. The situational awareness module provides a quick view of the status of tasks and activities managed within MRDSS to facilitate tracking of necessary actions.

3.4.2.9. Validate the currency, update as necessary, and generate back-up copies of MRDSS ULTRA data in the form of reports every 30 days, at a minimum. Updates include, but are not limited to: training events, deployment availability (DAV) codes, UTC assignments, MCRP team assignments, deployment or redeployment of assigned personnel, unit information, and contact information for medical readiness and medical logistics staffs.

3.4.2.10. The MRDSS Unit System Administrator will provide AFSC functional training managers MRDSS ULTRA accounts to enter RSVP training data for their personnel. The MR office enters other medical readiness training data. Document currency by updating training data in MRDSS ULTRA within 48 hours of training completion or as soon as possible as mission allows.

### 3.5. Medical Readiness Staff Function (MRSF)

3.5.1. **Purpose.** The purpose of the MRSF is to provide executive oversight for all medical readiness issues to include the organizing, training, and equipping of all assigned personnel, and to ensure the unit is able to meet their assigned wartime and installation response missions.

3.5.1.1. MRSF meetings are chaired by and minutes approved by the unit commander, and will be held every other month, at a minimum. Meeting duration must be sufficient to address all required agenda items. **EXCEPTION:** ARC units must conduct this meeting at least quarterly; AFRC AE units will conduct this meeting semi-annually.

3.5.1.2. In consultation with the unit commander, the MR office will schedule MRSF meetings; develop the agenda and provide it to the members in advance; ensure team chiefs and AFSC Functional Training Managers are prepared to provide data, briefings, and updates as requested; and prepare MRSF meeting minutes following the meeting.

3.5.1.3. AFRC MRSF responsibilities are fulfilled through the EMC at least quarterly. ANG MRSF responsibilities are fulfilled either through the EMC or the Education & Training Committee. For the purposes of this AFI, MRSF will refer to any committee charged with this function, unless specifically noted.

3.5.2. **Membership.** The following individuals comprise the minimum required membership for the MRSF and should be identified in the minutes by their MRSF title(s):

3.5.2.1. Unit Commander (chairperson).

3.5.2.2. MRO, MRNCO, MRM (action office).

3.5.2.3. Executive management team, including directors (SGA, SGB, SGD, SGH, SGN SGP), squadron commanders, and unit superintendents. For AE units, the Executive Management Team includes unit-appropriate representatives, such as the Chief Nurse, DO, Flight Commanders and NCOIC's, MRO, MRNCO and other invitees as appropriate.

3.5.2.4. Bioenvironmental Engineer (BEE).

3.5.2.5. Public Health Emergency Officer (PHEO).

3.5.2.6. Public Health Officer (PHO).

3.5.2.7. Medical Logistics Officer.

3.5.2.8. Medical EET Chief.

3.5.2.9. Reserve Affairs Liaison, when appointed.

3.5.2.10. Other individuals as directed by the chairperson, including RMO, team chiefs, UDM, Self-Aid and Buddy Care (SABC) manager, AFSC function training managers, etc.

3.5.3. **Agenda.** MRSF meetings will follow the prescribed agenda format, including approval of past minutes, discussion of any open items, standard agenda items, and new business. The MRSF will address the following standard agenda items, at a minimum:

3.5.3.1. Medical Readiness Training Update. The comprehensive training update should include AFSC training statistics, SABC statistics, and UTC training briefed by designated POCs. The Unit Medical Readiness Training Monitor will brief a summary of all team training, any other identified training statistics, and recommended scheduling modifications to the MRTEP.

3.5.3.2. Unit Plans Review. Provide a review of required plans, including the MCRP, wing/base plans, and applicable MOUs/MOAs/MAAs.

3.5.3.3. Exercise Update. The MR office will present the post- incident/exercise summaries (PIES) and after-action reports (AAR), to include findings, discrepancies and deficiencies, to the MRSF for review and discussion. Discuss corrective actions and track them until tested (via subsequent exercise), re-evaluated and closed. Discuss any recommended scheduling modifications to the MRTEP.

3.5.3.4. UDM Update. Address UTC personnel assignments, highlighting any shortages, vacancies, and hard-to-fill positions. Also address the status of deployed personnel and upcoming deployments, if applicable. Deployment AARs should be presented and discussed here as well.

3.5.3.5. MCRP Team Chief Update. Team chiefs will brief staffing, overall team training status to include make-up training, and equipment statistics (includes HSMR AS assets), equipment inventory status for their teams, and checklist currency. At the commander's discretion, team chiefs may provide updates on a rotating basis, as long as all team chiefs report during the year. Problem areas should be tracked more frequently.

3.5.3.6. Logistics Update. Include a review of assigned WRM and installation medical response assemblages, if not already briefed by MCRP team chiefs. Include assets maintained for other organizations. Review must include at a minimum, materiel status of assigned assemblages, critical item shortages, open items/lessons learned from most recent inventory, inventory schedules, and Deferred Procurement program exercise results.

3.5.3.7. Unit Reports Update. Provide an overview of unit SORTS, ART and DRRS ESORTS data, as applicable. Note: these discussions may be classified. Classified material is not required, but if given, record in minutes, "Classified report provided and understood by members," or similar phrase.

3.5.3.8. Self- inspection Update. Include status of any open items from self- inspections, most recent HSI, ORE/ORI, and staff assistance visits.

3.5.3.9. MC-CBRN program funding status and execution update.

3.5.3.10. Other Topics. Other topics discussed regularly but not necessarily identified as standard agenda items include RCA business planning, coordination with community leaders regarding response initiatives, and trip/conference reports.

3.5.4. **Minutes.** Meeting minutes will be prepared IAW AFMAN 33-326, *Preparing Official Communication,* and will provide a clear, concise summary of discussions and events and will include sufficient historical information to fully describe issues being discussed. Use MRSF minutes to document MRSF members present or absent, unit MCRP review and approval, and well as MRTEP coordination and approval. Attachments must include data provided, copies of PIES, AARs, handouts and copies of presentation slides, if used. EMC minutes are not required to be sent to AFRC/SG/A3 or ANG/SG. Sample MRSF minutes can be found at **https://kx.afms.mil/kxweb/sg3xp**.

## Chapter 4

## MEDICAL READINESS PLANNING

**4.1. General.** Unit level planning is critical to ensuring the unit is capable of meeting expeditionary and emergency management missions. It includes providing input to unit plans, Wing plans and local community plans.

**4.2. Planning Responsibilities.** Planners at the unit level will research planning initiatives at all levels to understand the unit's mission within the full scope of the Air Force Medical Service (AFMS).

4.2.1. **AFMS.** The AFMS is responsible for organizing, training and equipping the medical support forces necessary to sustain maximum mission capability and effectiveness. The medical planning process must encompass all aspects of medical support for expeditionary operations, humanitarian assistance and installation response. Specifically, the Air Staff level planners must provide an employment strategy and training framework for deployable unit type codes (UTCs), MCRP team response, and individual personnel capabilities. Air Staff planners develop capabilities to meet combatant command requirements and assign those capabilities to medical units for organizing, training and equipping. The A3 community provides the operational capability/support for AE units.

4.2.2. **MAJCOMs.** MAJCOM medical planners provide guidance to medical unit personnel at base-level on all aspects of medical readiness planning, in addition to providing readiness functional expertise to command leadership. MAJCOM/SG staffs provide management and oversight of unit medical readiness programs, including UTC apportionment, exercise planning, formal training allocation, and general guidance. For AE units, this role is performed by the MAJCOM/A3 staff.

4.2.3. **Air Components.** Air component medical planners are the primary resources for medical planning in their respective theaters of operations. They develop medical support strategy and tactics, write medical annexes, and identify medical requirements for major operational plans (OPLANs), concept plans (CONPLANs), and functional plans (FUNCPLANs). They publish medical operational guidance for each contingency, amend medical support as needed, and identify recommendations for improvement during/following contingency operations.

4.2.4. **Unit Level Planners.** Unit level planners assess the medical unit's capabilities to support all contingencies, provide oversight to training programs and requirements, and advise the unit commander on the status of the unit readiness mission. They provide oversight to the development of the Medical Contingency Response Plan (MCRP), write the Medical Readiness Training and Exercise Plan (MRTEP), and prepare inputs to the Wing plans. Additionally, they coordinate, in writing, with all civilian/non-federal agencies, and DOD/federal agencies, both on-base and off-base, to establish mission support on and off the military installation.

**4.3. Medical Contingency Response Plan (MCRP).** The MCRP captures planning information and establishes procedures for the unit's wartime, humanitarian assistance, and installation response missions. See **Attachment 2** for the MCRP format and annex details.

4.3.1. **GSUs and Co-located Units.** All medical treatment facilities (MTFs), including deployed medical units, must reflect their medical response to contingency scenarios in an MCRP. Depending on geographical proximity, unit resources and capabilities, or mission integration, smaller units may reflect their capabilities as annexes in a larger unit MCRP.

4.3.1.1. Opportunities for a unified response (i.e. city-wide response) to any emergency should be considered as rationale for an integrated MCRP. All integrated MCRPs must be approved by the parent MAJCOM/SGXs of all affected units.

4.3.1.2. In the case of multi-service, or multi-unit areas, i.e. San Antonio, Colorado Springs, etc., units will discuss their roles in response to a city- wide event in the Basic Plan. Units co-located with sister service medical facilities should provide copies of their MCRP to the other unit and incorporate capabilities into both unit response plans, as appropriate. At a minimum, units will discuss their interactions with local disaster management officials (e.g. the city/county emergency management office) in the Basic Plan.

4.3.2. **ARC Units.** AFRC generation medical units follow higher headquarters guidance upon mobilization. ANG medical units will follow wing, state and higher headquarters guidance when applicable. When present for duty, non-MTF active duty medical personnel and AFRC medical units co-located with an active duty MTF are considered available as manpower resources for the local MTF and may be included in the MCRP.

4.3.3. **Plan Organization.** The MCRP will include the following sections: cover page, letter of transmittal, security instructions, record of changes, plan summary, table of contents, basic plan, annexes, and distribution list. All annexes outlined in **Attachment 2** must be addressed. If a particular annex does not apply, annotate the annex as "Not Applicable." Any annex deemed not applicable must also be addressed in the MRSF meeting and documented in meeting minutes, justifying the decision.

4.3.3.1. Responsibilities, missions and tasks must be included in the plan. Reference the IGESP, as applicable.

4.3.3.2. Key Assumptions. The following assumptions should be included in the plan, as applicable.

4.3.3.3. TRICARE contracts will be written to ensure that provider networks and services can be adjusted as necessary to compensate for changes in MTF capabilities and capacities.

4.3.3.4. Deployment of personnel and medical support for deploying personnel will be IAW AFI 10-403, *Deployment Planning and Execution,* and the Installation Deployment Plan (IDP).

4.3.3.5. MTFs designated as NDMS FCCs will utilize separately developed NDMS operations or patient reception plans that describe NDMS operations for their region.

4.3.3.6. Established procedures and AFTTPs will be used to request support and coordinate AE services.

4.3.4. **Memorandums of Understanding (MOUs), Memorandums of Agreement (MOAs), and Mutual Aid Agreements (MAAs).** Support to the medical unit from off-base agencies must be coordinated in writing, IAW AFI 25-201*, Support Agreements Procedures*. Do not duplicate existing agreements and contracts, such as the TRICARE contract. Coordination documentation for MOUs, MOAs, and MAAs must be kept in the MR office.

4.3.4.1. The MOU/MOA/MAA should state all specific details associated with the agreement, to include levels of support for various emergencies. Agreements should be established for the following capabilities at a minimum:

4.3.4.1.1. Cooperation with the community healthcare system and emergency response organizations to understand and leverage the medical response capabilities that exist outside the installation.

4.3.4.1.2. Utilization of facilities to carry out quarantine, isolation and/or pharmacy dispensing activities beyond the medical unit's capability. (Not applicable to AFRC medical units.)

4.3.4.1.3. Transportation of casualties beyond the medical unit's capability. Include capability for transporting potentially contaminated patients. (Not applicable to AFRC medical units.)

4.3.4.1.4. Reception of casualties, to include potentially contaminated casualties, at off-base receiver hospitals. (Not applicable to AFRC medical units.)

4.3.4.2. Ensure MTF response planning includes integration and coordination with follow-on response capabilities from local, state, and federal agencies. (Not applicable to AFRC medical units.)

4.3.4.3. Ensure off-base medical support is familiar with the MCRP and the Consolidated Emergency Management Plan (CEMP) and how the off-base medical support fits into an incident response that may occur on the installation. (Not applicable to AFRC medical units.)

4.3.4.4. Requests for civil support with no existing MOU/MOA/MAAs are required to comply with AFI 10-802, *Military Support to Civil Authorities (MSCA),* otherwise known as Defense Support to Civil Authorities (DSCA) unless it is immediate response to save lives, prevent human suffering, or mitigate great property damage. Under those circumstances, the unit commander has the authority to respond. The MR office should be prepared to advise the commander on the DSCA process and follow-up actions required.

4.3.4.5. For on-base agencies tasked to support the plan, coordination and concurrence with the MCRP constitutes agreement with its contents. In addition, the MCRP must be coordinated through appropriate Wing agencies, such as the Wing Plans office, Public Affairs, Judge Advocate office. Coordination will be accomplished via AF Form 1768, *Staff Summary Sheet*, or other routing format that provides concurrence by signature.

4.3.4.6. Ensure the Executive Staff, MRSF, Wing plans office and Wing Judge Advocate office review MOU/MOA/MAAs before final approval. MOU/MOA/MAAs will be reviewed annually and renewed every three years.

4.3.4.7. In the event that a unit is unable to obtain coordination with an off-base agency, the unit should develop a memorandum for record (MFR) and attach all correspondence (e-mails, letters, phone records, etc.) to document their attempts to gain formal coordination.

4.3.5. **Plan Review.** The MRSF must review the MCRP annually. Documentation of the review must be recorded in the minutes and maintained in the MR office. Team chiefs will review and update their respective annexes and checklists annually. Minor changes may be corrected with replacement pages, but must be coordinated with all affected agencies and distributed according to the original plan distribution. The MCRP will be rewritten at least every three years or when the number of changes is significant (35% of the document), whichever is sooner. This will ensure a thorough review of wing and medical unit mission changes are considered, as well as civilian community growth and local infrastructure changes. Submit MCRP rewrites to the MAJCOM for review after full coordination with applicable agencies, but prior to publication. Plan reviews will be accomplished by MAJCOMs within 60 days. Concurrence is implied, if no comments from the MAJCOM are received within that period.

ANG units will provide a copy of the approved plan to all contributing and supported agencies, including Plans and Operations Military Support Officers (POMSO), co-located AC MTFs and the Office of the Air Surgeon, Medical Readiness Plans and Operations Branch (ANG/SGXP).

4.3.6. **Plan Distribution.** The MR office will manage the preparation, coordination, publication and distribution of the MCRP. Distribute copies of the MCRP and appropriate checklists to each office that plays a role in its execution. Also send a copy to the parent MAJCOM (not applicable to ARC) as well as any gained units. The MR office will maintain additional copies for transfer to the shelter, Medical Continuity of Operations (MCOOP) alternate command and control (C2) location, installation Emergency Operations Center (EOC) and deployment location, as applicable. The MCC will maintain a master copy of all MCRP supporting checklists.

4.3.7. **New MCRP Teams.** The following teams are added to existing MCRPs and should be inserted into existing plans as page changes/insertions as specified below.

4.3.7.1. **Triage Team(s):** The Triage Team will be comprised of at least one provider (physician, dentist, PA or IDMT) and one nurse or medical technician to triage patients arriving at the MTF and a similar team to provide re-triage after patient decontamination, when appropriate. The Triage Team should be activated at the same time as the Clinical Teams to ensure triage capability is available. Insert triage team guidance in the MCRP as Annex D, Appendix 2, Tab 9.

4.3.7.2. **Information Services Disaster Response Team (ISDRT).** The ISDRT is comprised of the Information Services Flight Commander / Chief Information Officer (CIO) (Team Chief), Deputy Information Services Flight Commander, Information Services Flight Superintendent, Information Systems Security Officer (ISSO), System Administration Team Lead, HIPAA Security Officer and HIPAA Privacy Officer. The team is responsible for coordinating network / IS response, recovery, and protection activities associated with a disaster or incident that affects the organization's ability to access/control information services. The ISDRT may be a sub-team of the MCC but personnel on the ISDRT should not be assigned duties on other disaster teams and must retain the capability to be activated independently. Reference AFI 41-211, *Management of Medical Information Services,* paragraphs 3.2.3.1 through 3.2.3.3. for additional guidance. Insert ISDRT guidance in the MCRP as Annex P, Appendix 1, Tab 1.

**4.4. Expeditionary Operations Planning.** Wartime medical planning is initiated at the combatant command and air component command levels, but the unit level planner plays an important role in the successful execution of the wartime mission. Joint Publication 4.04, *Health Services Support*, provides doctrine for the planning and execution of force health protection and health service support at the operational level, throughout the range of military operations. AFDD 2-4.2, *Health Services,* addresses Air Force health services doctrine to reflect current AFMS capabilities and how to organize and employ those capabilities in support of expeditionary operations. Supporting tactical doctrine provides more detailed guidance and can be found at: **https://kx.afms.mil/doctrine**. Additionally, unit concepts and procedures for supporting expeditionary operations must be included in the MCRP, which is described in paragraph **4.3.** and **Attachment 2** of this AFI.

4.4.1. **UTC Apportionment.** UTCs apportioned to the unit are listed in the medical resource letter (MRL) and can be found in MRDSS ULTRA. The MRL is the AFMS tool for planning and managing expeditionary medical capabilities. In addition to reflecting current UTC apportionment, the MRL also reflects anticipated changes, including potential UTC transfers, moves, or gains for up to the next five years. Information provided in the MRL for a specific unit includes, but is not limited to: UTC(s)

currently apportioned to the unit; UTCs the unit is projected to gain or lose; whether assigned UTCs are manpower or equipment; AEF assignments (past, present and projected) for each UTC; and for equipment UTCs, what logistics account is responsible for maintaining them and where the assets are physically located.

4.4.2. **Additional Planning Resources.** The MRO and MRNCO will be thoroughly familiar with the MISCAPs and MEFPAK Playbooks for all assigned UTCs, as well as any relevant AF Tactics, Techniques and Procedures (AFTTPs), which can also be found at **https://kx.afms.mil/doctrine**. Other resources include AFI 10-401, *Air Force Operations Planning and Execution,* and AFI 10-403, *Deployment Planning and Execution.* The Medical Supplement to the AF War Mobilization Plan, Volume 1 (WMP 1) provides additional guidance and is found at **https://kx.afms.mil/sg3xp**. The AEF Center also provides planning resources at **https://aefcenter.afpc.randolph.af.mil**.

4.4.3. **CONUS Re-Distribution Plan.** When directed by official decree of the President of the United States or the Secretary of Defense, Joint Forces Command (JFCOM) will integrate the Services' as well as other governmental, and non- governmental agencies' medical resources to provide evacuation and treatment for patients returning to CONUS from the AOR. Medical units will continue to provide healthcare to the beneficiary population. Typically, if the local MTF cannot provide adequate medical care to beneficiaries with remaining staff, the MTF will arrange for care through extended hours of operation, TRICARE network providers, or by engaging the Department of Veterans Affairs (VA) through the DOD-VA Resource Sharing Agreement.

4.4.3.1. The CONUS Re-Distribution Plan provides direction and time phasing for CONUS facility expansion and patient distribution. Individual mobilization augmentees (IMA) and pre- trained individual manpower (PIM), consisting of the Individual Ready Reserve, Retirees, and Standby Reserve will be utilized as needed. The MCRP outlines reception, training, and support requirements for these personnel. The Department of Veterans Affairs (VA) and the National Disaster Medical System (NDMS) are affiliated organizations for CONUS medical support under the CONUS Re-Distribution Plan.

4.4.3.2. Department of Veterans Affairs (VA). The VA health care system is the primary backup to the DoD in time of war or national emergency. Reference November 16, 2006, *Memorandum of Agreement between the Department of Veterans Affairs and Department of Defense* regarding VA furnishing healthcare services to members of the Armed Forces during a war or national emergency. Units will identify medical support requirements beyond the MTF's capabilities and address these requirements in the MCRP. MOU/MOA/MAAs and MCRP coordination document VA support.

4.4.3.3. The National Disaster Medical System (NDMS). The NDMS is a federally coordinated system that augments the nation's medical response capability. The overall purpose of the NDMS is to establish a single integrated national medical response capability for assisting state and local authorities in dealing with the medical impacts of major peacetime disasters and to provide support to the military and the Department of Veterans Affairs medical systems in caring for casualties evacuated back to the U.S. from overseas armed conventional conflicts. Designated AF MTFs serve as Federal Coordinating Centers (FCCs) within the NDMS, providing support and leadership to the local hospitals contributing to the NDMS bed capability. AF FCCs will:

4.4.3.3.1. Develop, maintain, and exercise an NDMS operations and patient reception plan for the assigned area in conjunction with other Federal, State and local agencies, offices of emergency management, media, and other agencies, as required.

4.4.3.3.2. Establish and maintain MOU/MOA/MAAs with local hospitals for participation in NDMS, as well as with those providing support as detailed in the MCRP. MOU/MOA/MAAs identify the types of support and the conditions under which that support becomes available.

4.4.3.3.3. Plan and implement at least one annual NDMS area exercise. Accomplish planning with all participating facilities to encourage maximum participation and ensure the existing plan is tested to the fullest possible extent. Post Incident/Exercise Summaries (PIES) generated as a result of this exercise will be briefed to the MRSF. The annual NDMS exercise may be conducted in table top format as long as a full- scale exercise is conducted every third year.

4.4.3.3.4. Provide USTRANSCOM/GPMRC with the name, rank, address, office symbol, duty title, telephone and FAX numbers, and e- mail addresses of the FCC POC, with an information copy to AFMSA/SGXH and parent MAJCOM/SGX NDMS representative.

4.4.3.3.5. Report minimum and maximum bed numbers for each NDMS participating hospital as required to USTRANSCOM/GPMRC.

**4.5. Emergency Management Planning.** In addition to the expeditionary capability of the warfighting mission, AFMS medical units play an important role in the protection of AF installations. AF overseas medical units also support the defense of overseas installations and provide support to the host nation through requests from the Department of State and with local MAAs

4.5.1. **Defense Support to Civil Authorities (DSCA).** Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, the President may direct any federal agency to provide support to State and local agencies. AFI 10-802, *Military Support to Civil Authorities*, outlines how the Air Force will provide support.

4.5.2. **Immediate Response Authority.** Imminently serious conditions resulting from any civil emergency or attack may require immediate action by military commanders, or by responsible officials of other DOD agencies, to save lives, prevent human suffering or mitigate great property damage. When such conditions exist and time does not permit prior approval from higher headquarters, local military commanders, and responsible officials of other DOD components are authorized by DODD 3025.1, *Military Support to Civil Authorities,* to take necessary action to respond to requests of civil authorities.

4.5.3. **National Response Planning.** Several Federal laws and specific plans outline military support responsibilities for emergency response. The MRO/MRNCO should be familiar with all of these plans. Specific information and taskings are provided in **Attachment 5**.

4.5.3.1. The National Response Plan (NRP) provides the structure and mechanisms for coordinating federal support to state and local governments. Response capabilities are grouped into Emergency Support Functions (ESFs), which outline the responsibilities of different agencies in providing support during an emergency. In addition to wartime operations, NDMS may be tasked under ESF 8 of the NRP.

4.5.3.2. National Incident Management System (NIMS). The Department of Homeland Security provides oversight to emergency management through the NIMS. The NIMS provides a consistent

nationwide approach to enable Federal, State, Local, and Tribal governments and private-sector and nongovernmental organizations to work together effectively and efficiently to prepare for, prevent, respond to, and recover from domestic incidents.

4.5.3.3. Air Force Incident Management System (AFIMS). AF Instruction 10-2501, *AF Emergency Management (EM) Program, Planning and Operations,* implements the AF Incident Management System and aligns AF EM planning and response with the NRP. The AFIMS tasks each AF installation to develop a Comprehensive Emergency Management Plan (CEMP) 10-2. The MTF will ensure the support outlined in the Medical Contingency Response Plan (MCRP) is consistent with the installation CEMP 10-2.

4.5.3.3.1. Emergency Operations Center (EOC). EOCs are the command and control support elements that direct, monitor, and support the installation's actions before, during and after an incident. At the local level the EOC Director is normally the Mission Support Group Commander. Each medical unit will provide appropriate representative to the EOC upon activation.

4.5.3.3.2. The Medical Control Center supports the EOC by maintaining communications with it, receiving and executing taskings, monitoring medical response operations, relaying information, providing personnel, casualty, capability, and resource data as necessary, and accomplishing required reports.

4.5.4. **Host Nation Requirements.** For installations outside the United States, support during emergency operations is provided through established host nation support agreements; by direction of the Combatant Command; or upon direction of the installation commander to save life, limb, eyesight or property. Requests for US military support of humanitarian assistance and disaster response outside the United States are typically submitted by the host nation through the Department of State (DoS).

4.5.5. **In-Garrison Expeditionary Site Plan (IGESP) and Expeditionary Site Plans (ESP).** The expeditionary nature of Air Force operations requires extensive planning to ensure proper deployment, beddown and operation of Forward Operating Locations. The Air Force process for conducting this planning is outlined in AFI 10-404, *Base Support and Expeditionary Site Planning*.

4.5.6. **Mass Prophylaxis Plan. (Not applicable to AE units.)** Medical units will include a mass prophylaxis plan as a part of the installation disease containment plan (DCP) required in AFI 10-2604, *Disease Containment Planning Guidance.* A CBRN event or naturally occurring epidemic may require the stand-up of a point of dispensing (POD) in order to distribute medical countermeasures in a timely manner to affected segments of the population. The Pharmacy Team will work with the PHEO, the public health officer, and the logistics team chief to establish procedures for managing Strategic National Stockpile (SNS) assets.

## Chapter 5

## MEDICAL READINESS TRAINING PROGRAM AND REQUIREMENTS

**5.1. Training Philosophy.** All medical personnel must be fully trained to meet the task requirements associated with wartime, humanitarian assistance, and installation response missions. The AFMS Training System is designed to optimize the training of individuals, teams, and units into effective medical capabilities tasked to create a fit and healthy force, enhance human performance, prevent casualties, and restore the health of the fighting force.

5.1.1. **Foundational Training.** All Airmen, regardless of rank, fill a duty AFSC (DAFSC). Airmen are trained to proficiency upon entry into the Air Force, or join the Air Force with verifiable AFSC-specific credentials. Enlisted personnel receive initial medical readiness training through the Expeditionary Medical Readiness Course (EMRC) in conjunction with their AFSC-awarding courses. Officers receive initial medical readiness training as part of the Commissioned Officer Training (COT) or Reserve Commissioned Officer Training (RCOT) courses, or through a commissioning program such as a service academy, Reserve Officer Training Course (ROTC) or Officer Training School (OTS). This AFI addresses training that builds upon those foundational skills, including the initial readiness lectures and exercises provided in accession training.

5.1.2. **Professional Education.** The AFMS acknowledges professional credentialing, practical experience, and other foundational training/education sources may meet the substance and spirit of specific training requirements. A unit commander has the authority to assess individuals, UTCs, and their unit as "mission ready."

**5.2. Training Categories.** All medical readiness training requirements are divided into four types: individual training, deployment training, unit training, and integrated training. Specific training requirements for each category are identified in **Attachment 3**.

5.2.1. **Category I: Individual training - Core.** This training is required for all AFMS personnel regardless of their deployment status. Specific exceptions are noted in **Attachment 3**.

5.2.2. **Category II: Deployment training.** Personnel assigned to standard and associate UTCs (A/DWS, A/DWX, A/DXS) must accomplish Category II training in addition to their Category I training and training in accordance with AFI 10-403, *Deployment Planning*, para. 1.6.2.2. Personnel assigned to UTCs coded as A/DXX, A/DPS, and A/DPX will be trained in accordance with AFI 10-403, para. 1.6.2.3. and FAM posturing guidance. Additional training may be required to meet theater-specific requirements. These theater-unique training requirements will be identified in deployment reporting instructions or tasking line remarks.

5.2.3. **Category III: Unit training.** This training is accomplished at the unit level and is required for all assigned personnel. Team training conducted at the unit is designed to maximize team member interaction and role reinforcement and includes leadership elements.

5.2.4. **Integrated training.** Integrated training refers to joint or combined training efforts and is more fully addressed in **Chapter 9**.

5.2.5. DELETE

**5.3. Medical Readiness Training and Exercise Plan (MRTEP).** Although the MRTEP does not necessarily meet the definition of a "plan" for the purposes of this AFI, the MRTEP is used as a planning document. Each MTF will develop an annual MRTEP to outline training and exercise requirements scheduled during the calendar year period. Medical readiness training requirements are varied and include individual effort, local seminars and exercises, formal courses, AF and Joint exercises, and specific predeployment events, among others. Some medics, such as Enablers, are not assigned to MTFs or to an AEF Tempo Band. Under such circumstances, their training should not exceed 24 months for any training requirements that refer to AEF Tempo Band timelines. MR office personnel have the responsibility of incorporating training events, exercises, and courses into a schedule that meets the training needs of all personnel, while considering the MTF's business plan and resource availability.

5.3.1. **Format.** The MRTEP will be the primary resource for management and scheduling of unit medical readiness training and exercise requirements. The training section of the document should reference individual, team, and leader training (see para **5.10.**) for home station and expeditionary operations. The exercise section of the MRTEP should include a comprehensive listing of all planned exercises, to include a description of the medical unit's role, responsibilities, and assessment objectives. It should be formatted to include the following items at a minimum.

5.3.1.1. Table of Contents

5.3.1.2. Executive Summary: Identify the unit, its major readiness missions, and other operational relationships (through MOUs or base plans) which will affect training objectives.

5.3.1.3. Training: Identify all required medical readiness training for the upcoming calendar year.

5.3.1.3.1. Training Part I: Identify unit personnel, leaders, and teams requiring formal training with a tentative schedule of class dates occurring in the next calendar year. Provide a list of projected requirements for training beyond this calendar year, i.e. training required every 48 months and not scheduled to occur during this specific calendar year.

5.3.1.3.2. Training Part II: Identify MCRP team training requirements and any other training to be conducted locally on an annual basis.

5.3.1.3.3. Compile Part I and Part II into a comprehensive schedule and include it as an attachment. Enabler training requirements should be incorporated based on a 24 month cycle.

5.3.1.4. Exercises: Include all exercises that will require individual or unit participation. Every effort should be made to coordinate medical exercise requirements with scheduled wing/base exercises, using that schedule as a starting point to capitalize on available opportunities and avoid conflicts in planning.

5.3.2. **Review, Approval and Distribution.** The MRSF must review and approve the MRTEP annually, prior to the beginning of the next calendar year. Once approved, distribute copies to the parent MAJCOM/SGX, AFRC and ANG units who are identified in the MCRP as contributing organizations, and all MCRP team chiefs. AE units must provide their plans to their respective MAJCOM/A3T. Update the MRTEP during the calendar year to accommodate necessary scheduling changes. Changes must be approved by the MRSF, documented in MRSF minutes, and distributed to all recipients of the published MRTEP.

**5.4. Training Equivalency.** The commander must ensure, either through formal courses, exercises, inspections and deployments, or through equivalency credit, that training is conducted for all missions.

Credit may be awarded for specific training elements at all levels, up to and including integration training. Supplemental guidance for commanders is available as listed below.

5.4.1. **Formal Courses.** Training elements at all levels may be met by formal courses. Examples of these courses include Aeromedical Evacuation Contingency Operations Training, the Expeditionary Medical Readiness Course (EMRC), the Basic Expeditionary Medical Readiness Training, Commissioned Officer Training, the EMEDS course, Combat Casualty Care Course (C4), Joint Operational Medical Managers Course (JOMMC), Contingency Aeromedical Staging Facility (CASF) course, and Critical Care Air Transport Team (CCATT) course, among others. Credit for UTC formal training is provided by attending formal UTC courses only. There is no UTC formal training equivalency credit. The only waiver authorities for this training are the appropriate MEFPAK/SG, and AMC/A3 for AE UTCs.

5.4.2. **Included Course Equivalency.** Formal courses may include other required training elements. A full list of included courses/elements is provided at **Attachment 4**.

5.4.3. **Exercises and Deployments.** Matrices to be used when granting UTC sustainment training credit for deployments or exercises are available at *UTC Sustainment Training Equivalency Credit for Deployments or Exercises* on **https://kx.afms.mil/sg3xp**. UTC Sustainment training is defined as training that occurs in the non- formal training setting that is used to keep the UTC members' skills current. The following guidance applies to sustainment training:

5.4.3.1. Commanders may grant UTC sustainment training credit for their personnel who deploy to a "real world" bare-base scenario/operation or participate in a JCS-, EOC, or MAJCOM/A3-sponsored exercise. Additionally, a list of ACC MEFPAK EMEDS/UTC Sustainment Credit Approved Exercises can be found on the ACC MEFPAK website at: **https://afkm.wpafb.af.mil/ASPs/CoP/OpenCoP.asp?Filter=MD-SG-00-15**.

5.4.3.2. Sustainment training credit may also be granted for locally-sponsored UTC Mission Essential Task-driven exercises with prior MEFPAK approval. Local exercises must use UTC equipment packages to qualify for sustainment credit. Training credit packages should be submitted to the appropriate MEFPAK NLT 60 days prior to the start of the local exercise.

5.4.3.3. Individuals receiving UTC sustainment training credit will restart their training cycle "clock" to the last day of deployment or to the day the exercise ends. Their training currency will be good for 20 months from that new date.

5.4.4. **Professional Credentialing.** The unit commander, after consultation with his Executive Staff may award equivalency credit for individual training requirements (RSVP tasks) being met by professional training, credentialing, and daily operations. For example, a medical technician who works in the emergency room and provides bandaging and splinting activities daily does not need to participate in readiness training for basic first aid, bandaging, and splinting.

5.4.5. **Documentation.** Medical readiness training will be documented in MRDSS ULTRA. Supporting documentation, including military or civilian certificates, professional certification, waiver letters, or after-action reports should be cited and maintained if practical. Equivalency credit must be annotated when awarded.

**5.5. Reserve Component Training.** Reserve Component (RC) Training. See **Chapter 6** for RC training programs and their administration.

**5.6. Training Requirements Overview.** This section outlines training requirements for expeditionary and emergency management personnel and their teams. Specific unique and recurring training requirements for home station and deployment are summarized in the Medical Readiness Training Matrix at **Attachment 3**. Training requirements are summarized below under the categories of Individual Training, Team Training, and Leadership Training.

5.6.1. **Office of Primary Responsibility (OPR).** The MR office serves as the primary focal point for unit medical readiness training activities. Local readiness officers/NCOs/managers may also direct questions to MAJCOM/SGXs, MEFPAKs, AFEMSI, and other medical readiness subject matter experts, as necessary.

5.6.2. **Documentation.** Document personnel training for all members in MRDSS ULTRA. This automated training and tracking program is the sole source of documentation for medical personnel training. Print and file an AF Form 1098, *Special Task Certification and Recurring Training*, in the member's training folder only when the individual is scheduled to PCA, PCS, deploy, separate, or retire. Training documentation for inspection purposes can be obtained from the MRDSS ULTRA reports menu. A full discussion of medical readiness documentation is located in **Chapter 3**.

**5.7. Individual Training Requirements (Category I).** The proficiency of airmen to perform the full scope of practice for their AFSCs is the most critical aspect of team performance. Individual training is a broad categorization that consists of core training requirements all AFMS personnel must complete. Individuals begin Category I training and are counted in unit training statistics upon inprocessing at their first duty station. Specific training elements in each category are listed in **Attachment 3**. (ARC: The RSVP requirements begin when an individual returns to the unit after completion of their 3-level AFSC-awarding technical school.)

5.7.1. **Readiness Skills Verification Program (RSVP).** RSVP applies to all individuals who hold a medical AFSC and is the readiness portion of AFSC-specific sustainment training designed to ensure all medical personnel maintain adequate skills to perform their duties during wartime, humanitarian assistance, and installation response contingencies. RSVP training should begin as soon as personnel arrive at their first duty stations, with credit awarded as applicable for skills learned in technical training or professional education. Lists of critical knowledge and performance skills required of all deploying Airmen are determined by the AF/SG Consultants and Career Field Managers (CFM). AFEMSI works with the AF/SG Consultants and CFMs to maintain, refine and validate RSVP tasks and training sources, in an effort to standardize training across the AFMS. RSVP knowledge and performance items, along with associated training sources, are listed on RSVP checklists, which are accessible within MRDSS ULTRA.

5.7.1.1. Personnel assigned to a standard UTC must complete the RSVP training for their Control AFSC (CAFSC) for enlisted and Duty AFSC (DAFSC) for officers. In addition, personnel who are utilized as authorized substitutes on a standard UTC must complete RSVP training for the AFSC they are filling to meet their role on the UTC, as well as their own AFSC. **EXCEPTION:** For the Patient Decontamination Team, UTC FFGLB, authorized substitutes will complete RSVP training for their own AFSC, versus the AFSC they are substituting for.

5.7.1.1.1. Every effort should be made to send substitutes to a formal UTC course, when one exists, before they deploy.

5.7.1.1.2. Unit commanders may grant credit for specific RSVP training tasks that are accomplished as part of regular duties, participation in a deployment or exercise, or attendance of UTC formal training. Documentation must be provided as evidence that this requirement has been met.

5.7.1.2. Preferably, personnel should not be assigned to a readiness tasking or standard UTC until they hold a fully qualified AFSC (4XX3 for officers or 4XX51 enlisted). However, personnel not holding fully qualified AFSCs (4XX1 for officers and 4XX31 for enlisted) may substitute IAW AFI 10-403, as long as sufficient oversight and skill capability is present on the UTCs. A unit commander must review UTC assignments to ensure mission capability.

5.7.1.3. Personnel assigned to MCRP teams must be prepared to perform team tasks at any time, regardless of skill level. Therefore, individuals must maintain currency in RSVP training at all times.

5.7.2. **Additional Training for Clinical AFSCs.** For some clinical personnel, daily practice in a peacetime environment meets practice requirements in a readiness environment. For others, daily practice does not mirror the trauma skills needed to care for combat casualties. RC clinicians may be granted equivalent training credit based on their civilian employment experience when appropriate documentation is provided.

5.7.2.1. Centers for Sustainment of Trauma and Readiness Skills (C-STARS). C-STARS are military-civilian partnerships, providing centrally-funded, advanced-sustainment training courses located at civilian Level-I trauma centers. C-STARS Cincinnati – CCATT Advanced Course – is the only platform approved for attendance by personnel assigned to or deploying in a CCATT UTC. C-STARS attendance is mandatory for all providers, nurses, and clinical technicians assigned to primary trauma or critical care UTCs, including: FFCC*, FFDAB, FFMFS, FFEP1, FFEP5, FFGKN, FFGKT, FFQEK, FFQE3, FFQE4. C-STARS sites have dedicated faculty on site who oversee all aspects of the training experience. Although training occurs in high-volume civilian centers, all platforms emphasize individual skill development and utilization of those skills in the deployed team context.

5.7.2.1.1. Personnel assigned to the UTCs specified in **5.7.2.1.** (for FFCC*, see para **5.7.2.1.3.**) and not performing Level I trauma duties will attend C-STARS every 24 months. Surgeons at Level 1 trauma centers who are unable to meet the American College of Surgeons' recommendation to operate and manage 35 multi-trauma patients per year must attend C-STARS every 24 months. MR offices should consider limited C-STARS class sizes in the scheduling process and appropriately stage their personnel over several classes.

5.7.2.1.2. Personnel assigned to the UTCs specified in **5.7.2.1.** (for FFCC*, see para **5.7.2.1.3.**) who ***are*** performing Level 1 trauma duties will attend C-STARS every 48 months. Personnel may be granted C-STARS waivers by their respective specialty consultant on a case-by-case basis.

5.7.2.1.3. Active duty CCATT personnel will complete training at C-STARS Cincinnati within 12 months following completion of the CCATT Initial Course, and every 24 months thereafter. ARC CCATT personnel will complete C-STARS Cincinnati training every 48 months, normally beginning in the cycle immediately following the one in which they completed the CCATT Initial Course. ARC CCATT personnel identified to support a CCATT

deployment must have completed C-STARS Cincinnati within the previous 24 months prior to deployment.

5.7.2.1.4. CCATT members who are identified for deployment during the year in which they completed the CCATT Initial Course must also complete C-STARS Cincinnati prior to deployment. All CCATT personnel must complete C-STARS Cincinnati a minimum of 90 days prior to deployment.

5.7.2.1.5. ANG personnel assigned to the following UTCs: FFCCU, FFDAB, FFMFS, FFEP1, FFEP5, FFGKN, FFGKT, FFQEK, FFQE3, FFQE4 will complete C-STARS within 90 days prior to deployment. ANG personnel assigned to FFCCT and FFCCE will follow the guidance in paragraphs **5.7.2.1.3.** and **5.7.2.1.4.**

5.7.2.1.6. Clinical personnel assigned to any UTC are eligible to attend C-STARS on a space available basis.

5.7.2.2. AFEMSI oversees standardized program curricula for all C-STARS locations and associated skill sustainment platforms. AFEMSI monitors these programs for quality and effectiveness, and works with the AF/SG Consultants and CFMs to update the curricula as needed.

5.7.2.3. Medical treatment facilities may have existing training affiliation agreements with local civilian facilities to provide care for acute patients. These agreements provide an opportunity for Air Force medical personnel to work within a civilian hospital to maintain skill currency.

5.7.2.4. Units with co-located squadron medical elements (SME) or other medical personnel not assigned to the unit will provide necessary Category I training and track this training in MRDSS ULTRA. **EXCEPTION:** AFSOC operational support medical (OSM) flights may conduct their own Category I training; AFSOC OSM and all AE Squadrons track their own training in MRDSS ULTRA.

5.7.3. **CCATT UTC Personnel.** Personnel assigned to CCATTs are required to participate in aerial flight to accomplish the CCATT mission. All CCATT personnel must complete the requirements for operational support flier (OSF) status IAW AFI 11-402, *Aviation and Parachutist Service, Aeronautical Ratings and Badges*. CCATT personnel must maintain currency in OSF requirements as long as they are assigned to a CCATT UTC. Personnel may not be employed or deployed as CCATT members if they have not completed or are not current in OSF requirements.

5.7.3.1. OSF-qualified CCATTs must be issued aeronautical orders (AO) through the home station host aviation resource management (HARM) office prior to participating in aerial flight activities. CCATTs must be issued appropriate flying protective clothing and equipment upon initial UTC assignment and for deployment as defined in AFTTP 3-42.51, *Critical Care Air Transport Teams*. Aeromedical evacuation missions may take CCATT personnel to worldwide locations; government passports are required for all CCATT personnel.

5.7.3.2. Additional requirements may be imposed by Combatant Commanders to participate in aerial missions within respective theaters during operations, i.e. high risk of capture (HRC) training, isolated personnel reports (ISOPREP), etc.

5.7.3.3. Additional information is provided at the CCATT website, located on the Air Force Portal: **https://www.my.af.mil/gcss-af/afp40/USAF/ep/globalTab.do?channelPageId=-1324678&command=org&com.broadvision.session.new=Yes**.

5.7.4. **Personnel Assigned to the Global Reach Laydown Team (UTC FFGRL).** Global Reach Laydown teams provide vital health and preventive medicine services in the early stages of deployment, often in austere or bare base locations. In addition to local training to maintain currency in all pertinent contingency skills and RSVP training, all personnel assigned to FFGRL must complete the Contingency Preventive Medicine course and participate in Eagle Flag.

5.7.4.1. Contingency Preventive Medicine (CPM). This course is initial UTC training and is required upon assigned to a GRL team. All GRL team members must complete the previously available CONOPS course, the current 2-week CPM course, or the computer-based training and field portions of the upcoming CPM course.

5.7.4.2. Eagle Flag. This exercise is conducted by the Air Force Expeditionary Center at Ft Dix, New Jersey. Eagle Flag provides sustainment training for GRL team personnel and all members are required to attend Eagle Flag (or other MAJCOM approved exercise) at least once every 48 months.

5.7.4.3. Equivalency Credit. Members may request/receive credit for real world training and/or deployments. Members who have deployed 14 days or more to an austere environment in a 48 month period and have performed duties consistent with deployment as a GRL or Preventive Medicine Team (FFPM1/2) members, may be exempt from training requirements listed above. Requests should be forwarded to HQ AMC/SGX who will coordinate approval/disapproval with HQ AMC/SGP.

5.7.5. **Personnel in Training Status.**

5.7.5.1. Interns, residents, and personnel in fellowship training status who are assigned to a UTC must complete medical readiness training (MRT) IAW this chapter and **Attachment 3**.

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

5.7.6. **Squadron Medical Element (SME)/Geographically Separated Unit (GSU).** Medical personnel and nonmedical personnel assigned to these medical elements will complete the requirements in this chapter, as well as specialized training for their unique medical missions. Each unit may be paired by the MAJCOM with a larger medical unit in order to facilitate training.

5.7.7. **Higher Headquarters/MAJCOMs.** Individuals assigned to higher headquarters/MAJCOMs will complete the requirements in this chapter and **Attachment 3**, when assigned to a D- coded UTC or tasked to deploy. A unit training monitor will be appointed to track staff training.

5.7.8. **Nonmedical Personnel.** Nonmedical personnel assigned to a deployable medical UTC will satisfy all of the applicable requirements described in this chapter.

5.7.9. **Chaplains.** Chaplain Service personnel assigned to an MTF are encouraged to participate in MRT. The MR office will coordinate with the base senior chaplain to schedule this training.

5.7.10. **CBRNE Defense Awareness Training.** This training is required in accordance with AFI 10-2501, *Air Force Emergency Management Program Planning and Operations,* and must be documented in MRDSS ULTRA. CBRNE Defense Awareness Training is a prerequisite for the CBRNE

Defense Survival Skills Course described in para. **5.8.1.** below. Refer to AFI 10-2501, Tables 6.3 and 6.4. and paragraph 6.6.1.2.2. for additional guidance.

5.7.11. **CBRN Emergency Medical Preparedness and Response Course (EMPRC).** This Category I training is unique for all DOD military *medical* personnel and is different from the CBRNE training provided by base civil engineers. AFMS new accessions are required to accomplish CBRN EMPRC within 12 months of arriving at their first duty station. Sustainment training must be completed every 36 months once available. Depending on an individual's AFSC and duties, they will complete one or more of the four CBRN EMPRC courses below. This training is documented in MRDSS ULTRA. The requirements for completing Medical Effects of CBRN Warfare and Threat and Future Battlefield Environment training prescribed in DODI 1322.24, *Medical Readiness Training*, as well as Depleted Uranium training are met through completion of Clinician/Provider or Operator/Responder CBRN EMPRC. See **https://kx.afms.mil/sg3xp** for additional information.

5.7.11.1. Clinician/Provider Course. This training is required for all personnel with a physician, nurse, dentist, physician assistant or Independent Duty Medical Technician (IDMT) primary AFSC (PAFSC).

5.7.11.2. Executive/Commander Course. This training is required for personnel filling a C-prefix (commander), or having a 40C0 or 9G100 (group superintendent) duty AFSC. Personnel will be granted credit for the Executive/Commander course if they have completed either the Clinician/Provider or Operator/Responder courses, as appropriate for their PAFSC. Personnel who complete the Executive/Commander course and are subsequently reassigned to a non-command position must also complete the course appropriate for their AFSC within 120 days of reassignment. Unit Medical Readiness Training Managers will ensure unit commanders' duty AFSCs are appropriately entered in MRDSS ULTRA and updated as necessary.

5.7.11.3. Operator/Responder Course. This training is required for all personnel holding a medical primary AFSC (PAFSC) who do not meet the criteria for the Clinician/Provider and Executive/Commander courses. Personnel assigned to medical readiness duties must also take the Operator/Responder course, regardless of their PAFSC.

5.7.11.4. Basic Course. This training is required for all personnel holding a non-medical AFSC (i.e. 3S2XX, 8F0XX) but working in a medical unit or staff function.

5.7.11.5. Medical civilian and contractor personnel should take the appropriate course for military members in their position. For example, a contractor dentist would complete the Clinician/Provider course. Completion certificates will be maintained by the MR office. These individuals may be manually entered in MRDSS ULTRA to track this training.

5.7.12. **Air Force Emergency Response Operations (ERO) Training.** ERO training is mandatory for first responders, as defined in AFI 10-2501, which includes personnel assigned to the Medical Control Center personnel, Aerospace Medicine Team, Field Treatment Team, Public Health Team, Bioenvironmental Team, Manpower Team, and any other team members that might be required to support emergency operations. Training for these individuals will be tracked and documented by the MCRP team chiefs in MRDSS ULTRA. Additional First Responder/First Receiver training is covered in AFI 10-2501, *Air Force Emergency Management (EM) Program Planning And Operations,* and AFH 10- 2502, *USAF Weapons of Mass Destruction(WMD) Threat Planning and Response Handbook*. Individuals whose emergency response duties involve operating entirely within the unit, such as

pharmacy, laboratory, radiology, or surgical functions, may be exempted from this requirement at the unit commander's discretion.

**5.8. Deployment Training Requirements (Category II).** Deployment training requirements include those skills required for personnel to perform the full scope of practice for their AFSCs in a deployed setting. Individuals begin Category II training upon assignment to an A/DWS, A/DWX, or A/DXS coded UTC, or upon notification of a deployment tasking. Although training frequency for Category II training is specified in **Attachment 3**, training may occur more frequently for some personnel to ensure currency for the duration of a deployment.

5.8.1. **CBRNE Defense Survival Skills Course.** This training, provided by base civil engineers, is the classroom training follow-on to the CBRNE Defense Awareness Training course described in paragraph **5.7.10.** above. CBRNE Defense Survival Skills must be completed in accordance with AFI 10-2501 and documented in MRDSS ULTRA.

5.8.2. **Expeditionary Training Requirements for Ground-based UTCs (including EMEDS and support UTCs).** All UTC training should include an understanding of the AEF structure and the AFMS rotational force presentation strategy; current medical operations; military intelligence for operational theaters; and individual preparation responsibilities. All personnel assigned to deployable ground-based UTCs must meet the requirements in **Attachment 3**.

5.8.2.1. Depending on clinical directives for each specialty, personnel assigned to deployable UTCs must be current in Basic Life Support (BLS), Advanced Trauma Life Support (ATLS), Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and National Registry of Emergency Medical Technicians (NREMT) and/or Prehospital Trauma Life Support (PHTLS). This training is managed by the Education and Training Office, which will validate requirements for each specialty. Representatives from the Education and Training Office are given MRDSS ULTRA accounts by the MRDSS ULTRA Unit System Administrator and will enter/update this training data in MRDSS ULTRA. Certification must remain current throughout any projected deployment vulnerability period and may not lapse during a deployment.

5.8.2.2. Formal Courses. Personnel assigned to deployable UTCs will complete formal courses as developed by MEFPAK responsible agencies.

5.8.2.2.1. UTC formal training (with valid course numbers) must be accomplished as outlined in the following paragraphs every 48 months, unless otherwise directed by MEFPAK or higher authority. UTC sustainment training is accomplished between formal training cycles and is designed to keep UTC members' skills current.

5.8.2.2.1.1. EMEDS Basic UTCs attend EMEDS course or participate in a sustainment exercise every 24 months. UTCs would attend the formal course one cycle and an RTOC sponsored or MEFPAK approved UTC Mission Essential Task driven exercise the next. UTCs can not receive sustainment/exercise credit two consecutive 24 month periods.

5.8.2.2.1.2. EMEDS +10 UTCs attend EMEDS course every 48 months. UTCs attend the formal course one cycle and complete sustainment training the next. Sustainment training will consist of reviewing UTC TTP, MISCAPS, UTC METLS and allowance standard.

5.8.2.2.1.3. EMEDS +25 UTCs will train by reviewing the UTC TTP, MISCAPS, UTC METLS and allowance standard until formal EMEDS training is available for the FFEP4 and FFEP5 UTCs.

5.8.2.2.1.4. Enablers/Specialty Set UTCs beyond the EMEDS Plus 25 platform. For these UTCs training will consist of reviewing the UTC CONOPS/TTP, MISCAPS, UTC METLS and allowance standard. Hands-on experience with equipment is required for those units with co-located equipment sets. There is no requirement to attend a formal course. Participation in exercises is highly desired when the opportunity is available.

5.8.2.2.2. EMEDS Formal Training Scheduling: The MR office must schedule personnel to attend formal training via the parent MAJCOM POCs at least 120 days prior to course start date. Course dates should comply with AEF schedule activity windows.

5.8.2.2.2.1. For active duty, the ACC scheduler will compile and return "master" class rosters the MAJCOM POCs 60 days prior to class start date. MAJCOM POCs will validate participants, make necessary changes if required, and return the roster to the ACC scheduler by the specified deadline. For AFRC, the individual, in conjunction with their unit, will submit an AF Form 101 to their wing Training Office. The wing Training Office will submit the AF Form 101 request to HQ AFRC/SG and Cc the NAF for a TLN to attend the specified class date. If a seat in the class is available the TLN will be issued. If a seat is not available HQ AFRC/SG will disapprove the TLN and provide alternate class dates for member to attend.

5.8.2.2.2.2. Training line numbers (TLN) will be issued not later than 14 days prior to class start date to allow the student to complete all administrative requirements. If cancellations or substitutions are required after TLNs are issued, the MR office must submit a request through the unit commander to the MAJCOM SGX office. Within 14 days of class start date, justification for removal/substitution is limited to emergency leave, hospitalization, profile or early deployment. MAJCOM SGX offices will concur/non- concur and forward the request to ACC/SGXP. No show letters will be sent to the appropriate MAJCOM/SGX.

5.8.2.3. Field Training. Personnel assigned to deployable UTCs that have corresponding initial formal UTC courses will complete field training as part of the formal UTC course. The RTOC will continue working solutions for UTCs without formal courses. Reference **Attachment 7** for required training topics.

5.8.3. **Expeditionary Training Requirements for Aeromedical Evacuation (AE) UTCs.** AE team training must focus on integration of all AE UTCs with ground-based UTCs and Joint capabilities to create the Theater Aeromedical Evacuation System (TAES).

5.8.3.1. AE Integration Courses.

5.8.3.1.1. Aeromedical Evacuation Contingency Operations Training (AECOT).

5.8.3.1.1.1. All A3 owned personnel assigned to AE UTCs will complete initial AECOT within 12 months of assignment. Newly accessed ARC personnel will complete the initial AECOT course within 18 months of completion of Basic Military Training/Commissioned Officer Training and AFSC formal course training. Personnel assigned to AE units will at a minimum complete sustainment training every 60 months. Participating in an RTOC sponsored or MEFPAK (AMC/A3OE) approved AE UTC Mission Essential Task (MET) driven exercise, such as JRTC or an ORI, is the preferred method of completing sustainment training. Sustainment training credit may also be granted by local commanders to personnel who deploy in an AE UTC for a period of 30 days or more. Personnel who do

not meet the sustainment training requirement by one of these two methods must re-attend the AECOT course.

5.8.3.1.1.2. Personnel not in an AE Squadron (SG Personnel) that are assigned to specific UTCs supporting enroute staging/clinical support (i.e. MASF) will complete initial AECOT training within 12 months of being assigned to a ground medical AE UTC, and will complete sustainment training every 48 months thereafter. Sustainment training for MASF personnel will be to participate in an RTOC or MEFPAK (AMC/SG) approved exercise. See paragraphs **5.4.3.1.** and **5.4.3.2.** for guidance on how to grant/obtain approval for sustainment training credit from the MEFPAK for ground medical UTCs. Active duty CCATT personnel will complete initial AECOT within 12 months of initial CCATT course attendance; ARC CCATT personnel will attend AECOT within 18 months of initial CCATT course attendance. MASF personnel will attend AECOT every 24 months for the first three cycles after placement on the UTC; then every 48 months thereafter. Waivers for initial AECOT attendance for CCATT personnel may be requested IAW AFTTP 3-42.51.

5.8.3.1.1.3. AECOT Formal Training Scheduling. The MR office must schedule personnel to attend formal training via the parent MAJCOM POC at least 120 days prior to the course start date. For active duty, the AMC scheduler will compile and return the master class roster to the MAJCOM POCs NLT 6 days prior to the class start date. MAJCOM POCs will validate their personnel and make changes if required and return the roster to HQ AMC/SGX (AECOT Course scheduler) by given suspense date.

5.8.3.1.1.4. Cancellations for the AECOT course must be submitted at a minimum of 30 days prior to the class start date. If it is within the 30-day window and there is no replacement, a request for cancellation should be signed by the medical unit commander and submitted to HQ AMC/SGX via e-mail or fax. Within 14 days prior to class start date, justification for removal/substitution is limited to emergency leave, hospitalization, profile, or early deployment. MAJCOM/SGX offices will concur/non-concur with last minute cancellations.

5.8.3.1.2. Specific AE UTC MISCAPS, CONOPS and UTC training requirements are located on the HQ AMC/A3OE (MRA) website at **https://private.amc.af.mil/a3/a33/A33E/index.htm**. Additional guidance will be forthcoming in AFI 10-2912, currently under development.

5.8.3.1.3. Any other formal course directed by MAJCOM.

5.8.3.2. Formal UTC Courses.

5.8.3.2.1. CCATT validation and training.

5.8.3.2.1.1. All members selected for CCATT duty will undergo a position-specific skill validation process administered by AFEMSI under the authority of HQ AMC/SG as CCATT MEFPAK. Personnel must be approved for CCATT duty through the validation process prior to assignment to a CCATT UTC and entry into the CCATT training pipeline. Reference AFTTP 3-42.51 for validation process requirements.

5.8.3.2.1.2. All CCATT personnel will attend the initial CCATT course at USAFSAM within six months of assignment. Personnel may not be employed or deployed as CCATT members until they have completed the initial CCATT course and C-STARS Cincinnati.

They must also complete all additional training requirements as outlined in AFTTP 3-42.51, Critical Care Air Transport Teams.

5.8.3.2.2. CASF Course. All CASF UTC personnel will attend initial CASF training within 12 months of assignment, prior to being deployed and every 48 months. Sustainment training will be in the form of an exercise every other cycle. For example, formal training will occur one 24 month period and sustainment training will occur the next 24 month period. If participation in an RTOC sponsored exercise can not be accomplished in the off cycle, a review of the TTP, and 44-165, *Administering Aeromedical Staging Facilities*, MISCAPS, UTC METLS and allowance standard will suffice as sustainment training. UTCs can not receive sustainment/ exercise credit two consecutive 24 month periods.

5.8.3.2.2.1. CASF Formal Training Scheduling: The MR office must schedule personnel to attend formal training via the parent MAJCOM POC at least 120 days prior to the course start date.

5.8.3.2.2.2. For active duty, the AMC scheduler will compile and return the master class roster to the MAJCOM POCs NLT 6 days prior to the class start date. MAJCOM POCs will validate their personnel and make changes if required and return the roster to HQ AMC/SGX (CASF Course scheduler) by given suspense date. For AFRC, the individual, in conjunction with their unit, will submit an AF Form 101 to their wing Training Office. The wing Training Office will submit the AF Form 101 request to HQ AFRC/SG and Cc the NAF for a TLN to attend the specified class date. If a seat in the class is available the TLN will be issued. If a seat is not available HQ AFRC/SG will disapprove the TLN and provide alternate class dates for member to attend.

5.8.3.2.2.3. Cancellations for the CASF course must be submitted at a minimum of 30 days prior to the class start date. If it is within the 30-day window and there is no replacement, a request for cancellation should be signed by the medical unit commander and submitted to HQ AMC/SGX via e-mail or fax. Within 14 days prior to class start date, justification for removal/substitution is limited to emergency leave, hospitalization, profile, or early deployment. MAJCOM/SGX offices will concur/non-concur with last minute cancellations.

**5.9. Unit Training Requirements (Category III).** Unit training includes elements of individual and team training, but is required for all members of the unit. This training provides overall mission and doctrine for the AFMS, and connects that information to the role of the unit and individual, introducing members to specific team assignments.

5.9.1. **MCRP Team Training.**

5.9.1.1. Each team must train annually to meet capabilities identified in its team annex. Each team chief will clearly identify training requirements and develop an annual training schedule that will be forwarded to the MR office for inclusion in the MRTEP.

5.9.1.2. Disaster response training will be driven by local base/wing requirements. Units should scale training requirements to meet identified vulnerabilities/threats and planned response, to include management of casualties in the MTF, including CBRN casualties; awareness of the types of disasters that the MTF might expect; and protection and decontamination of medical personnel,

patient and medical facilities during CBRN conditions. The IGESP and the MCRP will reflect the level of support provided by the medical unit.

5.9.1.3. Team chiefs will conduct, document, and track team training for their MCRP teams. Lesson plans will be developed and maintained by the team chief and reviewed annually, prior to conducting training. Sign-in rosters, including dates of training, subjects covered, attendees, and instructor signature, will be maintained in the team binder. Team training statistics will be maintained in MRDSS. Make-up training must be conducted and documented for personnel missing training sessions.

5.9.1.4. Air reserve component (ARC) personnel assigned to augment active duty (AD) unit teams must be included in the development of the training schedule. Designated training will be coordinated between the team chiefs, the MR office, and RC unit leadership.

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**5.10. Leadership Training (Crosses all categories).**

5.10.1. **Command and Control (C2).** In preparation for leading in the deployed environment, unit and UTC team leaders must fully understand C2 and conditions at the deployed location, using the *Deployed Commanders Handbook*, available at AEF Center website at: **https://aefcenter.afpc.randolph.af.mil**. Specific areas to study to improve situational awareness include:

5.10.1.1. Joint Force commander's mission, concept of operations, phasing, and desired end state.

5.10.1.2. Joint force laydown, including the line and medical C2 for operational control (OPCON), tactical control (TACON), administrative control (ADCON), and support.

5.10.1.3. Joint and air component medical concept of operations, including casualty flow from injury to definitive care, blood and medical supply, host nation medical care, casualty estimates, and reachback.

5.10.1.4. Theater specific risks and force health protection, including intelligence data on climate, topography, endemic diseases, and environmental factors.

5.10.1.5. Operational mission of the base and their units/teams during all phases of the mission.

5.10.1.6. Population at risk. Although wartime troop strengths are classified, a fundamental understanding of the population at risk, its general size and characteristics, and any variances over time, is essential to effective planning and resourcing.

5.10.2. **Pre-deployment Exercise.** If possible, UTC and/or deployed unit leaders should participate in a pre-deployment tabletop exercise without subordinate unit personnel, to enhance communication with other leaders and enhance theater familiarity. Prior communication with the deployed site is authorized for command and control personnel to enhance mission preparation.

5.10.3. **Clinical Care.** Deployed unit leaders must be prepared to comply with appropriate clinical care directives and clinical practice guidelines. Tools to assist commanders and a list of subject matter experts can be accessed via the AFMSA/SGX website at: **https://kx.afms.mil/sg3xp**.

5.10.4. **Pre-deployment Training.** Any required pre-deployment training will be specified in reporting instructions. Ensure all personnel comply with training requirements and carry documentation of training when deploying.

## Chapter 6

## AIR RESERVE COMPONENT MEDICAL READINESS TRAINING

**6.1. General.** This chapter provides specific guidance for active component (AC) support to reserve component (RC) training, including IMA and unit training, and identifies specific requirements for ANG and AFRC medical units. It does not apply to ARC AE units. This chapter replaces RC supplements to this AFI.

**6.2. Air Reserve Component (ARC) Medical Annual Tour Training Program.** The purpose of the annual tour (AT) program is to provide Reserve medical personnel RSVP and upgrade training (UGT) in an AD clinical setting. Additional training requirements may also be met during AT such as UTC and theater specific training requirements, however, the primary purpose is to complete RSVP and UGT items that can not be accomplished at the Reserve Medical Unit (RMU) level. Additional information for planning an effective AT is provided in AFRCI 10-204, *Air Force Reserve Exercise and Deployment Program* and AFMAN 36-8001, *Reserve Personnel Participation and Training Program* and applicable Memorandums of Agreement/Understanding (MOA/U).

6.2.1. **Scheduling.** AC medical units and AFRC/SG readiness personnel must negotiate training dates and expectations well in advance of the anticipated AT IAW the applicable MOA/MOU. ANG medical units will apply for OSATs IAW the ANG Regional Training Cycle through NGB/SGXs Training and Tracking (TnT) website **https://tnt.ang.af.mil/**.

6.2.1.1. Each AD medical facility will appoint in writing a Reserve Affairs Liaison and alternate to facilitate reserve training at their respective facility.

6.2.1.2. The Reserve Affairs Liaison will identify what training capabilities the facility can support and forward the information to HQ AFRC/SGM and NGB SGXT NLT 15 March of each calendar year to include preferred dates/time frames to schedule the ATs; maximum/minimum number of personnel they can support per group; number of tours that can be supported; AFSCs that can be supported as well as the maximum/minimum number of each AFSC; limitations such as training, billeting, transportation, messing, etc.

6.2.2. **AT Monitor.** The RMU will appoint in writing an AT Monitor and alternate. One of the monitors will be an Air Reserve Technician (ART). The RMU AT Monitor will:

6.2.2.1. Establish contact with the Reserve Affairs Liaison once notified by the Numbered Air Force (NAF)/SG or NGB/SG of the approved AT to negotiate AFSC mix, dates, capabilities, etc.

6.2.2.2. Prepare and distribute training plans (T-Plans) 90 days before tour start date to host facility, applicable NAF/SG and HQ AFRC/SGM.

6.2.2.3. Forward credentials of health care providers, as defined in AFI 44-119, *Clinical Performance Improvement*, to host facility NLT 60 days prior to start date of tour or IAW MAJCOM or MTF policy. Unit AT Monitor will request host facility credentials committee special requirements.

6.2.2.4. Prepare and distribute electronic copies of after-action reports (AAR) for ATs to host facility, applicable NAF/SG, and HQ AFRC/SGM or NGB SGXT NLT 30 days after end of tour.

6.2.2.5. Failure to follow the established timelines could result in the cancellation of the AT.

**6.3. Air Force Reserve Command Training Guidance.** The following specific guidance is provided for AFRC units. In addition to those roles and responsibilities listed in **Chapter 2**, the AFRC Medical Unit Commander will:

6.3.1. **Oversight.** Designate either the EMC or the Education and Training Committee (E&TC) as the primary oversight of the medical readiness training function. This oversight is necessary to ensure medical readiness training requirements are scheduled based on the 24 month AEF schedule, comply with applicable directives, and are included in the unit's annual training plan developed by the Strategic Planning Committee. If the E&TC is designated to provide oversight, they will forward to the EMC any issues requiring input or resolution from a higher authority.

6.3.2. **MRO/MRNCO.** Appoint in writing a MRO and MRNCO. The appointment letter should include assignment as the certification official for medical readiness training (excluding RSVP training). To maintain program continuity, personnel will remain in their position for a minimum of 24 months. Where possible, every effort will be made to avoid placing additional duties on the MRO/MRNCO unrelated to readiness, i.e. Security Manager, Building Custodian, etc.

6.3.3. **Exercise Evaluation Team (EET).** Appoint in writing a medical EET Chief and representatives to the Wing EET IAW local requirements. The MRO/MRNCO will not be the sole exercise evaluation team members. The medical readiness staff will identify exercise goals and objectives to the EET Chief who develops the scenario, executes the exercise, and evaluates results in order to fully test medical readiness and fulfill exercise requirements as outlined in this instruction.

**6.4. Individual Mobilization Augmentee (IMA) Program Management.** AC units of attachment are responsible for providing training to their attached IMAs. The IMAs point of contact in the unit is the Reserve Liaison Officer/NCO or civilian manager.

6.4.1. **Unit Reserve Liaison Officer/NCO.** This individual will:

6.4.1.1. Ensure that IMA reservists receive required expeditionary medical operations training.

6.4.1.2. Provide to the IMA a copy of the MRTEP to facilitate scheduling.

6.4.1.3. Notify RMG DET 15 of an IMA reservist who fails to comply with training requirements.

6.4.2. **Unit MR Office.** This office will:

6.4.2.1. Obtain a list of attached IMAs at least annually from the unit AF reserve liaison officer.

6.4.2.2. Ensure all pertinent training is tracked.

6.4.2.3. Forward training statistics to RMG DET 15, as required.

6.4.3. **IMA reservists.** These individuals will:

6.4.3.1. Plan for required MR training and complete training as required. Medical reservists in non- pay participating individual ready status are not required to complete training unless identified for deployment, at which time they will receive training on a JIT basis.

6.4.3.2. Request orders using the Air Force Reserve Order Writing System (AROWS-R) if attendance will be in AT or Special Tour status. RMG DET 15 must receive the request at least 30 days in advance of scheduled training.

6.4.3.3. Medical IMA reservists may complete training requirements in one of three capacities.

6.4.3.3.1. Annual tour.

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

6.4.3.3.3. Special tour-Reserve Personnel Appropriation (RPA) man days. IMAs must request orders using AROWS-R 30 days in advance of scheduled training.

**6.5. Air National Guard Training Guidance.** The following specific guidance is provided for ANG units (in addition to guidance provided elsewhere in this AFI).

6.5.1. **Roles and Responsibilities.**

6.5.1.1. The National Guard Bureau Air Surgeon (NGB/SG), in addition to those roles and responsibilities listed in **Chapter 2**, will:

6.5.1.1.1. Provide guidance to State Air Surgeons, State Joint Staffs, Regional Planners, and the senior full-time medical person; identify regional Lead State Air Surgeons and planners; and plan/program for any additional training these individuals may require.

6.5.1.1.2. Program and plan for exercising and training to include directed federal, state, local, and regional planning, training, and exercising in support of DSCA.

6.5.1.1.3. May grant State Air Surgeons specific authority to implement/oversee specific areas of these or other responsibilities found in this AFI.

6.5.1.2. The ANG Medical Unit Commander, in addition to those roles and responsibilities listed in **Chapter 2**, will:

6.5.1.2.1. Designate either the EMC or the E&TC as the primary oversight of the medical readiness training function. This oversight is necessary to ensure medical readiness training requirements are scheduled based on the 24 month AEF schedule, comply with applicable directives, and are included in the unit's master training calendar. The oversight body will review training currency statistics and adjust training schedules as needed in order to maintain mission capable rates. If the E&TC is designated to provide this oversight, they will forward to the EMC or organization commander any issues requiring input/resolution from a higher authority. All requests for training waivers must first be reviewed and approved (in writing) by the EMC or organization commander prior to NGB/SGX final review.

6.5.1.2.2. Appoint, in writing, a MRO/MRNCO. The appointment letter should include assignment as the certification official for medical readiness training (excluding individual AFSC-specific training). Every effort will be made to avoid placing additional duties on the MRO/MRNCO unrelated to readiness.

6.5.1.2.3. Appoint both a primary and an alternate PHEO IAW AFI 10-2603, *Emergency Health Powers on Air Force Installations*. For the ANG, the terms Casualty Management Officer and PHEO are interchangeable. One of these two positions will be a provider. The other will occupy one of the full- time positions within the medical unit and will be familiar with the unit's CBRN response capabilities.

6.5.1.2.4. Appoint an EET Chief who should also serve as the unit exercise planner. Upon appointment, forward their name and contact information to NGB/SG.

6.5.1.2.5. Receive a medical intelligence briefing from the PHO as required. Document completion in the EMC minutes.

6.5.1.3. ANG EMEDS commanders, who have not already attended, will apply for the Joint Operations Medical Managers Course (JOMMC) immediately upon assignment to the position.

6.5.1.4. The MRO/MRNCO, in addition to the roles and responsibilities listed in **Chapter 2**, will:

6.5.1.4.1. Remain in these positions for a minimum of 24 months, where possible.

6.5.1.4.2. Attend the ANG-specific planner's course, when it becomes available. The NGB/SG will identify additional initial medical readiness training requirements for the MRO/MRNCOs and other unit-level leadership. Newly assigned MRO/MRNCOs should be granted every opportunity to attend the next scheduled Medical Readiness Symposium to include any MAJCOM-specific offerings.

6.5.1.4.3. Ensure required material is provided to the EMC/E&TC at least quarterly.

6.5.1.5. The Chemical, Biological, Radiological, Nuclear (CBRN) Medical Defense Officer/NCO (MDO), in addition to the roles and responsibilities listed in **Chapter 2**, will:

6.5.1.5.1. Ensure personnel assigned to the MC-CBRN response teams as outlined in **Attachment 2** are trained to an appropriate level to ensure full capability is available. Reference AFTTP 3-42.32, *Home Station Medical Response to CBRNE,* AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations* and ANG CONOPS for Allowance Standards 886A, 886C, and 886H for specific requirements and resources for obtaining training.

6.5.1.5.2. Provide assessment information to the EMC regarding toxic industrial chemicals/materials (TICS/TIMS) on base, as well as in the local community that could pose a health threat to the installation.

6.5.2. **EMC/E&TC.** Document in EMC/E&TC minutes the unit review of ART data and ensure areas of discrepancy are addressed with resolution action including appropriate get-well dates (GWD) (see paragraph **6.5.1.2.2.**).

6.5.3. **Training**

6.5.3.1. ANG units will use MRDSS ULTRA to document all training.

6.5.3.2. ANG medical personnel can receive appropriate UTC sustainment training credit for participation in an NGB/SG approved regional/defense support to civil authorities (DSCA) exercise or real world event that satisfies MEFPAK and NGB/SG requirements (see para. **5.4.3.**).

6.5.3.3. ANG ERT may receive training credit during their respective regional exercise. Regional planners and State Air Surgeons are required to ensure regional exercise schedules and scenarios address NGB/SG identified training requirements for these teams. Each ERT will maintain exercise summaries that reflect training goals and achievements. Individual training accomplishments will be documented in the unit's readiness requirements tracking system.

6.5.4. **Exercises.**

6.5.4.1. ANG units possessing HSMR assets identified for Homeland Security support will perform an inventory every 24 months, perform a set-up once every 72 months, and may utilize the

equipment during NGB/SG required FEMA/Regional DSCA exercises. Inventories should be conducted annually IAW AFI 41-209.

6.5.4.2. Regional/DSCA exercise summaries should be forwarded to supporting or supported bases, local, state or regional agencies, as well as the NGB/SG Medical Readiness Operations Branch. These summaries should be used to reaccomplish MOUs, redefine roles, responsibilities and expectations, drive training requirements and identify shortfalls in planning and resourcing.

## Chapter 7

## EXERCISE REQUIREMENTS, PLANNING AND DOCUMENTATION

**7.1. General.** Exercise requirements are generated by this AFI and other directives including AFI 10-2501, AFI 10-2603 and AFI-10-2604. For funding requirements for reconstitution of exercised WRM assemblages see AFI 41-209, Chapter 13. A full list of requirements is given in **Attachment 6**. This chapter provides an overview of base-level exercise planning roles and responsibilities.

**7.2. Purpose of Exercises.** Exercises are conducted to evaluate an organization's capability to execute one or more portions of its response or contingency plans. Exercises should be scenario- driven and be designed to validate procedures and improve processes outlined in plans and planning documents. Each exercise should provide a realistic rehearsal for installation medical response or deployment situations, and may be conducted in a tabletop, function, or full-scale format. As a result, exercises may provide excellent training opportunities but should not replace established training programs.

**7.3. Exercise Types.** Exercises fall into one of three categories: tabletop or walkthrough exercises (TTX)**,** limited scope exercises which including functional (FX) and command post exercises (CPX), or full- scale field training exercises (FTX). The scope of the exercise varies widely from type to type. Exercise planners can successfully blend exercise types (for example, a field exercise where aeromedical evacuation is managed as a functional exercise only) to achieve objectives. Review the exercise objectives carefully to determine the appropriate exercise method for the situation.

7.3.1. **Tabletop or Walkthrough Exercises (TTX).** A tabletop exercise is frequently used to test a new plan or procedure. It is designed to allow participants to examine and resolve problems in an informal, stress-free environment. The success of the exercise is largely determined by group participation and the identification of problem areas. These exercises are particularly effective if lead by an experienced facilitator. Tabletop exercises should be utilized judiciously. Follow the restrictions provided in AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations***,** Table 7.1. The Medical Continuity of Operations (MCOOP) exercise may be conducted as an annual TTX, however, actual relocation of the command and control function must take place every other year.

7.3.2. **Functional Exercise (FX) or Command Post Exercises (CPX).** A functional exercise is a fully simulated exercise that tests multiple functions of an organization's response to a simulated event. It is a time-pressured, realistic simulation. These exercises work well in a training environment if facilitated by experienced exercise controllers.

7.3.3. **Field Training Exercise (FTX).** An FTX simulates a real event as closely as possible. To accomplish this realism, it requires the mobilization and actual movement of personnel, equipment and resources. FTXs are excellent evaluation and training tools, but they are often costly and time-consuming to plan and execute.

**7.4. Exercise Design.** Exercises should be designed to locate and eliminate problems in response and contingency plans before an event occurs. Additionally, exercises enable personnel to practice their roles, and gain experience and confidence prior to a contingency situation.

7.4.1. **Exercise Objectives.** Well constructed exercises include these objectives:

7.4.1.1. Test and evaluate plans, policies and procedures

7.4.1.2. Reveal planning weaknesses

7.4.1.3. Reveal gaps in resources

7.4.1.4. Improve organizational coordination and communications.

7.4.1.5. Clarify and practice roles and responsibilities

7.4.1.6. Improve individual and team performance

7.4.1.7. Demonstrate capabilities to associated organizations; gain support and develop teamwork.

7.4.1.8. Build upon past lessons learned to establish competence in all contingency- related functions.

7.4.2. **Participants.** Exercise participants are determined by the size and scope of the exercise. A TTX might include only key decision makers, while an FTX can include all members of the organization, supporting organizations, and the community. Additionally, the exercise participants may include simulated victims, controllers, evaluators, and observers. The planner must ensure safety for all participants during the exercises, and provide transportation, messing, billeting, and administrative support when required.

7.4.3. **Exercise Development and Planning Factors.** Various planning factors combine to establish an effective exercise program.

7.4.3.1. Realism. Exercises must be realistic and contingency based. Medical unit response and contingency deployment capabilities vary widely. Therefore, each medical unit's exercise program must be tailored to their local capabilities on and off base, support/assistance agreements, local jurisdiction, other military unit capabilities, and contracts.

7.4.3.1.1. Minimize simulations, emphasize participation, and assess actual abilities consistent with safety, exercise objectives, and real-world constraints.

7.4.3.1.2. Overseas locations must also consider host nation agreements, noncombatant evacuation operations, humanitarian operations, and other factors.

7.4.3.1.3. Exercise scenarios should maximize opportunities for training by appropriately incorporating team or individual participation and operational processes and procedures.

7.4.3.2. Threat Vulnerability. Accurately assesses the threat vulnerability on base and in the community and design exercise objectives consistent with that threat. Keep in mind that documents referencing specific vulnerabilities may be classified.

7.4.3.3. Community Participation. Test MOAs/MOUs/MAAs by inviting local community partners and on-base agencies to participate in the exercise, as appropriate. As a minimum, all agreements with local civilian medical and emergency response agencies for MC-CBRN response should be exercised annually.

7.4.3.4. Wing/Base Exercise Schedule and Availability. The medical unit should aggressively pursue opportunities to participate in Wing exercises. However, the absence of Wing exercises does not alter the unit's overall requirements. In these situations, the medical unit should continue to conduct exercises IAW applicable directives.

**7.5. Required Exercises.** Exercise requirements are generated by this AFI and other directives including AFI 10-403, *Deployment Planning*, AFI 10- 2501, *Air Force Emergency Management (EM) Program Planning and Operations,* AFI 10- 2603, *Emergency Health Powers*

*On Air Force Installations* and AFI 10- 2604, *Disease Containment Planning*

*Guidance*. Medical units must participate in other non- medical exercises to include mobilization/deployment exercises IAW AFI 10- 403, and response exercises dictated by AFI 10- 2501.These requirements may be met by participating in Wing exercises. If so, there is no requirement to duplicate them in a medical personnel-only exercise. If the Wing does not meet the exercise requirement, the medical unit must be prepared to meet the requirement independently. Additionally, exercises approved by the Exercise Oversight Committee (EOC) may serve as a vehicle for meeting these requirements. A full list of requirements is at **Attachment 6**.

7.5.1. **Mass Casualty.** A mass casualty exercise may include varying numbers of casualties but in general, should include a sufficient number of casualties to test and stress the facility and its available resources. Medical unit participation in a mass casualty must be consistent with capabilities and responsibilities identified in Wing plans and the MCRP.

7.5.1.1. If the Wing exercise plan does not adequately test the unit's capabilities (for example, the exercise stops at the entrance to the medical facility), the medical unit should develop internal exercises to supplement or extend the exercise.

7.5.1.2. If the medical facility does not have an emergency department, do not automatically transfer casualties to the local community. Aircraft accidents and CBRN events may quickly overwhelm local community resources, forcing the military medical unit to stabilize and stage casualties for several hours. This potential situation should be exercised.

7.5.1.3. Mass casualty exercises must include testing and evaluation of all MCRP teams and their responsibilities. At least one exercise per year must include off- base response agency participation. NOTE: for AFRC, exercises will be IAW applicable base plans.

7.5.2. **Medical Continuity of Operations (MCOOP).** The medical unit's MCOOP must be exercised to identify patient staging, dispersion and tracking processes and capabilities, communications and command and control procedures. Include transportation, CE, and security forces requirements in MCOOP planning and exercises. The medical command and control function must fully relocate every other year, set up functionality and operate out of the relocation facility. TTX is authorized for remaining portions of MCOOP operations.

7.5.3. **Recalls.** Recall procedures should describe the methods used to locate and call back to duty unit personnel. Recall exercises demonstrate the unit's ability to return to duty in response to a contingency situation. Recalls will be conducted in accordance with **Attachment 6**.

7.5.4. **Major Accidents.** A major accident is an accident that warrants response by the installation Disaster Response Force, of which the medical first responders are a part. It differs from day- to- day emergencies and incidents that are handled routinely by base agencies. A major accident may involve one or more of the following: hazardous substances; a class A mishap resulting in damage to DoD property, injuries to DoD personnel, or damage or private property or personnel caused by Air Force operations; extensive property damage; grave injury or death; or an adverse public reaction. Examples include nuclear weapon accidents, nuclear reactor facility accidents, HAZMAT spills, aircraft crashes and fires.

7.5.5. **Terrorist Use of CBRN.** Response to a CBRN event requires many of the same response actions as other types of incidents; however, responders must also establish and maintain a chain of custody for evidence preservation as directed by the Incident Commander. Additionally, responders must be alert for physical indicators and other outward warning signs of additional CBRN events and the potential for secondary attack. The CBRN exercise must include testing and evaluation of all MCRP teams and their responsibilities. Scenarios designed to evaluate medical CBRN response will involve wearing of Personal Protective Equipment (PPE) for those teams assigned protective suit ensembles. (For AFRC, teams should exercise with AS 886H training PPE.) At least one exercise per year must include off-base response agency participation. Waivers to the 50 CBRN casualties in one exercise requirement identified in **Attachment 6** may be approved by the parent MAJCOM/SG.

7.5.6. **Natural Disasters.** Natural disasters include all domestic emergencies except those created as a result of enemy attack or civil disturbance. The exercise scenario should be typical to the area (hurricanes in Florida, tornadoes in Kansas, earthquake in California) and should include exercising NDMS FCC capability, when applicable.

7.5.7. **Operational Readiness Exercise (ORE).** Operational Readiness Exercises prepare forces for situations they may encounter in the deployed environment. They must reflect the most stringent CBRN threats the unit could face.

7.5.8. **Deployment Exercise.** Medical personnel must participate in Wing Commander directed exercises that test the wing's ability to prepare and process personnel and equipment for deployment, IAW AFI 10-403, *Deployment Planning*, and the installation deployment plan.

7.5.8.1. The wing is tasked to hold at least one exercise that includes no less than 25% of the wing's tasked personnel and equipment, followed by any number of exercises that when cumulatively added together shows that a minimum of 50% of personnel and equipment have been exercised. This requirement may be met through operational readiness exercises, operational readiness inspections, AEF deployments, JCS exercises, and major operation and campaign deployments.

7.5.8.2. For units that do not have a supporting Wing deployment processing function (normally smaller non-flying wings or geographically separated units (GSUs)), the deployment exercise requirement will be met by conducting a test of the unit's internal deployment functions. This includes Personal Readiness Folder (PRF) review, personal equipment review (bag drag), and transportation coordination for a minimum of 25% of the unit's assigned standard UTCs. Units that do not have assigned standard UTCs will process at least two individuals, with the goal of testing the deployment process itself.

7.5.8.3. Enablers assigned to medical units and nonmedical units will participate in a mission exercise annually, at a minimum. Units tasked with deployable Enabler personnel UTCs will exercise with their associated medical WRM assemblage annually, if assigned.

7.5.8.4. Pilot units with personnel UTCs and associated WRM assemblages/equipment will incorporate exercising with this equipment into deployment exercise scenarios.

7.5.9. **Mass Prophylaxis Plan Exercise.** The mass prophylaxis plan exercise must test and evaluate the medical unit's ability to stand-up a POD and distribute medical countermeasures. The number of exposed patients should be sufficient to test and stress the facility and its available resources. The exercise must test the use of the 886E AS for initial response and should test expanded response capabilities such as requesting Strategic National Stockpile (SNS) or WRM assets. The mass prophylaxis plan exercise may be conducted in conjunction with the CBRN exercise or a mass casualty exercise.

**7.6. Exercise Credit.** Units may take exercise credit for real world response of similar scope and magnitude to exercise intent. For example, a response to a bus accident with multiple casualties utilizing numerous MCRP teams may satisfy a MARE requirement. The same post-event procedures, such as a post-incident hotwash, Post-Incident/Exercise Summary (PIES), and MRSF review/discussion must occur. Credit may be taken only when objectives are met for the specific exercise type.

**7.7. Exercise Evaluation Team.** The relationship between the MR office and medical EET is a partnership. The medical planners in the MR office will assist the EET chief plan exercises throughout the year to ensure aspects of medical plans and checklists are tested.

7.7.1. **Responsibilities.** The medical EET chief and other members of the EET will represent medical exercise requirements at wing exercise development meetings. Prior to meeting with the wing, the EET and MR office will meet to identify particular areas appropriate for testing in a specific exercise, incorporating open items in the MRSF minutes from previous exercises. See **Chapter 2** for additional responsibilities.

7.7.2. **Membership.** EET members are selected by the medical unit commander based on functional expertise, ability, and maturity. The commander may request team nominations from the MR office.

**7.8. Documentation.** Required documentation will include:

7.8.1. **Post-Incident/Exercise Hotwash.** The individual who was in command of the operation during the exercise will conduct a hotwash immediately following the exercise, when practical. Team chiefs, all medical EET members, the readiness staff and key players should attend. Use this session to provide cross-feed among participants and identify key deficiencies, areas for improvement, and problems not noted by the base EET. Key items identified in the hotwash will be included in the PIES.

7.8.2. **Post-Incident/Exercise Summary (PIES).** The unit must generate a PIES for each incident or exercise it participates in, regardless of which agency conducted the exercise. It is compiled by the MR office within 30 days of the event, with verbal and written input from team chiefs, observers and EET members, and is submitted to the unit's MRSF for review at the next MRSF meeting. This summary documents the unit's participation in an actual or exercise event, and addresses the effectiveness of planning guidance, training programs, and operational response. A sample PIES can be found in the AFI 41-106 Supplemental Materials at: **https://kx.afms.mil/sg3xp**.

7.8.2.1. PIES will include the following information, as applicable to the exercise or incident:

7.8.2.1.1. Incident/Exercise Overview. Include the date(s) and location(s) as well as the number and types of casualties, type of incident/exercise from the list at **Attachment 6**, and a list of participating teams and/or organizations, as applicable.

7.8.2.1.2. Exercise Goals and Objectives

7.8.2.1.3. Exercise Results/Achievement of Objectives

7.8.2.1.4. Findings and Observations

7.8.2.1.5. Recommended Changes to Checklists and Plans

7.8.2.1.6. A list of exercise requirements fulfilled

7.8.2.1.7. A brief summary of participation by each MCRP team

7.8.2.2. PIES will be reviewed by the MRSF and attached to the meeting minutes. Identified findings, observations and areas of concern will be discussed, identified as open items, assigned OPRs, and tracked through the MRSF until resolved. Resolution of exercise findings requires identification and implementation of corrective action, testing in a subsequent exercise, presentation and discussion during the next MRSF meeting, and closure in meeting minutes. Unit commanders will elevate corrective actions beyond the unit to the Wing or MAJCOM as appropriate. The MRSF will track these actions until completion.

7.8.3. **After-Action Reports (AAR).** After-action reports are submitted after participation in MAJCOM-level or higher exercises. See **Chapter 8** of this AFI and AFI 10-204, *Readiness Exercises and After-Action Reporting Program*, Chapter 5, for additional guidance.

## Chapter 8

## MEDICAL READINESS REPORTING

**8.1. Operational Readiness Reports.** Operational readiness reports provide higher headquarters and other interested organizations, up to and including the Office of the Secretary of Defense and National Command Authority, necessary information to make critical decisions with regard to deployments, manpower and resource requirements. The first three reporting systems described below are populated and updated at the unit level each month, giving commanders the opportunity to assess and report their unit capabilities. The remaining reporting processes are accomplished as needed to relay vital information to higher headquarters before, during or after a deployment or major event, as directed in this AFI and referenced governing directives.

8.1.1. **Global Status of Resources and Training System (GSORTS).** GSORTS, also known simply as SORTS, is a Joint Chiefs of Staff (JCS) owned system used to measure and report the status of a unit's resources and training readiness, measured against that which is required to undertake its wartime mission. The Air Force uses SORTS data to monitor unit readiness, determine budgetary allocations, answer congressional inquiries, analyze readiness trends, and support readiness decisions. Medical units report on personnel readiness/availability, training, and equipment and supplies (WRM) readiness in SORTS.

8.1.1.1. SORTS serves a threefold purpose: it provides data critical to crisis action planning, supports the deliberate planning process, and is used in assessing the ability to meet Title 10, USC, responsibilities to organize, train, and equip forces to support combatant commanders. SORTS provides a major indicator of a unit's readiness status but it is not designed to measure the unit's combat capability.

8.1.1.2. Overall guidance for preparing and submitting SORTS reports is provided in AFI 10-201, *Status of Resources and Training System.*

8.1.2. **Defense Readiness Reporting System (DRRS) Enhanced Status of Resources and Training System (ESORTS).** DRRS ESORTS was designed to enhance the information currently provided in SORTS, focusing on force capabilities assessed against appropriate outcomes and process measures. It is a secure web-based information system describing the status of organizations that contribute to the warfighting system. It was built around explicit measures of performance relative to assigned standards, resources, and force sustainment requirements. ESORTS contains all the basic resource information that underlies GSORTS with the major difference being that the resource information is automatically provided by authoritative databases. The unit commander uses this information, in conjunction with observed performance and military experience/judgment, in assessing his or her unit's readiness. Mission essential tasks (MET) and mission essential task lists (METL) and associated standards and conditions, developed specifically for DRRS, are available to assist the commander in his unit capability assessment. DRRS ESORTS guidance is currently under development. Units will use the guidance provided on the DRRS secure website as well as any MAJCOM supplemental guidance. DRRS for all commands can be accessed through the PACOM secure website at: **http://www2.hq.pacom.smil.mil**

8.1.3. **AEF Reporting Tool (ART).** ART supplements SORTS data by providing commander assessed ratings for each individual UTC, versus the unit as a whole. It provides a picture of a specific UTC's ability to perform its mission as defined in the UTC mission capability statement (MISCAP).

ART provides the ability to evaluate UTCs prior to tasking them, enabling the AEFC to select the UTC with the best capability to meet the tasking. ART also helps to forecast shortfalls or limitations, which allows for resolution before they become critical issues or impair AEF sourcing. Only D-coded UTCs are reported in ART. Reference AFI 10-401, *Air Force Operations Planning and Execution,* para. 7.15. for P-code definitions.

8.1.3.1. This SIPRNET tool uses the same measured resource areas as SORTS, but enables commanders to report the ability of an individual UTC to perform its mission anywhere in the world at the time of the assessment.

8.1.3.2. Overall guidance on preparing and submitting ART reports is provided in AFI 10-244, *Reporting Status of Aerospace Expeditionary Forces.* An unclassified training version of ART can be found at: **https://aefcenter.afpc.randolph.af.mil** and can be used for familiarization, using notional data, before submission of the actual unit ART report via the classified SIPRNET site at: **http://aefcenter.langely.af.smil.mil**

8.1.4. **Reporting Readiness Training.** Only personnel assigned to deployable UTCs (D-Coded UTCs) are used to calculate training percentages for SORTS, ART and DRRS. Specific training requirements that are considered reportable are identified in **Table 8.1.** below. This training will be included in SORTS T-level calculations and will be provided to the unit commander for consideration during ART and DRRS ESORTS readiness assessments. Although individual training requirements listed below may be applicable to a broader range of UTCs or personnel, they are only reportable for the UTCs or personnel identified below.

**Table 8.1. SORTS and ART Reportable Medical Readiness Training**

| SORTS TRSA field | Training Requirement | Reportable for |
|---|---|---|
| TRSA1 | UTC Training:<br>AECOT Course | All personnel assigned to AE UTCs, including FFVNM and FFCCT/E. |
| | UTC Training:<br>EMEDS Course | All personnel assigned to the following UTCs: FFDAB, FFMFS, FFEP1, FFEP2, FFEP3, FFEP6, FFFOC, FFPM1, FFPM2, FFPM3, FFPCM. |
| | UTC Training:<br>CCATT Course | All personnel assigned to the following UTCs: FFCCT, FFCCE, FFCCP, FFCCN, FFQE4. |
| | UTC Training:<br>CASF Course | All personnel assigned to the following UTCs: FFVNF, FFVSF, FFVCF. |
| TRSA2 | CBRNE Defense Survival Skills Training | All personnel assigned to standard deployable DWS, DWX, or DXS coded UTCs. |
| TRSA3 | Self-Aid and Buddy Care (SABC) | All personnel assigned to standard deployable DWS, DWX, or DXS coded UTCs. ARC UTCs FFGK1 and FFDAF, FFDAG, FFDCC, FFDCD, FFABC personnel will only use SABC for reportable training calculations. For AFRC UTCs TFRR8, 6KAAE, and 9AFS2 SABC will count in ART training calculations only. |

8.1.4.1. Personnel assigned to a UTC identified in **Table 8.1.** must accomplish all of the training listed that is required for that UTC in order to be considered trained for reporting purposes. For

example, an individual assigned to UTC FFMFS must complete the C-STARS course, Medical Effects of CBRN Warfare, CBRN Defense Training and SABC in order to be considered trained. This individual would be considered untrained if they failed to complete, or became non-current in one of the four training items.

8.1.4.2. Note that Reportable Medical Readiness Training information in **Table 8.1.** is intended solely for reporting purposes and is not intended to represent the minimum nor the total training requirements for a unit, UTC, or individual. See Attachment3 for a complete list of medical readiness training requirements.

8.1.5. **Commander's Assessment.** The unit commander is responsible for assessing the "mission ready" status of the unit and its assigned UTCs, teams, and individual personnel. The commander must ensure, either through formal readiness-sponsored training activities or through equivalency credit, that training is conducted for all missions. The commander's assessment must be a combination of objective data and subjective review of actual operational expertise. The relative importance of each is determined by the commander, with a constant mission focus, rather than on academic, square-by-square compliance. The commander should use all available resources, including consultation with the executive team and readiness office, in order to make the final mission capability assessment.

8.1.5.1. Materiel readiness. A UTC could be 95% available, but be missing 2 critical items which make it non-deployable. Conversely, an 80% rating could represent a capable UTC.

8.1.5.2. Inspection results. Positive results on ORIs, Health Services Inspections (HSIs), Unit Effectiveness Inspections (UEIs), and other inspections provide insight into a unit's preparedness. Individual factors within a composite score should also be reviewed, with emphasis on Special Interest Items that reflect mission capability.

8.1.5.3. Exercise results. After-action reports for major accident response exercises (MARE), other base exercises and joint exercises highlight positive operational areas and those which still require work. Medical EET members should design exercises which test specific capabilities and provide specific feedback to individuals, teams, and the commander.

8.1.5.4. Professional reviews. The commander must consider the overall capability of the medical staff and of individual members. Credentialing difficulties, probationary providers, weak in- service programs, and medical-legal issues are all warning flags that more training is required and a unit may not be ready for the rigors of a deployed environment.

8.1.5.5. Unit reports. Raw team and unit scores provide critical data for the commander's assessment. However, scores should be reviewed in context to identify staffing, training, and capability gaps before a final assessment is made.

8.1.6. **Mission Capability Indicators.** The unit commander has many training indicators available which may be used to guide the mission capability assessment. Additionally, the unit commander may use the following indicators to guide the mission capability assessment:

8.1.6.1. Materiel readiness. A UTC could be 95% available, but be missing 2 critical items which make it non-deployable. Conversely, an 80% rating could represent a capable UTC.

8.1.6.2. Inspection results. Positive results on ORIs, Health Services Inspections (HSIs), Unit Effectiveness Inspections (UEIs), and other inspections provide insight into a unit's preparedness.

Individual factors within a composite score should also be reviewed, with emphasis on Special Interest Items that reflect mission capability.

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8.1.6.5. Unit reports. Raw team and unit scores provide critical data for the commander's assessment. However, scores should be reviewed in context to identify staffing, training, and capability gaps before a final assessment is made.

**8.2. Other Reports.**

8.2.1. **Medical Report for Emergencies, Disasters and Contingencies (MEDRED-C).** The MEDRED-C provides information on unit status, resource availability, and patient care activities during contingency operations (actual or exercise). The unit commander will ensure the MEDRED-C is submitted IAW procedures outlined in AFI 10- 206, *Operational Reporting*, which provides line-by-line instructions and reporting guidance. Liberal use of the REMARKS section is encouraged. This is one method of ensuring the MAJCOM and Air Staff receive valuable information regarding medical operations in the AOR.

8.2.2. **After-Action Reports (AAR).** AARs are formal documentation of a unit's participation in the CJCS Exercise Program, other joint exercises, Air Force exercises, and real world operations including humanitarian, peacekeeping, and noncombatant evacuation operations (NEO). They are prepared for review principally outside the medical unit, and are submitted in accordance with AFI 90-1601, *Air Force Lessons Learned Program.* Multi-member UTCs will submit a consolidated input, prepared by the senior member, in lieu of individual reports. See AFI 10-204, *Readiness Exercises and After-Action Reporting Program,* for a description of the types of AARs. In all cases, prior to drafting the AAR, the author must ensure the appropriate classification level is applied.

8.2.2.1. AFI 90-1601 describes processes to collect, validate, disseminate, and track MAJCOM and AF-level lessons learned. Prior to submitting a lesson through this system, the medical unit commander should institute a local strategy for validating observations and improving processes or equipment identified in the lessons learned process. Observations should be corrected at the lowest level possible which affords the appropriate outcome.

8.2.2.1.1. Deployment commanders or UTC team chiefs should collect observations from team members during and following a deployment, consolidating them in a single document for medical unit and MRSF review. Ongoing issues regarding clinical care directives, including Joint Commission standards, and HSI requirements should be addressed in the deployment AAR. Each observation should be accompanied by a "lesson learned" – the action or equipment identified to solve the problem, or a recommendation for that action/equipment. The report must be completed within 30 days of return from a deployment, contingency, or other operation.

8.2.2.1.2. Upon receipt of the report, the MRSF will review all observations and determine the appropriate level for addressing each one. Observations identified for local correction will be tasked within the unit and tracked in the MRSF in the same manner as PIES action items. Items identified for wing correction will be staffed to the Wing IG for review and action. Items requiring higher headquarters (HHQ) action will be entered in the AF Lessons Learned program.

8.2.2.2. AARs approved by the MRSF for HHQ action will be forwarded to the Wing commander for information and posted in the AF-JLLIS (Joint Lessons Learned Information System) for parent MAJCOM validation.

8.2.2.2.1. The MAJCOM will ensure the AARs are in the AF-JLLIS database. Additionally, the MAJCOM will address lessons identified that can be resolved at their level and forward those beyond their scope to HAF.

8.2.2.2.2. HAF level reports may be submitted by MAJCOMs, FOAs, DRUs, and HAF supporting agencies to AF/A9L. A courtesy call from these agencies to AFMSA/SGXT is recommended to expedite the process for lessons learned. AF/A9L will forward the lesson to the AF/SG Lessons Learned (L2) POCs.

8.2.2.2.3. Once AFMSA/SGXT receives an AAR or lesson, they will coordinate with the appropriate AFMS consultants, MEFPAK Responsible Agencies, MAJCOMs, and other organizations to ensure lessons learned are incorporated into doctrine and training as needed.

## Chapter 9

## TRANSITIONING THE AIR FORCE MEDICAL READINESS TRAINING SYSTEM

**9.1. Strategy.** The future AF medical training system will define requirements through mission essential tasks (METs), determined by MEFPAK responsible commands, MAJCOMs, and Air Staff guidance. These METs will be performed by teams to a defined standard, and airmen on these teams must be proficient at individual tasks critical to mission success (for the purpose of presenting the concepts within this chapter, the term "teams" is used to refer to either deployable UTCs or MCRP teams, or both, unless specified.) Team leaders will be trained in MET performance and applicable joint and Service doctrine to ensure effective C2, required support, and reachback utilization. METs will be presented in mission training plans (MTPs), which will set the training and assessment requirements for each team, assigned individual members and the team leader. MTPs will be web-based to allow rapid revision, and for use in planning, conducting, assessing, and reporting training performance.

**9.2. Factors Impacting Transition.** Four factors are critical to the development and implementation of this transition.

9.2.1. **Capabilities-based Planning.** The USAF has shifted from a programs/platforms mentality to capabilities- based thinking and planning. With respect to readiness, the current requirement for reporting numbers of personnel and percentages of equipment on hand will not be adequate to describe a ready force. Commanders and their planners will need to know which of their units are capable of performing specific tasks critical to mission success. The DoD has directed that all Services observe, assess, and report their units' ability to perform METs to a measurable standard. This observed performance is the ultimate measure of force readiness.

9.2.2. **Joint Interoperability.** The USAF fights jointly. In recent years, DoD leadership has reinforced commitment to joint interoperability and joint training in most strategic planning and training documents. The transition to a training strategy using METs enables joint interoperability in two major ways:

9.2.2.1. METs published in the Air Force Universal Task List (AFUTL) and assigned to AFMS teams are consistent in structure, vocabulary and performance standards to collective team tasks used in the Universal Joint Task List (UJTL) by our sister Services. Common METs between Services define interoperable capabilities, and may be used as a basis for joint training opportunities in future joint exercises. When determining interoperability, unique Service elements, including the conditions under which METs are performed and performance criteria must be considered.

9.2.2.2. This strategy expands training opportunities by allowing the use of joint field exercises as training venues for AFMS teams, when appropriate. Teams which are likely to deploy with medical teams from a different Service or in direct support of a joint operation, such as casualty staging and CCATTs, are prime candidates for a joint exercise.

9.2.3. **Readiness Reporting.** Ultimately, tactical level tasks representing each AFMS UTC and MCRP team will be assessed in Defense Readiness Reporting System (DRRS) Enhanced Status of Resources and Training System (ESORTS). However, until existing reporting capabilities are expanded to allow for this level of granularity, tactical (team level) tasks will utilized to focus training and bring meaning to the assessment of higher order MET lists (METL) used for reporting in DRRS ESORTS. See **Chapter 8** for additional information regarding readiness reporting.

9.2.4. **Business Planning.** Medical treatment facility commanders are expected to execute a business plan that maximizes the use of assigned personnel and available resources. This strategy allows a commander to plan and execute effective training at a predictable cost in terms of both resources and medical treatment facility production in three ways; readiness case analysis, currency case analysis, and business case analysis.

**9.3. Constant Deployer Model (CDM).** The AFMS supports the AEF strategy and postures its deployable forces in ten equally capable AEFs. These deployable forces are assigned to large medical treatment facilities using a CDM. The model maximizes laydown of key clinical teams at the few facilities most able to provide the complex clinical caseload required for clinical currency while simultaneously providing sufficient copies of a UTC to support each AEF pair. By concentrating deployment capability at large facilities, individuals and teams are able to leverage their home- station responsibilities to maintain readiness currency in individual tasks, and to a large degree, team METs. A disadvantage of this laydown strategy is that teams may not be co-located as force packages and may need to converge at an external training event for force package training. For example, all UTCs required for an AF Theater Hospital may not be located at one place, and may have to converge for training. A focus on MTPs will optimize the training of individuals, teams and leaders in the context of this force laydown strategy, ensuring all are trained on the same tasks prior to deployment.

**9.4. Formal Training.** Formal training courses, including medical accession schools, technical schools, functional courses, and graduate medical education, will focus curricula on METs and standards, supporting individual tasks and enabling leader tasks. At each level of performance, formal courses will enhance an airman's ability to contribute to team performance, as well as a leader's ability to direct the teams to which they may be assigned.

**9.5. Individual Training.** The proficiency of airmen to perform their individual tasks is the most critical aspect of team performance. Each individual task will have performance standards and conditions that establish the environment in which the task is performed. These standards are set to ensure each airman's role contributes to the team's ability to meet collective task standards. Together, the task, conditions, performance standards, and criteria form the individual training objectives, training outline, and assessment criteria are used for individual training and performance assessment by supervisors and instructors. These individual tasks are mapped to a team's METL in the applicable Mission Training Plan (MTP).

9.5.1. **Clinician Training.** Individual training for clinical AFSCs will be focused on both procedural and assigned equipment clinical currency. Clinicians will continue to conduct individual training at home station, at C-STARS, or at Level 1 or 2 trauma centers.

9.5.2. **Installation Contingency Training.** Individuals on teams with installation response missions, such as MCRP teams, may be called to perform installation METs in real-world operations at any time. Therefore, individual training will be performed at a frequency that maintains proficiency. Unit Medical Readiness Training and Exercise Plans (MRTEP) will incorporate training events to meet these standards.

**9.6. Team Training.** Teams will conduct collective training in accordance with MTPs. UTCs that maintain equipment sets at home station will train at home station when possible. UTCs whose equipment sets are centrally maintained will train at a formal course. UTCs will train within the 24 month AEF schedule, prior to their vulnerability period. Whenever possible, team training will be provided in the training event

scheduled after individuals demonstrate proficiency in individual tasks, but before the team is expected to perform unassisted in an exercise or deployment.

**9.7. Leader Training.** Trained leaders enable teams of proficient airmen to accomplish METs, while an untrained leader can cause a team of proficient airmen to fail in their assigned tasks. Leaders will be trained in MET performance and applicable joint and Service doctrine to ensure effective C2, required support, and reachback utilization. The new transitional strategy will not create special programs or platforms for leader training, but will identify collective tasks, or steps within those tasks, that require leader action or focus to ensure success. These tasks will be noted within MTPs, providing action or doctrinal references, and will serve as the basis for leader mentoring, self- study, and curriculum focus at formal courses.

**9.8. Mission Training Plans (MTPs).** MEFPAK responsible agencies (ACC, AMC, and AFSOC) will develop MTPs as part of their training management responsibilities. MTPs will be developed based on force module packaging or for stand-alone UTCs as determined by the MEFPAK, and will be incorporated into the appropriate AF Tactics, Techniques and Procedures (AFTTP).

9.8.1. **Purpose.** MTPs provide training requirements that will result in a fully trained, mission capable asset to the combatant commander. This objective is accomplished by ensuring individuals are proficient in their individual tasks, the team is proficient in its collective tasks, and the leaders are well prepared for their roles and responsibilities.

9.8.2. **Overview.** The MTP provides commanders and unit training managers a descriptive, mission-oriented tool to guide and prepare the unit to perform its critical operations as defined by its mission-essential task list (METL). Each unit is expected to training as a minimum, to the standards set forth by the plan.

9.8.3. **Sections.** The MTP is divided into seven sections: the AFMS training strategy applied to capability/UTC (an overview); planning for training; individual training; collective team training; leadership training, exercises, and training assessment.

**9.9. Mission Rehearsal Exercises (MREx).** These exercises will focus on collective team tasks, or METs, identified as critical to mission success. Teams may have already been trained on these METs, they may require additional or new training. For example, an FFLG1, Medical Logistics Augmentation Team, might deploy to Charleston AFB to participate in an Aerial Port Squadron exercise.

**9.10. Transition Timeline.** The Joint community already uses METs for establishing training requirements and scheduling exercises. The AFMS has begun adopting this method by introducing METs within MEFPAK playbooks. Transition elements and further guidance will be provided by the AF Surgeon General's Office.

**9.11. Adopted Forms.**

AF Form 1098, *Special Task Certification and Recurring Training*

AF Form 1768, *Staff Summary Sheet*

AF IMT 847, *Recommendation for Change of Publication*

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Surgeon General

## Attachment 1

## GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

*This attachment is intended as a quick- reference tool and contains publications and acronyms and terms that are referenced in this AFI, plus some that are not but may be encountered during the performance of MRO or MRNCO duties.*

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***Abbreviations and Acronyms***

**AAAHC—**Accreditation Association for Ambulatory Healthcare

**AAR—**After-Action Report

**AC—**Active Component

**ACC—**Air Combat Command

**ACLS—**Advance Cardiac Life Support

**AD—**Active Duty

**ADCON—**Administrative Control

**ADVON—**Advanced Echelon

**AE—**Aeromedical Evacuation

**AECOT—**Aeromedical Evacuation Contingency Operations Training

**AECT—**Aeromedical Evacuation Control Team

**AEF—**Air and Space Expeditionary Force

**AEFC—**AEF Center

**AET—**Aeromedical Evacuation Technician

**AETC—**Air Education and Training Command

**AFAARS—**Air Force After-Action Reporting System

**AFB—**Air Force Base

**AFCAT—**Air Force Catalog

**AFCKSLL—**Air Force Center for Knowledge Sharing Lessons Learned

**AFDD—**Air Force Doctrine Document

**AFEMSI—**Air Force Expeditionary Medical Skills Institute

**AFFOR—**Air Force Forces

**AFI—**Air Force Instruction

**AFIA—**Air Force Inspection Agency

**AFIIP—**Air Force Instructional Input Program

**AFIMS—**Air Force Incident Management System

**AFIOH—**Air Force Institute for Operational Health

**AFMAN—**Air Force Manual

**AFMC—**Air Force Materiel Command

**AFMIC—**Armed Forces Medical Intelligence Center

**AFMLO—**Air Force Medical Logistics Operations

**AFMOA—**Air Force Medical Operations Agency

**AFMSA—**Air Force Medical Support Agency

**AFMC—**Air Force Materiel Command

**AFMS—**Air Force Medical Service

**AFPC—**Air Force Personnel Center

**AFPD—**Air Force Policy Directive

**AFRC—**Air Force Reserve Command

**AFRRI—**Armed Forces Radiobiology Research Institute

**AFSC—**Air Force Specialty Code

**AFSOC—**Air Force Special Operations Command

**AFSPC—**Air Force Space Command

**AFTH—**Air Force Theater Hospital

**AFTTP—**Air Force Tactics, Techniques and Procedures

**AFUTL—**Air Force Universal Task List

**AHRT—**All-hazards Response Training

**ALMS—**Advanced Lessons Management System (formerly Joint Universal Lessons Learned System (JULLS))

**AMC—**Air Mobility Command

**AMF—**Alternate Medical Facility (now MCOOP alternate command and control (C2) location)

**AMOCC—**Air Mobility Operations Control Center

**ANG—**Air National Guard

**ANGRC—**Air National Guard Readiness Center

**AO—**Aeronautical Orders or Action Officer

**AOR—**Area of Responsibility

**ARC—**Air Reserve Component (includes Air National Guard and Air Force Reserve)

**AROWS-R—**Air Force Reserve Order Writing System

**ART—**AEF Reporting Tool or Air Reserve Technician (ARC)

**AS—**Allowance Standard

**ASEV—**Aircrew Standardization Evaluation Visit

**ASF—**Aeromedical Staging Facility

**ASTS—**Aeromedical Staging Squadron

**AT—**Annual Training and Annual Tour (ARC)

**ATC—**Air Transportable Clinic

**ATLS—**Advanced Trauma Life Support

**ATNAA—**Antidote Treatment – Nerve Agent, Auto-Injector

**AWS—**Associated But Available To Support MTW and Steady State

**AWX—**Associated but Available To Support MTW But Not Steady State

**AXS—**Associated But Available To Support Steady State but Not MTW

**AXX—**Associated and Required In-Place and Not Available For MTW or Steady State

**BCA—**Business Case Analysis

**BDC—**Blood Donor Center

**BEE—**Bioenvironmental Engineer

**BLS—**Basic Life Support

**BEMRT—**Basic Expeditionary Medical Readiness Training

**BMT—**Basic Military Training

**BOS—**Base Operating Support

**BSC—**Biomedical Sciences Corps

**BSP—**Base Support Plan

**BTC—**Blood Transshipment Center

**BW—**Biological Warfare

**C2—**Command and Control

**C3—**Command, Control, and Communications

**C4—**Combat Casualty Care Course

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

**C4I—**Command, Control, Communications, Computer and Information

**CAF—**Combat Air Forces

**CASF—**Contingency Aeromedical Staging Facility

**CAT—**Crisis Action Team

**CBRN—**Chemical, Biological, Radiological and Nuclear

**CBRNE—**Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive NOTE: This term is being phased out and replaced with CBRN

**CBD—**Consultant Balanced Deployments

**CBT—**Computer-based Training

**CCA—**Currency Case Analysis

**CDC—**Centers for Disease Control

**CCATT—**Critical Care Air Transport Team

**CCDR—**Combatant Commander (formerly COCOM)

**CCLM—**Center for Clinical Laboratory Medicine

**CCMRF—**CBRN Consequence Management Response Force

**CCQAS—**Centralized Credentials Quality Assurance System

**CDM—**Constant Deployer Model

**CE—**Civil Engineering

**CEMP—**Comprehensive Emergency Management Plan

**CENTCOM—**US Central Command

**CEX—**Civil Engineering Emergency Management (Disaster Preparedness)

**CFM—**Career Field Manager

**CM—**Casualty Management

**CME—**Continuing Medical Education

**CMO—**Casualty Management Officer

**COMAFFOR—**Commander, Air Force Forces

**COMSEC—**Communications Security

**CONOPS—**Concept of Operations

**CONPLAN—**Concept Plan

**CONUS—**Continental United States

**COOP—**Continuity of Operations

**COT—**Commissioned Officer Training

**COTS—**Commercial-off-the-shelf

**CPM—**Contingency Preventive Medicine

**CPR—**Cardiopulmonary Resuscitation

**CPX—**Command Post Exercise

**CRT—**Crisis Response Team

**CRTC—**Combat Readiness Training Center

**CSC—**Combat Stress Control

**CSDC—**Consolidated Storage and Deployment Center

**CSS—**Commander's Support Staff or Commander's Senior Staff

**C- STARS—**Centers for Sustainment of Trauma and Readiness Skills

**CW—**Chemical Warfare

**CWPC—**Contingency Wartime Planner's Course

**DAFSC—**Duty Air Force Specialty Code

**DAV—**Deployment Availability

**DCAPES—**Deliberate and Crisis Action Planning and Execution System

**DC—**Dental Corps

**DCC—**Deployment Control Center

**DCP—**Disease Containment Plan

**DEPORD—**Deployment Order

**DHS—**Department of Homeland Security

**DIRLAUTH—**Direct Liaison Authorized

**DMLSS—**Defense Medical Logistics Standards Support

**DMS—**Defense Message System

**DNBI—**Disease Non- Battle Injury

**DOC—**Designed Operational Capability

**DOD—**Department of Defense

**DODD—**Department of Defense Directive

**DODI—**Department of Defense Instruction

**DOS—**Department of State or Date of Separation

**DOTMLPF—**Doctrine, Organization, Training, Materiel, Leadership, Personnel, and Facilities

**DP—**Disaster Preparedness/Director of Personnel

**DRG—**Disaster Response Group

**DRI—**Date Required In-place

**DRMD—**Detailed Resource Movement Document

**DRRS—**Defense Readiness Reporting System

**DRU—**Direct Reporting Unit

**DSOE—**Deployment Schedule of Events

**DSN—**Defense Switched Network

**DSCA—**Defense Support to Civil Authorities

**DTG—**Date Time Group

**DU—**Depleted Uranium

**DWS—**Deployable and Available To Support MTW and Steady State

**DWX—**Deployable and Available To Support MTW but Not Steady State

**DXS—**Deployable and Available To Support Steady State but Not MTW

**DXX—**Deployable But Required In Place and Not Available For MTW or Steady State

**E&TC—**Education and Training Committee

**EAD—**Earliest Arrival Date

**ECA—**Expeditionary Case Analysis

**ECD—**Estimated Completion Date

**EET—**Exercise Evaluation Team

**EFTO—**Encrypted for Transmission Only

**EM—**Emergency Management

**EMC—**Executive Management Committee

**EMEDS—**Expeditionary Medical Support

**EMRC—**Expeditionary Medical Readiness Course (also called MRPC)

**EOC—**Emergency Operations Center; also Exercise Oversight Committee

**EOR—**Explosive Ordinance Reconnaissance

**ERO—**Emergency Response Operations

**ERT—**Emergency Response Team

**E&TC—**Education and Training Committee

**ESF—**Emergency Support Function

**ESORTS—**Enhanced Status of Resources and Training System

**ESP—**Expeditionary Site Plan

**EUCOM—**US European Command

**EUMD—**Extended Unit Manning Document

**EXORD—**Execution Order

**FAM—**Functional Area Manager

**FCC—**Federal Coordinating Center

**FEMA—**Federal Emergency Management Agency

**FN—**Flight Nurse

**FOA—**Forward Operating Area; also Field Operating Agency

**FOB—**Forward Operating Base

**FOL—**Forward Operating Location

**FOUO—**For Official Use Only

**FPCON—**Force Protection Condition

**FRAG—**Fragmented UTC

**FSTR—**Full Spectrum Threat Response

**FTX—**Field Training Exercise

**FUNCPLAN—**Functional Plan

**FX—**Functional Exercise

**GCCS—**Global Command and Control System

**GCE—**Ground Crew Ensemble

**GEMS—**Global Expeditionary Medical System

**GEOLOC—**Geographic Location Code

**GMAJCOM—**Gaining Major Command

**GPMRC—**Global Patient Movement Requirements Center

**GSORTS—**Global Status of Readiness and Training System

**GSU—**Geographically Separated Unit

**GWD—**Get-Well Date

**GWOT—**Global War on Terrorism

**HAF—**Headquarters Air Force

**HARM—**Host Aviation Resource Management

**HAZMAT—**Hazardous Material

**HAZWOPER—**Hazardous Waste Operations and Emergency Response

**HNS—**Host Nation Support

**HRC—**High Risk of Capture

**HSI—**Health Services Inspection

**HSMR—**Home Station Medical Response

**HSPD—**Homeland Security Presidential Directive

**HTA—**High Threat Area

**IAW—**In Accordance With

**ICMOP—**Integrated Continental United States (CONUS) Medical Operations Plan (obsolete term replaced by CONUS Redistribution Plan)

**IC—**Incident Commander

**ICC—**Installation Control Center

**ICS—**Incident Command System; ref. National Incident Management System (NIMS)

**IDMT—**Independent Duty Medical Technician

**IDO—**Installation Deployment Officer

**IDP—**Installation Deployment Plan

**IDT—**Inactive Duty Training

**IG—**Inspector General

**IGESP—**In Garrison Expeditionary Site Planning

**IGX—**Inspector General Exercises

**ILO—**In-Lieu of Tasking (usually associated with support for Army deployment taskings)

**IMA—**Individual Mobilization Augmentee

**IM/IT—**Information Management/Information Technology

**IMR—**Installation Medical Response

**IPE—**Individual Protective Equipment

**IPPD—**In- Place Patient Decontamination

**ISOPREP—**Isolated Personnel Reports

**ISSA—**Inter- Service Support Agreement

**JCS—**Joint Chiefs of Staff

**JFCOM—**United States Joint Forces Command

**JIT—**Just-In-Time

**JMETL—**Joint Mission Essential Task List

**JMPC—**Joint Medical Planner's Course

**JOMMC—**Joint Operations Medical Managers Course

**JOPES—**Joint Operations Planning and Execution System

**JRTC—**Joint Readiness Training Center

**JTF—**Joint Task Force

**Kx—**Knowledge Exchange

**LAD—**Latest Arrival Date

**LAF—**Line of the Air Force

**LIMFAC—**Limiting Factor

**LMR—**Land Mobile Radio

**LOAC—**Law of Armed Conflict

**LOGDET—**Logistics Detail

**LRN—**Laboratory Response Network

**LRT—**Laboratory Response Team

**LTA—**Low Threat Area

**MAA—**Mutual Aid Agreement

**MAF—**Mobility Air Forces

**MAJCOM—**Major Command

**MANFOR—**Manpower Forces

**MASF—**Mobile Aeromedical Staging Facility

**MC—**Medical Corps

**MCC—**Medical Control Center

**MC-CBRN—**Medical Counter-CBRN

**MCOOP—**Medical Continuity of Operations

**MCRP—**Medical Contingency Response Plan

**MDNCO—**Medical Defense Non- Commissioned Officer

**MDO—**Medical Defense Officer

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

**MEFPAK—**Manpower and Equipment Force Packaging System

**MET—**Mission Essential Task

**METL—**Mission Essential Task List

**MFEL—**Manpower Force Element List

**MILPDS—**Military Personnel Data System

**MINCO—**Medical Intelligence Noncommissioned Officer

**MISCAP—**Mission Capability

**MNBC—**Medical Nuclear, Biological and Chemical

**MOA—**Memorandum of Agreement

**MOBAG—**Mobility Bag

**MOC—**Medical Operations Center

**MOOTW—**Military Operations Other Than War

**MOPP—**Mission-oriented Protective Posture

**MOU—**Memorandum of Understanding

**MPA—**Military Personnel Appropriation

**MPAT—**Military Patient Administration Team

**MPF—**Military Personnel Flight

**MR—**Medical Readiness

**MRA—**MEFPAK Responsible Agency

**MRDSS—**Medical Readiness Decision Support System

**MRDSS ULTRA—**Medical Readiness Decision Support System Unit-level Tracking and Reporting Application

**MRE—**Meals Ready to Eat

**MRL—**Medical Resource Letter

**MRM—**Medical Readiness Manager

**MRNCO—**Medical Readiness Noncommissioned Officer

**MRO—**Medical Readiness Officer

**MRPC—**Medical Readiness Planners Course (also called EMRC)

**MRSF—**Medical Readiness Staff Function

**MRT—**Medical Readiness Training

**MRTEP—**Medical Readiness Training and Exercise Plan

**MSC—**Medical Service Corps

**MSCA—**Military Support to Civil Authorities

**MSEL—**Master Sequence of Events List

**MTA—**Medium Threat Area

**MTF—**Medical Treatment Facility

**MTP—**Mission Training Plan

**MTT—**Mobile Training Team

**MTW—**Major Theater War

**NAF—**Numbered Air Force

**NATO—**North Atlantic Treaty Organization

**NBC—**Nuclear, Biological, Chemical

**NBCC—**Nuclear, Biological, Chemical, and Conventional

**NC—**Nurse Corps

**NDMS—**National Disaster Medical System

**NEO—**Non-combatant Evacuation Operation

**NET—**Not Earlier Than

**NGB—**National Guard Bureau

**NGO—**Non-government Organizations

**NIMS—**National Incident Management System

**NIPRNET—**Non-secure Internet Protocol Router Network

**NLT—**Not Later Than

**NOK—**Next-of-kin

**NORTHCOM—**US Northern Command

**NREMT—**National Registry of Emergency Medical Technicians

**NRP—**National Response Plan

**O&M—**Operations and Maintenance

**OCONUS—**Outside Continental United States

**OCR—**Office of Collateral Responsibility

**OJT—**On-the-job Training

**OPCON—**Operational Control

**OPLAN—**Operation Plan

**OPORD—**Operation Order

**OPR—**Office of Primary Responsibility

**OPSEC—**Operations Security

**ORE—**Operational Readiness Exercise

**ORI—**Operational Readiness Inspection

**OSAT—**Overseas Annual Tour

**OSF—**Operational Support Flyer

**OSI—**Office of Special Investigation

**PA—**Public Affairs

**PACAF—**Pacific Air Forces

**PACOM—**US Pacific Command

**PAFSC—**Primary Air Force Specialty Code

**PALS—**Pediatric Advanced Life Support

**PAM—**Preventive Aerospace Medicine

**PAR—**Population at Risk

**PAX—**Passengers

**PDHA—**Post Deployment Health Assessment

**PEM—**Program Element Manager (Monitor)

**PERSCO—**Personnel Support for Contingency Operations

**PHA—**Preventive Health Assessment

**PHEO—**Public Health Emergency Officer

**PHNCO—**Public Health Non-commissioned Officer

**PHO—**Public Health Officer

**PHTLS—**Prehospital Trauma Life Support

**PID—**Plan Identification Number

**PIES—**Post-Incident/Exercise Summary

**PIM—**Pre-Trained Individual Manpower

**PIMR—**PHA/Individual Medical Readiness

**PIN—**Personnel Increment Number

**PMI—**Patient Movement Item

**POC—**Point of Contact

**POD—**Point of Debarkation

**POE—**Point of Embarkation

**POM—**Program Objective Memorandum

**PPE—**Personal Protective Equipment

**PRF—**Personnel Readiness Function, also Personal Readiness Folder

**PRU—**Personnel Readiness Unit

**RAM—**Resident Aerospace Medicine

**RC—**Reserve Component

**RCOT—**Reserve Commissioned Officer Training

**RCS—**Report Control Symbol

**RDD—**Required Delivery Date

**RFF—**Request for Forces

**RMU—**Reserve Medical Unit

**ROMO—**Range of Military Operations

**RPA—**Reserve Personnel Appropriation

**RSG—**Regional Support Group

**RSO&I—**Reception, Staging, Onward Movement & Integration

**RSVP—**Readiness Skills Verification Program

**RTOC—**Readiness Training Oversight Committee

**SABC—**Self-Aid and Buddy Care

**SAV—**Staff Assistance Visit

**SEI—**Special Experience Identifier

**SERE—**Survival, Escape, Resistance, Evasion

**SFS—**Security Forces Squadron

**SIMLM—**Single Integrated Medical Logistics Manager

**SIPRNET—**Secret Internet Protocol Router Network

**SITREP—**Situation Report

**SME—**Squadron Medical Element

**SOCOM—**US Special Operations Command

**SOF—**Special Operations Forces

**SOFA—**Status of Forces Agreement

**SORTS—**Status of Resources and Training System

**SOUTHCOM—**US Southern Command

**SPACECOM—**US Space Command

**SPEARR—**Small Portable Expeditionary Aeromedical Rapid Response

**SSS—**Staff Summary Sheet

**STE—**Secure Terminal Equipment

**STONS—**Short Tons (equals 2,000 pounds)

**STRATCOM—**US Strategic Command

**STU—**Secure Telephone Unit

**TACC—**Tactical Airlift Control Center

**TACON—**Tactical Control

**TAES—**Theater Aeromedical Evacuation System

**TCN—**Transportation Control Number; also, Third Country National

**TDY—**Temporary Duty

**TLAMM—**Theater Lead Agent for Medical Materiel

**TLN—**Training Line Number

**TMIP—**Theater Medical Information Program

**TO—**Technical Order

**TPFDD—**Time-Phased Force Deployment Data

**TPFDL—**Time-Phased Force Deployment List

**TPMRC—**Theater Patient Movement Requirements Center

**TRAC2ES—**TRANSCOM Regulating and Command and Control Evacuation System

**TRANSCOM—**US Transportation Command

**TRG—**Training Group

**TSR—**Traumatic Stress Response

**TTP—**Tactics Techniques and Procedures

**TTX—**Tabletop Exercise

**UCC—**Unit Control Center

**UDM—**Unit Deployment Manager

**UEI—**Unit Effectiveness Inspection

**UGT—**Upgrade Training

**UIC—**Unit Identification Code

**UIM—**Unit Input Module

**UJTL—**Universal Joint Task List

**ULN—**Unit Line Number

**ULTRA—**Unit- Level Training and Reporting Application

**UMD—**Unit Manning Document

**USAFA—**United States Air Force Academy

**USAFE—**United States Air Forces in Europe

**USAFSAM—**US Air Force School of Aerospace Medicine

**USAMRICD—**United States Army Medical Research Institute of Chemical Defense

**USAMRIID—**United States Army Medical Research Institute of Infectious Diseases

**USTRANSCOM—**United States Transportation Command

**UTA—**UTC Availability (Replaced the AFWUS)

**UTC—**Unit Type Code

**UTL—**Universal Task List

**VA—**Veterans Administration

**VCNCO—**Vehicle Control NCO

**WBITS—**Web-Based Integrated Training System

**WBT—**Web Based Training

**WMD—**Weapons of Mass Destruction

**WMP—**War Mobilization Plan

**WRM—**War Reserve Materiel

**Z—**Zulu Time

***Terms***

**Accreditation Association for Ambulatory Healthcare (AAAHC)—**Formed in 1979 to assist ambulatory health care organizations improve the quality of care provided to patients.

**Aeromedical Evacuation (AE)—**The movement of patients under medical supervision to and between medical treatment facilities by fixed wing aircraft. Also called AE.

**Air and Space Expeditionary Force (AEF)—**The AEF construct establishes 10 AEFs, which may be thought of as "buckets of capability." Personnel are assigned to one of 10 AEFs. The 10 AEFs are grouped into five pairs numerically designated as 1- 2, 3- 4, 5- 6, 7- 8 or 9- 10. Each bucket pair represents a time frame within the AEF cycle during which time a person is vulnerable for deployment.

**AEF Cycle—**This is a life cycle for a unit to prepare for and perform its AF mission. This cycle includes periods of normal training, preparation, and on- call/deployment eligibility. Currently, the cycle is 20 months.

**Annual Training—**A training period related to the calendar year. Training required on an annual basis must be accomplished every calendar year, but not exactly every twelve months, e.g., an individual who attends an annual training event on 1 Jan 2007 is current until 31 Dec 2008.

**Clinician—**Medical personnel in clinical AFSCs who provide patient care. A complete list of clinical AFSCs is provided at: **https://kx.afms.mil/sg3xp**.

**Community Recovery—**The process of assessing the effects of an Incident of National Significance, defining resources, and developing and implementing a course of action to restore and revitalize the socioeconomic and physical structure of a community.

**Core requirements—**Those essential individual training requirements needed to accomplish the AFMS mission.

**Critical Infrastructure—**Systems and assets, whether physical or virtual, so vital to the US that the incapacity or destruction of such systems and assets would have a debilitating impact on security, national economic security, national public health or safety, or any combination of those matters.

**Defense Support of Civil Authorities (DSCA)—**Refers to DOD support, including Federal military forces, DOD civilians and DOD contractor personnel, and DOD agencies and components, for domestic emergencies and for designated law enforcement and other activities.

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

**Emergency Operations Center (EOC)—**The physical location at which the coordination of information and resources to support domestic incident management activities normally takes place. An EOC may be located in a permanent or temporary location. EOCs may be organized by major functional disciplines (fire, law enforcement, medical services…), by jurisdiction (Federal, State, regional, county, city, tribal), or by some combination.

**Emergency Responders (medical)—**Disaster Response Force members who deploy after first responders and provide additional support. They include follow- on medical personnel including additional ambulances, physicians, nurses, technicians, and other specialized teams. Teams such as radiology, laboratory, pharmacy, surgery, and nutritional medicine would not ordinarily leave the facility and are therefore not considered emergency responders. Examples of MCRP teams in the emergency responder category would be other clinical teams, the Field Treatment Team, Triage Team, the Public Health Team and the Nursing Services Team.

**Emergency Support Function—**A grouping of government and certain private sector capabilities into an organizational structure to provide the support, resources, program implementation, and services to help communities recover following domestic incidents.

**First Responders (medical)—**Teams who deploy immediately to the disaster scene to save lives and suppress and control hazards. They would join firefighters and law enforcement disaster response force personnel. These medics provide initial life saving/life sustaining care to casualties prior to the transport of the patient to the next level of care. .

**Incident Commander—**The individual with the overall authority and responsibility for conducting incident operations and is responsible for the management of all operations at the incident site, including the development of strategies and tactics and ordering the release of resources.

**Incident of National Significance—**Refer to the National Response plan or HSPD 5 for criteria and examples.

**Installation Medical Response—**Term that encompasses the full spectrum of installation medical response activities, including medical contingency response, WMD response, MC-CBRN response, home station medical response, defense support to civil authorities, civil support, and disaster response.

**The Joint Commission—**Previously called the Joint Commission on Accreditation of Healthcare Organizations. The name change reflects the Joint Commission's continuing efforts to improve the value

of accreditation and its utility as a mechanism for improving the quality and safety of patient care in all organizations.

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

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

**MINIMIZE—**A procedure used during periods of crisis or other abnormal operations to reduce the volume of record and long distance telephone traffic transmitted electronically. MINIMIZE applies to all users of Department of Defense (DOD) communications systems, including originators of card and tape traffic. When MINIMIZE is imposed, users of DOD electronic communications must determine that: 1) the information to be sent is required to avoid a seriously detrimental impact on mission accomplishment or safety of life; and 2) electronic transmission is the only way to get the information to the addressee in sufficient time to accomplish the purpose.

**Provider—**Those individuals who have direct patient care responsibilities, who by virtue of their scope of practice, may be called on to clinically manage or assist casualties during a contingency, be it wartime, humanitarian assistance or disaster response. For the purposes of this instruction, the term provider will pertain to all physicians, nurses, physician assistants, and only those dentists and medical technicians used in a first response capacity.

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

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

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

## Attachment 2

## MEDICAL CONTINGENCY RESPONSE PLAN (MCRP) FORMAT

**A2.1. Cover Page.** Include the publication date, title, base, OPR, and plan number (if directed).

**A2.2. Letter of Transmittal.** Include the Long Title of Plan, Purpose, and Plan Maintenance Schedule, as a minimum. The Letter of Transmittal is signed by the unit Commander.

**A2.3. Security Instructions and Record of Changes**

**A2.4. Plan Summary.** The plan summary should resemble an Executive Overview, addressing key issues and concepts described in the plan. Include the plan purpose, conditions of implementation, operations to be conducted, key assumptions, operational constraints, time to commence effective operations, command relationships, logistics appraisal, personnel appraisal, consolidated listing and impact assessment of shortfalls and limiting factors.

**A2.5. Table of Contents.**

**A2.6. Basic Plan.** Include a list of supporting plans and agencies, as well as a list of references used in the development of the plan (each reference does not require a specific date). Include Federal, DOD, AF, and MAJCOM policy and guidance as well as any applicable installation and unit guidance. Also list applicable maps, charts, and any MOUs/MOAs/MAAs that may apply, such as those referencing support provided by the VA. MOUs/MOAs/MAAs and applicable contracts containing contingency response clauses must be fully coordinated in writing and maintained in the MR office.

A2.6.1. **Contributing Organizations.** Include all units and organizations (military and civilian) that have a role in the plan or support the medical facility during contingency response operations. Briefly describe the support provided by these entities, a means of activating support agreements, if applicable, and provide a point of contact with a current address and phone number. All contributing organizations identified in the plan must coordinate on it prior to publication.

A2.6.2. **Execution.** Describe the conditions under which the MCRP will be executed, who directs the execution, and who executes the plan. Briefly summarize each annex, providing a descriptive statement for each major team, as appropriate, with the corresponding annex. The descriptive statement should indicate who is responsible for preparing and maintaining each annex and any supporting MCRP team checklists. Include a statement: each MCRP annex must be exercised annually. Required reading for all unit personnel includes: Basic Plan, Annex A, their own team annex, and general information annexes M through Z.

A2.6.3. **Threat Assessment.** Describe legitimate facility threats, to include: security issues, critical infrastructure, weather or geological concerns, and other hazards. Address specific vulnerabilities, limiting comments to unclassified sources.

**A2.7. Annexes.** Each annex provides definitive information as to how, where, when, and who performs specific functions in support of the unit's contingency response mission, allowing for the flexibility to adapt to changing emergency situations or environments and still effectively execute the mission. Each team annex should specifically address all environments in which teams may be required to respond and

operate, including accidents, natural disasters, and terrorist incidents. CBRN factors could be part of any response activity and therefore MC-CBRN responsibilities should be included in all MCRP team annexes and checklists. MCRP teams will be organized, trained, and equipped as determined by the MRSF. MCRP team chiefs are the Annex OPRs and are responsible for preparing and maintaining their annexes and all supporting team checklists. Each annex should specify its OPR by position, as in "The Administrator is the OPR for this Annex." Supporting MCRP team checklists must be designed to serve as a quick reference, chronological list of actions required in any given situation. Checklists must be easily accessible during an emergency and extra copies maintained at the MCOOP alternate command and control (C2) location in the event of a facility evacuation/relocation. List supporting MCRP team checklists (by subject or title) within each applicable annex. Include annexes in the following paragraphs, as a minimum. If annexes from this list do not apply, explain on the annex title page, and discuss the rationale for not using them in the MRSF during plan review and approval. To accommodate unique local requirements, additional appendices and tabs not assigned in this attachment may be added (e.g. Annex Y and Z).

A2.7.1. **Annex A - General Instructions.** Include information applicable to all medical personnel regardless of team assignment. Address the following:

A2.7.1.1. Recall Procedures. Recalls are initiated at the direction of the wing or unit commander, or designated representative to return medical personnel to duty in response to emergencies, disasters, contingencies, or to transmit important information. Types of recalls that should be considered in recall procedure development include total and selective. The total recall may involve telephone notification and reporting to duty or telephone notification to relay important, or time sensitive, information. The selective recall may involve the recall to duty of UTC personnel, deployment support teams, or key individuals or specific MCRP teams. The selective recall may also be used to relay important information, such as pending activation, to specific individuals. Units may elect to supplement or modify the recall procedures described here to fit special or unique circumstances, as appropriate. For example, overseas locations may consider development of "communications out" procedures if standard communications systems are routinely unavailable.

A2.7.1.2. Space Allocation. Include a description and diagram of team spaces as well as patient flow within the facility. Include any team operation areas that are outside the facility as well, such as patient decontamination or triage.

A2.7.1.3. Triage Categories. The triage officer examines all casualties and categorizes them according to a color-coded system. When using color-coding systems to represent triage categories, coordinate with local emergency response agencies to prevent confusion during actual emergencies or joint military/civilian exercises. The following categories and colors are used for standardization:

MINIMAL - **Green**
IMMEDIATE - **Red**
DELAYED - **Yellow**

***NOTE:*** EXPECTANT patients would normally be those patients who are hopelessly injured, or who obviously require inordinate medical treatment, to the detriment or neglect of other patients. As a rule,

this category is not applied in a peacetime disaster, unless the facility is totally overwhelmed with casualties.

A2.7.1.4. Command, Control, Communications, Computer, and Information (C4I). Indicate the location of the MCC and describe available C4I infrastructure. Describe back-up resources and procedures for maintaining communications and connectivity in the event of an outage. List actions required to restore communications and information systems connectivity if they break down, including repair points of contact and other base support.

A2.7.1.5. Base Mission Support. Outline the MTF's role in supporting the base mission with a clear delineation between deployment operations and installation medical response. Address the MTF's role in supporting base response to Incidents of National Significance and NRP activation. Do not duplicate guidance contained in the IGESP and CEMP 10-2, but ensure vital information is readily available to applicable personnel. Refer to AFI 10-802, *Military Support to Civil Authorities*, and **Attachment 5** of this AFI for additional guidance. At a minimum, address medical support for the wing EOC. Refer to, but do not duplicate information or guidance addressed in Annex T.

A2.7.1.6. Response Codes. Units that have internal emergency response code systems (i.e. code pink for child abduction, code black for intruder, etc.) will describe those codes and associated response procedures in this Annex and incorporate these activities into exercise scenarios whenever possible.

A2.7.1.7. Expeditionary Mission. Provide an overview of the unit's expeditionary and generation missions to include casualty receiving hospital, facility expansion requirements, NDMS support, etc. Consult MRDSS ULTRA for a full list of generation missions which should be included in this section.

A2.7.2. **Annex B - Medical Facility Commander/Medical Control Center (MCC).** Address at least those responsibilities listed in **Chapter 2** and briefly outline the chain of command to ensure continuity if the commander is unavailable. Outline contingency operations procedures, responsibilities, and any pre-delegated authorities relevant to the unit's contingency response operations. Delegations of authority allow for an expedient and efficient response to an emergency situation, particularly in instances of degraded communications or leader absences. Additionally, address medical reporting procedures utilizing examples and specific references to applicable directives, such as AFI 10-201, *Status of Resources and Training System*, AFI 10- 206, *Operational Reporting*, and AFI 10-244, *Reporting Status of Aerospace Expeditionary Forces.*

A2.7.3. **Annex C - Patient Support.** (Not applicable to the ANG.) Address maximum anticipated patient population during contingencies, projected changes in availability of medical services, including curtailment of routine services during contingency operations, and the impact on patient redistribution. Address enrolled patients as well as potential non- enrolled patients, such as base civil service employees or contractors who may seek care during an emergency. If routine care will not be curtailed, describe prioritization of care. Outline procedures for evacuation/dispersion of patients in the event of an impending natural disaster, such as a hurricane, wild fire, etc., or after an event has occurred. Reference established MOUs/MOAs for transfer of patients to other medical facilities, as applicable. Describe procedures for the actual transportation of patients to dispersed locations and how the determination will be made as to which types of patients go where. To avoid duplication, in Annex Q, address procedures for sheltering patients. In Annex V, describe aeromedical evacuation

(AE) procedures, to include civilian aeromedical evacuation options (Life Flight, etc.) and AE divert mission reception procedures, i.e. AE C2 POC contact numbers. In Annex W, address how applicable TRICARE contractor support will be utilized.

A2.7.4. **Annex D - Casualty Management.** (Not applicable to the ANG.) Describe casualty management for each respective team/work center, to include casualty flow within the facility and transportation of casualties to the MTF and other facilities. Outline procedures to respond to all contingencies, including incorporation of procedures outlined in TTP 3-42.32, *Home Station Medical Response to CBRNE Events,* Annotate tabs as "Not Applicable" if not required. If teams are called something other than those listed, annotate the tab as follows: Tab 1 - Immediate Treatment Team (Field Treatment Team).

A2.7.4.1. Appendix 1 - Aerospace Medicine Team. This team should be comprised of at least 1 physician, 1 nurse, two med techs, and one patient administration technician to provide data collection and communications support on scene. This team provides the medical first responders to the scene and is responsible for assessing the situation, providing initial casualty data to the MCC, and requesting additional support as necessary.

A2.7.4.1.1. Tab 1 - Field Treatment Team / Immediate Medical Response. This team should be comprised of additional providers, nurses, and med techs to provide additional triage and care at the scene for those casualties with the highest priority for treatment. Additional patient administration personnel assigned to this team can provide casualty tracking support and status updates. Utilize 886C AS for MC-CBRN response.

A2.7.4.2. Appendix 2 - Clinical Teams. Clinical teams are covered in this Appendix as listed below.

A2.7.4.2.1. Tab 1 - Minimal Team. This team treats patients with minor injuries who requires some attention, but whose injuries are so slight that they may not need a physician. Most of these patients can be promptly returned to duty.

A2.7.4.2.2. Tab 2 - Delayed Team. This team treats patients whose injuries do not jeopardize life if definitive treatment is delayed. Injuries in this category may require extensive surgery or extensive medical care

A2.7.4.2.3. Tab 3 - Immediate Team. This team treats patients whose injuries demand immediate medical or surgical intervention require immediate attention to save their lives or limbs.

A2.7.4.2.4. Tab 4 - Radiology Team. This team provides diagnostic imaging support during contingency operations.

A2.7.4.2.5. Tab 5 - Laboratory Team. This team provides diagnostic laboratory and transfusion services in support of contingency operations. Utilize 886I AS for MC-CBRN response.

A2.7.4.2.6. Tab 6 - Pharmacy Team. This team prepares and distributes medications in support of contingency operations. Outline a mass prophylaxis plan to support pre- and post-exposure requirements. Working directly with the Public Health Emergency Officer (PHEO)and Logistics Team Chief, outline procedures to request assets from the Strategic National Stockpile (SNS) (in CONUS), or establish overseas stockpiles and a mass prophylaxis distribution process. Include installation distribution priorities, locations, tracking mechanisms, and training requirements. Utilize 886E AS for MC-CBRN response.

A2.7.4.2.7. Tab 7 - Surgery Team. This team provides surgical therapies in support of contingency operations. Units that do not have surgical capability will address how they will manage surgical casualties and where/how they will be transferred for surgical services.

A2.7.4.2.8. Tab 8 - Nursing Services Team. This team provides support to other clinical teams as required and supports patient reception, stabilization, re- triage and transport, as necessary. This tab need not be used if assigned nursing staff is integrated into other MCRP teams.

A2.7.5. **Annex E - Public Health Team.** Describe support in providing: assessment of public health needs; public health surveillance; site selection consultation; communicable and vector- borne disease surveillance, prevention, control, and reporting; food safety and decontamination oversight; food borne illness outbreak investigations and food vulnerability assessments; medical intelligence and health threat assessment; and deployment health threat management and education. The Public Health Team also provides support to the PHEO during public health emergencies and installation contingency response scenarios outlined in AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations,* AFI 10-2603, *Emergency Health Powers On Air Force Installations,* AFI 10-2604, *Disease Containment Planning Guidance,* and AFTTP 3-42.32, *Home Station Medical Response to CBRNE*.

A2.7.6. **Annex F - Bioenvironmental Engineering (BEE) Team.** Outline support provided by the BEE team, to include: evaluations or assessments of environmental and occupational health hazards and recommended actions for control of these hazards; monitoring of base water supply to ensure potability, safety, and survivability; monitoring, evaluation, and direction for control of chemical, biological, and radiological hazards; and assistance in selecting base and unit shelters. This annex should outline procedures for responding to all installation contingencies and utilization of the 886H AS for MC-CBRN response.

A2.7.7. **Annex G - Medical Logistics Team.** Planning shall include the identification of WRM management and maintenance requirements. Outline procedures for distribution of BW/CW antidotes to applicable deploying forces.

A2.7.7.1. Describe in-garrison mission support, including procedures for emergency requisition, biomedical equipment repair/maintenance program, and WRM management procedures and responsibilities. Access MRDSS ULTRA for a complete list of assigned WRM assemblages in the MRL.

A2.7.7.2. If assets from the Strategic National Stockpile (SNS) will be necessary to protect AF personnel in the event of a suspected or confirmed bioterrorism attack or pandemic event, medical units will coordinate request and distribution of these assets through the local public health authority. Information on the SNS is available at the Centers for Disease Control and Prevention website, **www.cdc.gov**. Receipt and use of SNS assets must be a combined effort of the pharmacy, public health, logistics, and other teams. At a minimum, Annex G should address logistics support requirements for obtaining, transporting, safeguarding, issuing of SNS assets.

A2.7.8. **Annex H - Manpower/Security Team.** Indicate the team responsibilities in supporting the overall medical contingency response, with augmentation from other disaster response teams as required or available. Describe how Manpower Team members are deployed and managed during an emergency, as well as team communications resources and procedures. All personnel not specifically assigned to another response team will be assigned to the Manpower/Security Team. Address the Manpower/Security Team's roles in supporting wing/base terrorist threat procedures and in carrying

out Force Protection Condition actions within and around the MTF during periods of heightened terrorist threats or activity and elevated Force Protection measures. Refer to base/wing force protection plans but do not duplicate guidance in these plans. Address at a minimum, facility security, entry control procedures, communications, and plans for 24-hour coverage if/when necessary, and security support for in-place patient decontamination operations and mass prophylaxis dispensing locations. Depending on the size of the MTF, the following manpower sub-teams may be formed:

A2.7.8.1. Appendix 1 - Patient Movement Team.

A2.7.8.2. Appendix 2 - Facility Evacuation Support Team

A2.7.8.3. Appendix 3 - Facility Security Team

A2.7.8.4. Appendix 4 - Additional Manpower Request Procedures. If additional manpower support will be requested from co-located AFRC or ANG units in an emergency (IAW the base support plan), address those procedures here.

A2.7.9. **Annex I - Crisis Response Team (CRT).** (Not applicable to the ANG.) The primary responsibility of the CRT is to provide mental health/life skills services to victims and families on site and within the MTF during and post-disaster. CRT members will be trained to respond to a CBRN event IAW AFI 44-153, *Traumatic Stress Response.* The mission of the CRT it two-fold: traumatic stress response (TSR) and hostage negotiation consultation.

A2.7.9.1. TSR is designed to assist those affected by traumatic events to cope with the normal stress reaction in an effective manner. These actions are intended to minimize the impact of exposure to these events and prevent or mitigate permanent disability if possible. The CRT will provide TSR preventive services to unit and community members before potentially traumatic events occur and post-incident mental health screening, psychological first aid, education and referral necessary to manage stress resulting from a CBRN event.

A2.7.9.2. CRT members will be available to provide hostage negotiation consultation to security forces hostage negotiators during a hostage event. The CRT Hostage Negotiator Consultant is only an advisor to the Wing Hostage Negotiator, and does not directly interact with the perpetrators or hostages.

A2.7.10. **Annex J - Facilities Management Team.** Describe facility management activities in ensuring: maintenance and repair support; availability of required utilities; maintenance or repair of communication assets. Include procedures in response to contingency events, to include but not limited to, oxygen shut-off procedures and locations; HVAC shut-off procedures and locations; power locations; emergency water shut-off, alternate water source, and emergency entry control. Describe relationships and communication between the Manpower/Security Team and the Facilities Management Team during building evacuation and lock-down, force protection condition response, or patient/public movement control/restrictions within and around the facility. Facility security will be staffed by the Manpower/Security Team (see Annex H Appendix 3).

A2.7.10.1. Appendix 1 - Fire evacuation/protection plan and associated references, including assembly maps, alarm procedures and RACE (Rescue, Alert, Contain, Extinguish).

A2.7.10.2. Appendix 2 – Reconstitution procedures following a catastrophic event that renders the MTF inoperable (MCOOP).

A2.7.11. **Annex K - Nutritional Medicine/Food Service Team.** (Not applicable to the ANG.) Address this function (particularly overseas), even though food service may not be a formal unit function. Key activities include feeding of patients during a mass casualty event and feeding of responders and MCRP team members. Address how and where meals would be procured and distributed (the Manpower Team may be utilized to distribute these items throughout the facility and to medical personnel who remain at the scene). Also consider feeding of personnel during MCOOP operations, evacuation or shelter scenarios.

A2.7.12. **Annex L - Patient Administration Team.** Describe patient administration functions during all contingency scenarios. Describe patient tracking and status reporting procedures for both patients within the facility and those transported to other area medical facilities.

A2.7.12.1. Appendix 1 - Military Patient Administration Team (if applicable). If the unit is tasked to support NDMS operations, describe Military Patient Administration Team (MPAT) responsibilities. MPATs typically are comprised of representatives from Patient Administration, Mental Health, Military Personnel, Military Pay, American Red Cross, Mortuary Affairs, Legal Office, Public Affairs, Chaplain, and a Medical Evaluations Board (MEB) Coordinator in order to support a military patient with the full spectrum of personnel services in civilian NDMS hospitals and VA medical facilities. This AFI is not the prescribing guidance for these teams. Patient Administration personnel should consult NDMS representatives for support. Guidance listed below is provided for expediency.

A2.7.12.1.1. The Patient Administration MPAT members will: (1) Ensure current requirements for the personnel/casualty reporting system (e.g., SI, VSI, etc.) are compiled by the NDMS hospitals, (2) Assist in the discharge of military personnel back to duty status and expedite their return to the active-duty force, (3) Assist in gathering information and documentation for MEB/PEB actions, (4) Coordinate transportation requirements for military personnel being discharged, (5) Coordinate the transfer of military patients to long-term care facilities in the VA medical system or to a military medical facility, (6) Receive, review, correct, and process health records of military personnel being discharged from civilian hospitals.

A2.7.12.1.2. Mental Health or Social Worker team members will provide counseling and assist in any family-related problems for the military patient.

A2.7.12.1.3. The Military Personnel representative will assist in the accountability of military casualties; report to parent service patient availability for duty reassignment, disability retirement/ separation; ensure publication of appropriate orders (duty, patient squadron, etc.); generate personnel reports; and conduct notification procedures for general/flag officer admissions.

A2.7.12.1.4. The Military Pay representative will assist in providing pay and allowances support; and preparing, maintaining, transferring, and disposing of pay records for military patients returned to parent service control or medically retired/separated from active duty.

A2.7.12.1.5. A Chaplain representative will assist in providing spiritual consultation to military patients and their families. Additionally, the Chaplain representative will encourage local clergy involvement in establishing a community-focused pastoral/spiritual role, along with the Salvation Army in NDMS patient management. (Is the Salvation Army doing the same thing as the local clergy? Do they have a specific role?)

A2.7.12.1.6. The Public Affairs role includes providing a Media Operations Center from which to answer media queries and coordinate news releases.

A2.7.12.1.7. The Legal Office representative will provide active duty related legal consultation regarding wills, living wills, powers of attorney and other related documentation. Additionally, a Medical Law Consultant will provide assistance in safeguarding and releasing medical information, other medico-legal questions, and quality assurance/risk management considerations.

A2.7.12.1.8. Services support may include providing mortuary affairs (coordinating with local/county coroner and local/county morgue facility); coordinating transport of remains as appropriate; and assisting next-of-kin (NOK) with military funeral arrangements. Other support needs may include billeting, food service, and linen/laundry.

A2.7.13. **Annex M - Civil Disturbances.** Civil disturbances, bomb threats, and threats to personnel safety can affect the MTF in many ways. These disturbances may put the MTF at risk, produce military patients (or civilian patients needing expedient care) presented with wounds closely resembling wounds commonly received during wartime confrontations. Peaceful civil disobedience or bomb threats may impede civilian employees and military personnel living off base from coming to work. The only characteristic of civil disturbances, which is constant, is that they are unpredictable. Therefore, the facility commander must consider implementation of all or specific portions of this plan based on the most appropriate response to a particular civil disturbance situation. Additionally, mission activities can be impacted due to a worker strike, such as biohazard waste removal, laundry service, etc. Planning in advance for such interruptions of service will help mitigate the impact on patient care and mission accomplishment. This annex should include identification of likely scenarios, the impact on the facility operations, and recommendations to mitigate that impact.

A2.7.14. **Annex N – Patient Decontamination (** formerly titled Terrorist and Weapons of Mass Destruction (WMD) Threats). This annex outlines how the MTF, with or without inpatient capability, will provide thorough patient decontamination prior to patients entering the MTF or being transported to off base definitive medical care. The MTF may utilize the AFMS in-place patient decontamination (IPPD) or a fixed-facility engineered decontamination capability. This annex should outline procedures for responding to all installation contingencies to include utilizing 886A AS for MC-CBRN response. NOTE: This annex does not replace MC-CBRN activities described in each team annex.

A2.7.15. **Annex O - Transportation.** Address requirements for medical transportation, materiel handling, and personnel support. Primary emphasis on deployment requirements is on movement, marshalling and staging of medical personnel, baggage, WRM (if applicable) and other resources to fulfill mission requirements. Address procedures for sheltering of vehicles in response to impending storms or other natural events (as applicable). Describe procedures for relocation of supplies, equipment, and personnel to the C2 relocation site. Describe plans for patient transportation during a mass casualty event, including any MOAs/MOUs for additional vehicles to augment current capabilities, or for transportation support from local civilian sources. Reference the IGESP and/or CEMP, as appropriate.

A2.7.16. **Annex P - Medical Continuity of Operations (MCOOP).** The MCOOP concept, formerly called Alternate Medical Facility (AMF), must address methods for ensuring continuity of medical operations during an event that renders the MTF uninhabitable or during extended periods of evacuation. A critical element of MCOOP is staff accountability. Describe procedures for immediate

staff accountability following the event, including procedures for dispersing staff to local civilian hospitals or other agencies, such as local VA facilities, where they will augment assigned staff (reference applicable MOUs/MOAs/MAAs). Address the transfer of any necessary equipment or supplies to augmented facilities, as appropriate and feasible. If immediate evacuation of the MTF is required, describe where and how patients will be staged while awaiting transport, and which MCRP teams will support operations at that location (i.e. triage, manpower, etc.). Consider the need for sheltering in place if evacuation methods (aircraft/ambulances) are not readily available, and address those procedures in Annex Q. Address all requirements for patient dispersal to other facilities in Annex C. See Annex L for procedures to track patients after dispersal and during the event. Finally, describe procedures for an orderly return to normal operations at the MTF following reconstitution and termination of the event. Include the following appendices:

A2.7.16.1. Appendix 1 - Medical C4I. Address notification and relocation of the MCC and key staff to an alternate location from which they will track patients, perform staff accountability functions, and provide status updates to Wing leadership and higher headquarters as requested. List and describe methods that will be utilized to alert unit personnel, local civilian facilities and emergency responders, base agencies, and higher headquarters of a catastrophic event. Address methods for ongoing communications with the aforementioned agencies/personnel to provide updates, request assistance, etc. Keep in mind that cellular phone services may be overwhelmed and plan for alternative methods of communication. Include a list of land line phone numbers that can be used, including secure communications resources and capabilities. In addition, address procedures to establish information systems capability at the Medical Command and Control location (i.e. e-mail, access to LAN servers, etc.). Establish and describe redundant or back-up procedures for patient accountability and tracking, and for providing necessary patient care information to receiving facilities (in an appropriately secure manner) to minimize disruption of care.

A2.7.16.2. Appendix 2 - Transportation. Describe transportation procedures for dispersed staff, whether POVs will be used (keeping in mind that local roadways may be inaccessible or gridlocked), and if POVs will not be used or are inaccessible, the procurement of buses or other means of transportation.

A2.7.16.3. Appendix 3 - Public Affairs. A public information telephone number or announcement on local radio/TV should be established informing beneficiaries of the situation and where they should go to seek medical care. Additionally, consider establishing a method to provide situation updates to dispersed staff members.

A2.7.17. **Annex Q - Shelter Operations.** Two types of shelters should be addressed in this annex: sheltering in place, within the facility during a sudden severe storm, such as a tornado, or a HAZMAT event on base, and evacuation to an external designated shelter for an imminent, more extended event, such as a hurricane. This annex will outline procedures for both scenarios. Describe procedures for moving staff, patients, supplies, and equipment to shelter areas/spaces, as well as patient care and response capabilities from and within the shelter. Describe how long shelter operations can be sustained and supplies required for sustainment. Address the types of patients, staff and civilians might be in the shelter and how their needs will be met. If patients and staff are to be evacuated out of the area during a hurricane or similar event, as opposed to sheltering nearby, describe how the evacuation will take place, roles and responsibilities during evacuation, as well as how patients and staff will be tracked and contacted throughout the event. Planning is based on types of disasters likely to occur in the local area IAW the Installation CEMP 10-2.

A2.7.18. **Annex R - NDMS Peacetime Operations.** (Not applicable to the ANG.) This annex is required for MTFs designated as NDMS FCCs and optional for MTFs that do not have a direct role in supporting the NDMS. The MCRP can reference separately developed NDMS operations or patient reception plans that describe NDMS operations and are used instead of this annex. MTFs not designated as FCCs can use this annex to describe potential involvement with NDMS operations, if applicable. MPAT roles and responsibilities are described in Annex L, Patient Administration.

A2.7.19. **Annex S - Deployment.** List apportioned UTCs and describe the processes involved in managing and deploying those UTCs. Include personnel selection and deployment folder management, equipment and supplies, WRM management if applicable, weapons management, unit pre- processing, base deployment processing, and cargo marshalling.

A2.7.19.1. Appendix 1 - Deployment Support. Address support the MTF provides to the wing/base deployment processing line. Do not duplicate information contained in the base deployment plan, but address procedures and guidance specific to the MTFs role in wing/base deployment processing, such as pre- and post-deployment health screening (reference Annex E), deployable medical records management, immunizations, prophylaxis distribution, and the medical intelligence briefing.

A2.7.20. **Annex T - Disaster Response and Recovery.** Use this annex to describe response and recovery procedures for "worst case" scenarios, such as a catastrophic natural disaster directly affecting the installation and/or surrounding civilian communities. Response procedures should address the MTF's responsibilities in responding to providing life, limb, and eyesight saving treatment to victims of a disaster (active duty personnel as well as non-active duty and local civilian populations). Recovery procedures should address reconstitution plans for medical resources and reestablishing health care for active duty and non-active duty beneficiaries. Refer to AFI 10-229, *Responding to Severe Weather Events*, for severe weather response guidance.

A2.7.21. **Annex U - Blood Program.** (Not applicable to the ANG.) Describe procedures, personnel requirements, and facilities necessary to provide blood and blood derivatives for casualty treatment, if applicable. Planning should be consistent with AFI 44-105, *Air Force Blood Program*, and address situations that require activation of the blood program. Specify provisions for activating the blood donor center, blood transshipment center, or other assigned blood program missions, as applicable, to include procedures for center operation and resupply. Indicate agreements with local agencies for obtaining emergency blood supplies, as appropriate.

A2.7.22. **Annex V - Aeromedical Evacuation.** Use this annex to describe the facility's AE role and AE interface with base response activities, as applicable. Include a description of aeromedical staging activities and communications between the Aeromedical Staging Facility, Mobile Aeromedical Staging Facility, and MTF, as applicable. Describe civilian patient airlift capabilities and any MOUs/MOAs/MAAs involved. Describe procedures to be used in the event of an unanticipated diversion of AE missions to the base, or the unplanned requirement to support patients, both inpatient and outpatient, or remaining overnight.

A2.7.23. **Annex W - TRICARE.** (Not applicable to the ANG.) Address the role of the TRICARE contractor during contingency operations. The contractor is responsible for providing the medical unit with a copy of their contingency plan. Include information from the plan in this Annex and list it in the References section as well. Contract excerpt examples are provided below for reference and identify elements which should be discussed with details included in Annex W.

A2.7.23.1. The TRICARE contractor will ensure that provider networks and services can be adjusted as necessary to compensate for changes in MTF capabilities and capacities. The contractor will also ensure that all eligible beneficiaries who live in Prime service areas have the opportunity to enroll, add additional family members, or remain enrolled in the Prime program regardless of such changes. MTF capabilities and capacities may change frequently over the life of the contract without prior notice. The contractor will adjust the capabilities and capacities of the network to compensate for such changes when and where they occur over the life of the contract, including short notice of unanticipated facility expansion, provider deployment, downsizing and/or closures. The contractor will meet with the MTF Commander as soon as possible, but not later than 2 business days after a request, to fully understand the scope of the short notice of unanticipated facility expansion, provider deployment, downsizing and/or closures.

A2.7.23.2. All hospitals in the TRICARE contractor's provider network are encouraged to become members of the National Disaster Medical System (NDMS) and sign a MOA with the nearest Federal Coordinating Center (FCC).

A2.7.23.3. The TRICARE contractor will develop and implement, in conjunction with each MTF and Regional Director, a contingency program designed to ensure that health care services are continuously available to TRICARE eligible beneficiaries as the MTFs respond to war, operations other than war, deployments, training, contingencies, special operations, et cetera. The documented contingency program shall be provided to the Regional Director 6 months following the start of option period one and updated annually.

A2.7.23.4. The TRICARE contractor will participate in each MTF's Installation Level Contingency Exercise twice each year. The purpose of the exercise is to test the contingency program under a variety of situations and to provide information from which the contractor's contingency program shall be updated. The contractor will also participate in Regionally Coordinated Table Top Contingency Exercises twice each year.

A2.7.23.5. The TRICARE contractor shall implement the contingency program at any or all locations within forty-eight (48) hours of being notified by the Regional Director that a contingency exists.

A2.7.24. **Annex X - Facility Expansion.** (Not applicable to the ANG.) This annex is mandatory for MTFs tasked with a facility expansion mission and not required for MTFs that do not provide that capability. Include facility expansion procedures, if tasked. Include manpower and staffing requirements, as well as a description of facility expansion procedures and an expansion floor plan.

A2.7.25. **Annex Y – ANG Immediate Medical Response (ANG Only).** (AD and AFRC Units use annex for Local Use Only.) This team should be comprised of additional providers, nurses, and med techs to provide additional triage and care at the scene for those casualties with the highest priority for treatment. Additional patient administration personnel assigned to this team can provide casualty tracking support and status updates. Utilize 886C AS for MC-CBRN response.

A2.7.26. **Annex Z (For Local Unit Use).**

**A2.8. Distribution.** List all agencies/units which receive a copy of the plan, to include contributing agencies and civilian partners, and the number of copies they should receive.

## Attachment 3

## MEDICAL READINESS TRAINING (MRT) MATRIX

**NOTE**: Additional training requirements beyond those listed in this attachment may be levied by other AFIs, official messages or policy letters. Personnel must comply with all requirements until those requirements are officially rescinded by the tasking authority.

**CATEGORY I - INDIVIDUAL TRAINING - CORE.** Category I training is required for all AD/ARC AFMS personnel (unless specified otherwise in the table below) regardless of their deployment status. This includes personnel assigned to A/DWS, A/DWX, or A/DXS coded UTCs.

| **Training Requirement** | **Minimum Frequency** | **Reportable Y/N (see Table 8.1.)** | ***Reference*** | **Definition** | **Remarks/Training Source** |
|---|---|---|---|---|---|
| Readiness Skills Verification Program (RSVP) | IAW Task Frequency for personnel assigned to a A/DWS, A/DWX, or A/DXS UTCs | N | AFI 41-106 | RSVP is the readiness portion of AFSC- specific sustainment training and is designed to ensure all members maintain adequate skills to perform their duties during wartime, humanitarian assistance, and installation response contingencies. | For personnel not currently assigned to a A/DWS, A/DWX, or A/DXS coded UTC, RSVP training for UTC AFSC substitutions will be completed just-in- time (JIT) upon assignment to a A/DWS, A/DWX, or A/DXS coded UTC. **Source**: Checklists are available through MRDSS ULTRA at: **https://uim.mrdss.net/uim/sitaware** |
| SABC | IAW AFI 36-2238 | Y | AFI 36-2238<br>AFI 41-106 | Provides hands-on training in wound management and patient transportation/ evacuation in the non-clinical setting using non- standard medical equipment and supplies. Personnel will also accomplish training on individual first aid kit and use of the ATNAA. | Applicable to all AFSCs. AFRC units will only use SABC in reportable training calculations for their personnel assigned to D coded UTCs. For AFRC non-medical UTCs 6KAAE, TFRR8, and 9AFS2 SABC will count for ART reporting only. **Source**: CBT located on the Advanced Distributed Learning Service (ADLS) website at **https://golearn.csd.disa.mil** Lesson plans located on the Expeditionary Skills website at **https://kx.afms.mil/sabc** and handbooks located on the Air Force e-publishing website at **http://www.e-publishing.af.mil** |
| CBRNE Defense Awareness Training | IAW AFI 10-2501 | N | AFI 10-2501<br>AFMAN 10-100 | Instruction in the proper wear and use of the ground crew ensemble and mask during the various MOPP conditions. Includes understanding of alarms signals and use of personal chemical detection kits. | Required for all personnel, regardless of deployment status. Must be accomplished prior to attending CBRN Defense Survival Skills course. **Source**: see AFI 10-2501. |

| | | | | | |
|---|---|---|---|---|---|
| CBRN Emergency Medical Preparedness and Response Course (EMPRC) | - Initial training within 12 months of first duty assignment.<br>- Sustainment training every 3 years once available. | N | AFI 41-106 ASD-HA ltr,<br>28 Jun 07 | Clinician/Provider, Executive/Commander, Operator/Responder, and Basic courses as defined in para. **5.7.11.** | **Source:** Fulfilled through completion of CBRN EMPRC CBT. Credit is granted for Threat and Future Battlefield, Depleted Uranium, and Medical Effects of CBRN Warfare (below) upon completion of this course. See **https://kx.afms.mil/sg3xp** |
| AF Emergency Response Operations (ERO) Course | IAW AFI 10-2501 | N | AFI 10-2501 | The course consists of; an overview of the Air Force Emergency Management Program, the Air Force Incident Management System, major phases of incident management, roles and responsibilities of First Responders and Emergency Responders, Emergency Support Functions, and Incident Command System policies. | Required for all First Responders and Emergency Responders as defined in AFI 10-2501. Tracked by MCRP Team Chiefs as team training; see para. **5.9.1.** of this AFI for specific guidance and exceptions. **Source**: Advanced Distributed Learning Service through the AF Portal **https://golearn.csd.disa.mil** |
| Geneva Conventions/<br>Law of Armed Conflict (LOAC) | IAW AFI 51-401 | N | AFPD 51-4<br>AFI 41-106<br>AFI 51-401 | Those elements as prescribed by Headquarters Air Force/Judge Advocate (AF/JAO). | **Source**: May be fulfilled through completion of the Law of Armed Conflict course on the ADLS website at **https://golearn.csd.disa.mil** Additionally, all medical personnel must review current policy on medical personnel in combatant roles, located on **https://kx.afms.mil/sg3xp**. |
| Total Force Awareness Training | IAW AFI 36-2201 V1, AFGM1 | N | AFI 36-2201 V1, AFGM1 | Includes three 30-minute blocks of CBT: Information Protection, Force Protection, and Human Relations. Members may accomplish all three courses at once to synchronize their annual training requirements. | All training in these new courses is required annually. **Source:** accessed through the ADLS website at **https://golearn.csd.disa.mil**. |

**CATEGORY II - DEPLOYMENT TRAINING.** Personnel assigned to A/DWS, A/DWX, and A/DXS must accomplish Category I training and Category II training. Additional training may be required to meet theater-specific requirements. These theater-unique training requirements will be identified in deployment reporting instructions and/or line remarks.

| **Training Requirement** | **Minimum Frequency** | **Reportable Y/N (see Table 8.1.)** | ***Reference*** | **Definition** | **Remarks/Training Source** |
|---|---|---|---|---|---|
| Human Remains Preservation Training | JIT - Prior to deployment | N | AFI 41-106 | Designed to provide an understanding of: the duty of the U.S. to provide a full accounting and the impact of remains preservation on providing an accounting; the importance of ensuring the safety of the Service Member in the retrieval of remains in combat or combat- like conditions; procedures and best practices in the preservation of remains in combat and combat-like conditions; cultural implications regarding preservation of remains; medical planning considerations regarding preservation of remains. | **Source:** AFMAN 10-100 and presentation available at: **https://kx.afms.mil/kxweb/dotmil/file/web/ctb_077667.pdf** |
| Medical Ethics and Detainee Operations | JIT prior to deployment | N | DODI 2310.08E | Guidance for Medical Support to Detainee Operations | **Source**: **https://mhslearn.satx.disa.mil** |
| Combat Arms Training | IAW AFI 36-2226 | N | AFI 31-207<br>AFI 36-2226<br>AFI 41-106<br>AFPD 16-8 | Familiarization, use, and qualification with assigned weapon(s). | For UTC weapons requirements see **https://kx.afms.mil/sg3xp**. Dual qualification for enlisted weapons couriers, aircrew and some UTCs may be required. **Source**: training provided by the base CATM office. |
| CBRNE Defense Survival Skills Course | IAW AFI 10-2501 | Y | AFI 10-2501<br>AFMAN 10-100 | Instruction in the proper wear and use of the ground crew ensemble and mask during the various MOPP conditions. Includes understanding of alarms signals and use of personal chemical detection kits. | Training is in addition to the CBT. Evidence of completion of the CBT within 60 days must be provided. **Source**: Base Readiness and Emergency Management Flight, see AFI 10-2501. |

| | | | | | |
|---|---|---|---|---|---|
| UTC-Specific Training | - Initial upon assignment to a UTC<br>- Sustainment training every 24 months or as described in Remarks at right. | Y | DODI 1322.24<br>AFI 41-106 | Attendance of formal UTC training courses for UTCs that have courses. For UTCs that do not have formal courses, training will include discussion of UTC CONOPS/TTP and allowance standard (AS) review; hands- on experience with equipment is required for those units with co- located equipment sets. UTC Sustainment training consists of UTC TTP, MISCAP, METLS, and AS review, as well as participation in a sustainment exercise, if available. CASF UTCs will also review AFI 44-165 as part of sustainment training. See para. **5.8.2.** and **5.8.3.** of this AFI for additional guidance | EXCEPTION 1: Members of EMEDS Basic UTCs will either attend the formal EMEDS course or participate in a sustainment exercise every 24 months.<br>EXCEPTION 2: ANG will complete EMEDS training every 60 months.<br>EXCEPTION 3: AFRC EMEDS Basic UTCs will attend formal EMEDS course every 48 months. The cycle between formal course attendance, training will consist of UTC TTP, MISCAP, METLS, and AS review. Members will be current prior to deployment, IAW MEFPAK guidance.<br>Source: MAJCOM medical readiness training POC. |

**CATEGORY III - UNIT TRAINING.** Category III training is accomplished at the unit level and is required for all assigned personnel.

| Training Requirement | Minimum Frequency | Reportable Y/N (see Table 8.1.) | *Reference* | Definition | Remarks/Training Source |
|---|---|---|---|---|---|
| Unit Mission Brief | Initial upon unit assignment | N | DODI 1322.24<br>AFI 41-106 | Detailed explanation of the unit's role during mobilization in support of expeditionary and installation response operations. | **Source**: MRDSS ULTRA can provide the MRL data for the unit. The Capability Overview screen in MRDSS ULTRA provides UTC personnel information, the unit's generation missions, assigned WRM and installation response assets. Other sources of mission information within the MTF and the Wing are also good tools in developing this briefing. |
| USAF Medical Service Mission/ Doctrine Briefing/<br>CONOPS/ TTP | Every 12 months | N | DODI 1322.24<br>AFI 41-106 | Includes AEF CONOPS, Health Service Support for Humanitarian Operations, Contingency Operations, AFMS Wartime and Homeland Defense Doctrine. Levels of care and joint interoperability are also included. | **Sources**: AFDD 204.2; AFPD 10-4;<br>**https://aefcenter.afpc.randolph.af.mil** ; **https://kx.afms.mil/kxweb** |
| MCRP Training | Every 12 months | N | AFI 41-106 | Requirements determined by MCRP annexes and installation plans (i.e., driven by local requirements. | Not applicable to AFRC and AE. **Source**: Unit Medical Readiness Training and Exercise Plan (MRTEP) |

## Attachment 4

## MRT EQUIVALENCY MATRIX[1]

| | AECOT | EMRC | BEMRT | COT | EMEDS | JRTC | C4 | JOMMC | CCATT | FN/AET | CPM | C- STARS | CASF |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CATEGORY I | | | | | | | | | | | | | |
| Medical Effects of NBC Warfare | | X | | X | X | | | | | X | X | X | X |
| Geneva Convention/Law of Armed Conflict | X | | | | | | | | | | | | X |
| Threat & Future | | | | | | | | | | | | | |
| Battlefield Environment | | X | X | X | X | X | X | | | | | | |
| | | | | | | | | | | | | | |
| Depleted Uranium | | X | | | | | | | | | | | |
| CATEGORY II | | | | | | | | | | | | | |
| CBRNE Defense Survival Skills Training | | | | | | | | | | | X | | |
| CATEGORY III | | | | | | | | | | | | | |
| USAF Medical Service Mission and Doctrine Briefing/ CONOPS/TTP | X | X | X | X | X | X | | X | | X | | X | X |
| CATEGORY IV | | | | | | | | | | | | | |
| UTC-Specific Training | X | | | | X | X | | | X | | | | X |
| Deployment Processing | X | | | | | X | | | | | | | X |

**Legend:**

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

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

**BEMRT** (Basic Expeditionary Medical Readiness Training), Brooks City Base, San Antonio, TX

**COT** (Commissioned Officer Training), Maxwell AFB, AL

**EMEDS** (Expeditionary Medical Support), Brooks City Base, San Antonio, TX; Sheppard AFB, TX; Alpena CRTC, MI

**JRTC** (Joint Readiness Training Center), Fort Polk, LA

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

**JOMMC** (Joint Operations Medical Managers Course), Ft Sam Houston, TX

**CCATT** (Critical Care Air Transport Team Course), Brooks City Base, San Antonio, TX

**FN/AET** (Flight Nurse Course/Aeromedical Evacuation Technician Course), Brooks City Base, San Antonio, TX

**CPM** (Contingency Preventive Medicine Course), Brooks City Base, San Antonio, TX

**C-STARS** (Center for Sustainment of Trauma and Readiness Skills), University of Cincinnati, St Louis University, Baltimore Shock Trauma Center

**CASF** Contingency Aeromedical Staging Facility), Sheppard AFB, TX

**Notes:**

1. Blocks marked with an X indicate the requirements that are met by successful completion of the entire course indicated. **Attachment 3** training items that are not listed here are not accomplished as part of the courses listed above.

## Attachment 5

## NATIONAL RESPONSE PLANNING SUMMARY

**A5.1. General.** This attachment provides additional information on the plans and documents associated with the National Response Plan (NRP) and references support in deployed locations. Refer to the documents sited for full explanations. The national plans are as follows:

A5.1.1. **Defense Support to Civil Authority (DSCA).** Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, the President may direct any federal agency to provide support to State and local agencies. AFI 10-802, *Military Support to Civil Authorities*, outlines how the Air Force will provide support under four situations: immediate response, Memorandum of Understanding/Memorandum of Agreement, Presidential Declaration, or 10-Day Rule.

A5.1.1.1. For emergency management operations requiring medical assets to be deployed, installation assets may be tasked under the Immediate Response Authority outlined in DODD 3025.1 or through formal tasking procedures outlined in DOD or Joint Staff guidance.

A5.1.1.2. Local emergency management operations occurring at or near an AF installation will be directed by the installation commander following guidance maintained in the NRP and the installation CEMP 10-2.

A5.1.2. **The National Response Plan (NRP) (N/A for AFRC).** The NRP provides the structure and mechanisms for coordinating federal support to state and local governments. The NRP distinguishes between incidents that require Department of Homeland Security (DHS) coordination, and the majority of incidents occurring each year that are handled by responsible jurisdictions or agencies through other established authorities and existing plans. The NRP outlines a standardized organizational structure for command, control and coordination through the Incident Command System (ICS). In addition, the organization of response capabilities is grouped into Emergency Support Functions (ESFs), which outline the responsibilities of different agencies in providing support during an emergency.

A5.1.2.1. The MR office should be thoroughly familiar with ESF 8 in the NRP, particularly the functions listed for DOD. Medical units should establish mutual aid agreements (MAAs) with area medical facilities, ambulance services, etc., to ensure medical capabilities not organic to the MTF are available outside the installation during duty and non- duty hours. See AFM 10-2502, *USAF Weapons of Mass Destruction (WMD) Threat Planning and Response Handbook,* for additional considerations in developing MAAs.

A5.1.2.2. For ESF 11, the primary agencies are the Departments of Agriculture and the Interior. Under these agencies, the AFMS may be tasked to provide laboratory and diagnostic support.

A5.1.3. **National Incident Management System (NIMS) (N/A for AFRC).** The Department of Homeland Security provides oversight to emergency management through the NIMS. The NIMS provides a consistent nationwide approach to enable Federal, State, Local, and Tribal governments and private- sector and nongovernmental organizations to work together effectively and efficiently to prepare for, prevent, respond to, and recover from domestic incidents, regardless of cause, size, or complexity, including acts of catastrophic terrorism. The NIMS directs the use of a common Incident Command System (ICS), common terminology for ordering and tracking resources, and effective communications among responders, Emergency Operations Centers (EOCs) and with the public. The

ICS is a standardized organizational structure used to command, control, and coordinate the use of resources and personnel that have responded to the scene of an emergency.

A5.1.3.1. Air Force Incident Management System (AFIMS). The AF has tailored the NIMS to fit within the AF structure and meet unique AF requirements with the AF Incident Management System (AFIMS). AF Instruction 10- 2501, *AF Emergency Management Program, Planning and Operations,* implements the AFIMS and aligns AF Emergency Management (EM) planning and response with the NRP.

A5.1.3.1.1. Incident Commander (IC). The IC is a trained and experienced responder who provides on-scene tactical control of an incident using subject matter experts (SMEs) and support from other functionals. Normally ICs are senior fire or police personnel who've completed IC training. Incident management personnel who represent the major functional elements of the ICS comprise the ICS General Staff. These include section chiefs for: Operations, Planning, Logistics, and Finance/Administration.

A5.1.3.1.2. The AFIMS IC, normally the fire chief, will use the AFIMS to conduct emergency management operations. Depending upon the situation, other personnel may function as ICs if they have completed ICS training and meet DOD and Federal certification standards for the specific type of incident. A senior medical person (either the medical unit commander or the Public Health Emergency Officer) could be designated the IC for biological disease outbreaks, such as Severe Acute Respiratory Syndrome or pandemic flu, that occur on the installation. Attachment 2 in AFM 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations* shows the installation OPR for each ESF, identified on the basis of authorities, resources and capabilities.

A5.1.3.1.3. Installation Control Center (ICC). The ICC directs strategic actions supporting the installation's mission. The command post is part of the ICC, which functions as the essential C2 node. The ICC provides a communication link with higher headquarters and with civilian agencies. As the focal point for installation-wide warning, notification and operations, the ICC communicates directions and information, and also recommends courses of action concerning the incident. The ICC advises the Commanders Senior Staff and directs the EOC and UCCs. The Installation Commander serves as the senior leader of the ICC.

A5.1.3.1.3.1. Within the AFIMS construct, the Medical Team, which supports the ICC, includes the full spectrum of health services support provided by the base medical unit, whether in an expeditionary or homestation setting. MCRPs address specific roles, responsibilities, processes and procedures associated with medical response to emergencies and disasters, whether natural or manmade, including conventional attacks and acts of terror. Format, content, development and maintenance of the MCRP are addressed in Attachment2 of this AFI.

A5.1.3.1.3.2. This AFI, as well as AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations* and the AFTTP 3-42 series of publications are the primary references for medical support capability.

A5.1.3.1.4. Emergency Operations Center (EOC). EOCs are the locations from which the coordination of information and resources to support incident activities takes place. At the local level the EOC Director (normally the Mission Support Group Commander) oversees the execution of the 15 ESFs. Each medical unit will provide a representative to the EOC upon

activation. This individual will coordinate and communicate with the medical control center (MCC) and act as a liaison between the MTF and the Mission Support Team, via the EOC.

A5.1.3.1.5. The MCC supports the EOC representative by maintaining communications, receiving and executing taskings, monitoring medical response operations, relaying information, providing personnel, casualty, capability, and resource data as necessary, and accomplishing required reports.

A5.1.3.2. The AFIMS tasks each AF installation to develop a CEMP 10-2.

**A5.2. Host Nation Requirements (N/A for AFRC).** For installations outside the United States, support during emergency operations is provided through established host nation support agreements; by direction of the Combatant Command; or upon direction of the installation commander to save lives, prevent human suffering, or mitigate great property damage. Requests for US military support of humanitarian assistance and disaster response outside the United States are typically submitted by the host nation through the Department of State (DoS). DoS and/or DOD teams work cooperatively with the host nation to identify temporary military- specific support capabilities and resources necessary to minimize human suffering. The provision of direct medical services to host nation members will be focused on short-term objectives, transitioning to non-governmental or international organizations as soon as practical.

**A5.3. In-Garrison Expeditionary Site Plan (IGESP) and Expeditionary Site Plans (ESP).** The expeditionary nature of Air Force operations requires extensive planning to ensure proper deployment, beddown and operation of Forward Operating Locations. The Air Force process for IGESP and ESP is outlined in AFI 10-404, *Base Support and Expeditionary Site Planning*.

A5.3.1. **IGESP.** The IGESP is primarily developed for locations with a permanent Air Force presence, and is fully developed by the collaborative planning efforts of many functional experts with a deliberate planning time line. IGESPs were formerly known as Base Support Plans (BSPs).

A5.3.2. **ESP.** ESPs are primarily associated with locations without a permanent Air Force presence and may contain only the minimum data necessary to make initial beddown decisions. ESPs may be developed in short time frames to meet contingency needs without full staffing or coordination.

## Attachment 6

## READINESS EXERCISE REQUIREMENTS

| EXERCISE | FREQUENCY | REFERENCE | REMARKS |
|---|---|---|---|
| Medical Continuity of Operations (MCOOP) | TTX annually, with actual relocation of the command and control function every other year. | AFI 41-106 | Not applicable to ARC |
| Recall<br>- MCRP Teams<br>- UTCs<br>- Deployment support teams<br>- Entire unit | Quarterly, exercising each category once a year, and IAW Wing Exercise Schedule. | AFI 41-106 | Exercise and repeat until success levels identified in unit MCRP are attained. |
| Major Accidents<br>- Munitions<br>- Nuclear weapons<br>- Off- base response<br>- Air Show response<br>- HAZMAT Team<br>- Mass Casualty<br>- Radioactive Material | Annually for each category applicable to medical unit, except Air Show. An air show exercise must be conducted only before an air show by units that host one. | AFI 10-2501<br>Table 7.1 | For ARC Units: IAW Base/Wing exercise schedule and/or Commander's discretion. ARC response is based on the BSP/EMP as appropriate. |
| Terrorist Use of CBRN | Two annually, one of which must be a biological incident | AFI 10-2501,<br>Table 7.1 | Execute cross- functionally according to the local CBRN threat: incorporate all local response elements. Must include at least 50 CBRN casualties in one exercise, 25 of which should be moulaged. N/A for AFRC |
| Natural Disasters | Annually | AFI 10-229,<br>AFI 10- 2501 | Scenario should be typical to unit's geographical area. Must include NDMS FCC capability if applicable. |
| Operational Readiness Exercise (ORE) | Dependent on CBRN threat level or ORI preparation | AFI 10-2501<br>Table 7.1 | Schedule established by Wing Commander. |
| Deployment Exercise | At least one per AEF cycle | AFI 10-403<br>Para 1.5.1.3 | Exercise entire range of deployment responsibilities |
| National Disaster Medical System (NDMS) | Annually | DODD 6010.22 | Applies to facilities with an NDMS role. |
| Public Health and Disease Outbreak Exercise | Annually | AFI 10-2603<br>A4.4.<br><br>AFI 10-2604<br>Para 1.2.3.2 | Exercise using realistic outbreak scenarios appropriate to the installation's mission and vulnerabilities. The intent of the exercise is to validate the disease containment planning guidance. |

## Attachment 7

## FIELD TRAINING REQUIREMENTS FOR UTC FORMAL COURSES

**A7.1. Field Training.** Personnel assigned to deployable UTCs that have corresponding formal UTC courses will complete field training as part of that training. As a minimum, UTC formal courses will include the following:

A7.1.1. **Shelter Assembly.** Safe, ergonomic approach to shelter assembly training will be consistent with those shelters appropriate to that unit's mission.

A7.1.2. **Field Sanitation and Hygiene, Disease Prevention.** This training will consist of personal hygiene, food and water handling, waste disposal (human and medical), and other medical responsibilities. Operational measures for countering endemic disease, prevention of non- battle injuries, mental health, countering disease vectors in field and urban environments, environmental health threats, and force health surveillance will be covered.

A7.1.3. **Low-Light and Black-Out Operations.** Conduct medical operations during non- daylight hours with casualty reception and treatment at night as the primary focus.

A7.1.4. **Site Security.** This training will include principles and techniques for deployed medical facility security. Include an overview of applicable LOAC policies, force protection measures, and emergency communications procedures.

A7.1.5. **Fire Fighting.** Review fire fighting techniques as applicable to deployed medical facilities and structures. Include a review of patient evacuation procedures in the event of a fire or explosion at a deployed medical facility.

A7.1.6. **Casualty Movement.** Focus on techniques and procedures used to move casualties from one point to another, including basic litter carries, casualty loading, and casualty evacuation as appropriate to unit mission. During litter training, cover the basics of good body mechanics and proper commands, placing a patient onto the litter, using an overweight litter, proper strapping, 2-person and 4-person lifts/carries, 2 to 4/4 to 2 person switches, overhead lifts and use of vehicles of opportunity for litter loading/unloading.

A7.1.7. **Operational Command, Control and Communications.** This training will cover those activities that use information and business management systems to facilitate day-to-day operations in support of operational missions, including the use of radio communications, Information Management/Information Technology (IM/IT). Review AFTTP 3-42.1, *Health Service Support Command and Control in Deployed Operations*, and AFM 10-100, *The Airman's Manual.*

A7.1.8. **Wound & Casualty Management.** This training will include clinical aspects of medical management of casualties and disease non- battle injuries, particularly triage and initial evaluation; use of auto injectors; gunshot wounds; vascular, neurological, orthopedic, maxillofacial, and hypo/hyper thermal stress injuries; burns, bandaging, and splinting; hypovolemic shock; eye injuries; and use of blood products.

A7.1.9. **Combat Stress Control (CSC).** This training will focus on familiarization with basic principles of CSC management, as well as leadership, communication with troops, unit morale and cohesion and individual psychosocial stressors, before, during and after deployment.

**A7.2. Deviations.** Deviations from these requirements must be approved by the RTOC.