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Tactical Doctrine

AEROMEDICAL EVACUATION
LIAISON TEAM (FFQLL)

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The Air Force Tactics, Techniques and Procedures (AFTTP) 3-42 series of publications is the primary reference for medical combat support capabilities. This document builds upon AFTTP 3-42.5, *Aeromedical Evacuation*, by providing Tactics, Techniques and Procedures (TTP) for the Aeromedical Evacuation Liaison Team (AELT) identified by the Unit Type Code (UTC) FFQLL. This publication applies to all civilian employees and uniformed members of the Regular Air Force, Air Force Reserve, and Air National Guard. The doctrine in this document is authoritative but not directive. Ensure all records generated as a result of processes prescribed in this publication are maintained in accordance with Air Force Instruction (AFI) 33-322, *Records Management and Information Governance Program*, and are disposed in accordance with the Air Force Records Disposition Schedule, which is located in the Air Force Records Information Management System. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the Air Force (AF) Form 847, *Recommendation for Change of Publication*; route AF Forms 847 from the field through the appropriate functional chain of command. The authorities to collect or maintain the records prescribed in the publication are 10 USC § 9013, *Secretary of the Air Force*; Executive Order 9397 (SSN)*,* as amended; and AFI 36-2101, *Classifying Military Personnel (Officer and Enlisted)*. The applicable system of records notice (SORN), F036 AF PC C, *Military Personnel Records System*, is available at: **https://dpcld.defense.gov/privacy/SORNS.aspx**.

Chapter 1

OVERVIEW

1.1. Purpose. This AFTTP describes AELT (UTC: FFQLL) capabilities and its deployment, employment, and redeployment in support of Aerospace Expeditionary Forces, Humanitarian Assistance/Disaster Response (HA/DR), Defense Support of Civil Authorities (DSCA), and other Aeromedical Evacuation (AE) scenarios across the spectrum of military operations.

1.1.1. This document: (a) identifies and defines responsibilities; (b) describes command relationships; (c) reviews general planning considerations; (d) ensures tasks, functions and responsibilities are properly assigned; (e) describes allowance standards, equipment, and resources available to support global AE operations; (f) provides a source document for developing standard operating instructions, and training programs; and (g) recommends baseline training requirements and available AELT training platforms and programs.

1.1.2. Information in this AFTTP should be tailored and augmented with additional information found in related AE instructions, publications, AFTTPs, Technical Orders (TOs), Operation Plans, Special Instructions, Flight Crew Information Files, and other theater directives and instructions.

1.2. Caution. This document should not be used as permission to move patients (reference AFI 48-107V1, *En Route Care and Aeromedical Evacuation Medical Operations*). Patient eligibility for aeromedical transportation is in accordance with Department of Defense Instruction (DODI) 4515.13, *Air Transportation Eligibility* (additionally reference AFI 24-602V1, *Passenger Movement*, Air Force Policy Directive [AFPD] 24-6, *Distribution and Traffic Management*, and any current, operational Department of Defense [DOD], AF, or theater-specific directives).

1.3. Mission/Capabilities. The United States Air Force AE system provides fixed-wing movement of patients requiring in-flight care and supervision by AE crew members to locations offering appropriate roles of medical care. It is comprised of Regular Air Force (RegAF), Air Force Reserve (AFR), and Air National Guard (ANG) personnel. The AE system is designed to be flexible, enabling it to operate as far forward as aircraft are able, to conduct air operations across the full range of military operations and in all operating environments.

1.4. Roles and Responsibilities.

1.4.1. Air Mobility Command (AMC) is designated lead command for AE according to AFPD 10-9, *Lead Command Designation and Responsibilities for Weapon Systems*, AFPD 11-2, *Aircrew Operations*, and AFPD 10-21, *Rapid Global Mobility*. The lead command is responsible for establishing and standardizing AFTTP doctrine in coordination with user commands.

1.4.2. AMC Directorate of Operations, Strategic Deterrence, and Nuclear Integration (AMC/A3/10) is responsible for policy guidance and coordination with user commands related to AFTTPs.

1.4.3. AMC Surgeon General (AMC/SG). Maintains oversight of all clinical training to ensure medical clinical operations.

1.4.4. AELT (UTC FFQLL):

1.4.4.1. Constitutes a critical component of the Theater Aeromedical Evacuation System (TAES) which directly supports the En Route Casualty Care System. The desired operational effect of a properly employed AELT is to enable a TAES that fully supports the component or user service's AE requirements within required patient movement and/or operational timeframes.

1.4.4.2. Provides direct coordination between the user service generating casualties and the TAES. The AELT also verifies and coordinates physiology of flight issues and patient movement requirements.

1.4.4.3. Can deploy within 24 hours (AFR and ANG UTCs deploy within 72 hours) and be operational within 4 hours of equipment and personnel arrival. When tasked, the AELT should deploy with the AE Liaison Team Equipment Package, (UTC FFQL1) which includes organic communication systems, billeting equipment, and sufficient supplies to operate for 30 days without re-supply. This package is normally stored as War Reserve Materiel. Medical and AE Planners should deploy the FFQL1 UTC with the FFQLL UTC, evaluate the communication capability at the deployed location, and deploy the AE Communications Team (UTC FFQCR) when necessary.

1.4.4.4. May be located at any level where Air Force fixed-wing patient movement requests are initiated. May require DOD or host nation base support (see **Chapter 3** and **Chapter 6** for support requirements).

1.4.4.5. Can be configured to support diverse circumstances or requirements through paring and tailoring of personnel and/or equipment as required and authorized. The AELT may also be augmented with additional AELT manpower and/or equipment packages as required to support surge or 24-hour sustained operations. During initial phases of an operation, the AELT should deploy with AE Communications Team (UTC FFQCR).

1.4.4.6. Provides direct communication links and immediate coordination between the TAES and user services at any care echelon (e.g., Role 1-Role 4, Military Treatment Facility [MTF], patient staging entity, En Route Patient Staging System [ERPSS], HA/DR, or DSCA entity). The AELT is an AE support UTC which does not provide direct patient care, but should be ready to triage as needed to meet mission requirements.

1.4.4.7. Identifies, plans, and coordinates patient care needs in the aerospace environment to include the movement of medical equipment to ensure successful entry and movement within the TAES. Additionally, AELTs will facilitate requests to obtain authorizations and/or necessary waivers when there are deviations from approved inflight medical equipment and established patient movement procedures. (**Note**: AELTs must be prepared to coordinate the movement of seriously injured patients in a degraded, contested, or Command and Control (C2) outage environment. AELTs will use their best clinical and operational judgment to preserve life, minimize human suffering, and avoid strategic obstacles to the ground commander's mission objectives).

1.4.4.8. Manages operational and patient information (e.g., classified and unclassified information systems, patient privacy and confidential information).

1.4.4.9. Trains user services or entities on AE operations and processes to properly access the TAES to move their patients to appropriate levels of care.

1.4.4.10. Is highly variable and adaptive when it comes to command dependencies and required interactions to complete its mission. Refer to AFI 48-307V1, *En Route Care and Aeromedical Evacuation Medical Operations,* for a comprehensive overview of AE UTCs, both their structures and their roles, within the TAES and En Route Casualty Care System.

1.5. Risk. The AELT can deploy to forward combat locations in support of user service medical operations. AELTs will be at risk of personal injury due to direct fire, indirect fire, and fog of war accidents.

1.5.1. The mission responsibilities of the AELT may expose the team to additional threats to include non-battle injury (flight line injuries, endemic disease, climate, terrain and socio-economic conditions), conventional and unconventional weapons, weapons of mass destruction, chemical and biological agents, assault by hostile forces, and assault by potentially violent patients.

1.5.2. The AELT package offers no protection from conventional (kinetic), biological, chemical, or nuclear weapons and requires protective shelters from Expeditionary Combat Support sources (reference Joint Publication (JP) 3-11, *Operations in Chemical, Biological, Radiological, and Nuclear Environments*).

1.5.3. Historically, some AELTs have been placed close to, or within, hostile areas. Personnel should be fully versed in the Law of War, Conduct After Capture, theater specific rules of engagement, and may require pre-deployment combat skills and weapons proficiency training (reference deployment-specific line remarks).

1.6. Composition. The AELT is composed of two positions, a Flight Nurse (FN) and a Medical Service Corps (MSC) officer. Grade and skill level requirements may be found in the mission capabilities statement (MISCAP) on the Manpower and Equipment Force Packaging (MEFPAK) website at **https://usaf.dps.mil/teams/12956/default.aspx**.

1.6.1. Flight Nurse. The FN on the team primarily assists the medical unit in preparing AE patients for flight. The FN provides clinical and aeromedical expertise to ensure that each patient's administrative, aircraft-specific, and equipment requirements are met. The FN strives to anticipate a patient's clinical needs related to cabin altitude pressure and the stresses of flight. Additionally, the FN should be familiar with Air Mobility Operations and Aeromedical Evacuation Control Team (AECT) Operations in their respective areas of responsibility (AORs). The FN should be proficient in United States Transportation Command (TRANSCOM) Regulating and Command & Control Expeditionary System (TRAC2ES), Global Decision Support System, and Single Mobility System.

1.6.2. Medical Service Corps Officer. The MSC officer coordinates with the patient movement requesting elements (e.g., MTF, patient staging entity, ERPSS, HA/DR, or DSCA entity), other AE components (e.g., AECT, Patient Movement Requirements Center [PMRC], AE Operations Team), airlift center, aerial port element, and other patient coordinating functions as applicable. The MSC officer should also be familiar with communications equipment and etiquette to assist AE Communications Team personnel (FFQCR) if needed. The MSC should be proficient in TRAC2ES, Global Decision Support System, and Single Mobility System.

1.7. Team Member Selection.

1.7.1. Home station squadron commanders are responsible for the selection of team members assigned to the AELT in accordance with AFI 10-2912, *Aeromedical Evacuation Readiness Programs*. When filling FFQLL deployment positions, Commanders should fully consider a member's AE knowledge and experience, deployment history, leadership capabilities, and capacity to function independently with minimal Air Force supervision in potentially austere or minimally-secured environments. Members should possess or obtain training and personal equipment in accordance with current guidelines, reporting instructions and line remarks. **Note**: Grade and skill level substitutions should be in accordance with AFI 10-401, *Air Force Operations Planning and Execution*, AFI 10-403, *Deployment Planning and Execution*, United States Air Force War Mobilization Plan-1 Functional Annexes, Supported Command processing guidance, line-remarks, reporting instructions, and other functional AFIs.

1.7.2. The senior officer, regardless of Air Force Specialty Code, should serve as Team Chief and provide overall leadership to the team and any supplemental UTCs. The Team Chief should ensure team needs are addressed and should keep all supported Commanders informed regarding personnel and team assets through required situation reports. Successful team members must possess the ability to rapidly adapt to changing operational requirements.

Chapter 2

COMMAND AND CONTROL

2.1. General. Command and Control (C2) functions exercised over AE missions are consistent with those for all air mobility missions and are conducted in accordance with the C2 processes as described in JP 3-17, *Air Mobility Operations*, Air Force Doctrine Annex 3-30, *Command and Control*, Air Force Doctrine Annex 3-0, *Operations and Planning*, and Air Force Doctrine Annex 3-17, *Air Mobility Operations,* which includes specific sections on AE doctrine. In contingency operations, AE-specific items should be outlined in the military order (execute order, deployment order, operation order) and may include references such as Annex C, Appendix 30, and Annex Q from supporting deliberate planning products (Base Plan, Concept Plan, Operation Plan). AE assets are integrated within the inherent mobility structure established to support airlift operations through the Air Mobility Division to the wing and down to the assigned expeditionary AE squadron/flight.

2.2. Command and Control. When AELTs are deployed for contingency AE operations in support of a Geographic Combatant Commander, they should fall under the Operational Control or Tactical Control of the theater Commander, Air Force Forces/Joint Force Air Component Commander and should operate under the guidance of the theater Component-Numbered Air Force, Air Force Forces staff and Air and Space Operations Center (AOC). When deployed in support of Headquarters Air Mobility Command (HQ AMC) AE operations, the AELT should fall under the Operational Control or Tactical Control of the Air Forces Transportation Commander, and should operate under the guidance of the 618 AOC. For command authorities and Administrative Control/Operational Control/Tactical Control refer to Air Mobility Command Instruction (AMCI) 10-2102V1, *Presentation of Air Mobility Forces*.

2.3. Change of Operational Control. HQ AMC-managed theater airlift assets routinely perform Change of Operational Control to the appropriate Joint Force Air Component Commander/Air Force Component Commander as directed by the National Command Authority during peacetime and contingencies. United States Air Forces in Europe & Air Forces Africa and United States Indo-Pacific Command theater airlift assets will perform Change of Operational Control as directed by the National Command Authority. Airlift elements transiting another unified command's AOR will be monitored by the appropriate AOC. Transiting forces will not normally perform Change of Operational Control to the theater commander, unless directed.

2.4. Command Structure. In a contingency setting, AE assets fall under the Expeditionary Operations Group. The AELT Team Chief is the senior MSC Officer or Flight Nurse (or as designated by the Expeditionary AE Squadron Commander or Expeditionary Operations Group Commander of the parent wing). The AELT is typically under the authority of an AE Command Squadron (AECS, UTC FFQCC) when tasked; however, if there is no associated AECS, the AELT would then normally report to the AE Operations Team Officer in Charge.

Chapter 3

OPERATIONS

3.1. Introduction. The AELT directly supports execution of the AE mission and constitutes a critical component of the TAES. When mission requirements exceed the basic capabilities of the FFQLL UTC, it may be supported by additional UTCs.

3.2. Pre-deployment. Equipment packages have been centralized for storage and management and it is unlikely AELT personnel will have the opportunity to assist in preparation of the package prior to deployment. The AELT should ensure they are familiar with the operation order for the deployment location and any applicable Major Command waiver guidance. In order to support initial operating capabilities during the opening phases of an operation, AELTs, their equipment, and any support packages should be marshaled together at specific Continental United States or Outside the Continental United States locations.

3.3. Deployment.

3.3.1. The AELT may deploy to a bare base, advanced operations base, forward operating base, main operations base, onboard a ship, or any location or level where patient movement requests (PMRs) are initiated.

3.3.2. RegAF AELTs can rapidly deploy within 24 hours of notification, and AFR and ANG AELTs can deploy within 72 hours.

3.3.3. AELTs deploying as part of a base opening package must ensure clear communication with the Advance Echelon team so as to have a clear understanding of limiting factors within the employment location.

3.3.4. The AELT is considered a combat support function similar to user service medical components. Delivery methods used by user services for positioning combat support elements vary.

3.3.4.1. Combat support elements may be inserted via airland delivery when the airfield is considered secure enough for placing these elements. They may also follow combat forces via ground convoy according to the combatant commander's plan.

3.3.4.2. Insertion method determination is a Major Command or Component-Numbered Air Force AE planner responsibility in accordance with Joint Force Surgeon and TAES support requirements, FFQLL AFTTP, AE instructions, and doctrine. **Note**: Depending on the theater, the Component-Numbered Air Force AE Planner may be assigned to the Air Force Forces staff or the AOC/AECT.

3.3.5. The AELT deploys with sufficient supplies and equipment to operate for 30 days without re-supply.

3.3.6. The AELT requires Expeditionary Combat Support and DOD or Host Nation base support for services to include food, medical, security, logistics, Medical Equipment Repair Center, Bio-Environmental Engineering, Petroleum, Oils, and Lubricants, and Civil Engineering.

3.3.7. Site Selection.

3.3.7.1. Proper site selection should be accomplished as soon as possible after arrival at the operating location. In forward combat areas, the AELT should be located within the MTF that is designated as the first treatment stop for casualties. It is not necessary for AELTs to be located at fixed-wing airfields to be effective aeromedical liaisons. AELTs operating in rear combat support areas should be in close proximity to MTFs and patient staging areas (e.g., ERPSS). Additionally, during times of extremely high casualty flow, AELTs may deploy to Role 4 facilities to manage patient movement through the TAES.

3.3.7.2. Prior to beginning the site survey and selection process, the team should first coordinate with airfield management authorities and base operating support. AELT personnel should assess the terrain and physical surroundings to avoid setting up operations on an unsuitable site. Other site selection considerations include proximity to base support functions and security. While the FFQL1 equipment package includes a tent that is suitable for both sleeping and working, the team can utilize billeting and work space with the host command if it is available and advantageous to team operations.

3.3.8. Integrating Operations.

3.3.8.1. Integration of deployed AELTs within service operational elements (from small mobile surgical teams to Role 4 facilities) is critical for successful AE operations. To provide AE support to a user service, the AELT should be positioned to operate at a location where it will be able to feasibly support AE of user service and coalition forces. Being available when/where needed is critical to effective AE support.

3.3.8.2. To provide AE support to a user service, the AELT should be positioned with user service medical components. An AELT can also integrate with the Contingency Response Element or other airlift operations elements in order to best provide fixed-wing AE support of conventional and unconventional medical elements of the US military forces, coalition forces, or civilian elements. An AELT can be configured to support diverse circumstances and AE requirements across the spectrum of operations.

3.3.9. Initial Communications.

3.3.9.1. TAES communication links. Immediately upon arrival at the AELT's assigned duty location, the team should contact the AECS, AECT, and servicing PMRC to apprise them of their current status. The Iridium satellite phone, included in the FFQL1 package, is the quickest and easiest communication method to establish initial contact.

3.3.9.2. User Service Liaison. Immediately after arrival at a deployed location, AELT personnel should brief user service line and medical commanders, Contingency Response Element, Combat Control Team, and/or other airfield managers on TAES Concepts, the AELT's role in the TAES, and its base operating support requirements (e.g., food, medical, water, Petroleum, Oils, and Lubricants, logistics, Medical Equipment Repair Center, Bio-Environmental Engineering, Civil Engineering, Expeditionary Combat Support, air base security).

3.3.10. Security and Defense.

3.3.10.1. The AELT should be integrated into the host base to the maximum extent possible. Members should be responsible for ensuring personnel, equipment, weapons

and ammunition accountability as well as establishing and following workplace defense plans and emergency evacuation procedures.

3.3.10.2. Team members may be required to prepare defensive fighting positions and camouflage or harden AELT facilities. Personnel should be familiar with local policies for weapons use and storage, theater Rules of Engagement, and Special Instructions. AELT personnel can find numerous, useful resources, including AFTTP 3-4, *Airman's Manual*.

3.3.11. Establishing Operational Capabilities.

3.3.11.1. The AELT's initial operational capability to support an urgent patient movement can be achieved as soon as communications are established or within four hours of arrival at its assigned location.

3.3.11.2. The AELT meets initial operational capability requirements when it is able to provide knowledgeable, on-site, user service assistance and has established effective local patient movement communication links with AE components such as the AECT, PMRC, 618 AOC Tanker/Airlift Control Center (TACC), AECS, and other patient coordinating components as applicable.

3.3.11.3. Use of an events log, establishment of Sequence of Events, and launch and recovery checklists can be beneficial to success (example launch and recovery checklists may be found in the FFQNT area on the MEFPAK website at **https://usaf.dps.mil/teams/12956/default.aspx**).

3.4. Mission Operations. The AELT is employed according to Joint Force Surgeon requirements in support of the Operation Plan implemented by a Geographic Combatant Commander or other authorized command authority. The AELT can be located at any level where PMRs are initiated. The AELT works with the user MTF when no other AE components (e.g., ERPSS) are present. The AELT provides no patient care and has no inherent staging capabilities. The user MTF is responsible for AE patient staging and on-load activities.

3.4.1. Patient Movement Request (PMR). Identifying a patient movement requirement to the PMRC is the responsibility of the component service.

3.4.1.1. Ideally, PMR information is transmitted to the PMRC via TRAC2ES. However, TRAC2ES may not be available due to lack of Non-classified Internet Protocol Router Network during the initial stages of some operations. In this case, follow local directives and procedures for patient movement message traffic.

3.4.1.2. Initial operations PMR transmission. In these situations PMR (format provided by the PMRC) is transmitted via Very High Frequency, and Satellite Communication radio assets as a means of providing communications to the PMRC. The AELT may receive mission information from AECT or PMRC for relay to the MTF.

3.4.2. Patient Validation/Manifestation Process. Before air mobility assets are dedicated to an AE mission, the patient movement requirement should be validated by the PMRC. Refer to AFI 48-307V1 for a detailed explanation of the patient validation for flight process.

3.4.2.1. The Theater Validating Flight Surgeon oversees a review of the clinical information in the PMR to ensure the need for movement and to verify the patient's ability to endure transport. The PMRC also determines the movement method and the

timeframe required to transport the patient to care. Once these factors have been confirmed, the patient is classified as "validated." At this point, the validated requirement is communicated to the servicing AOC/AECT for coordination of intra-theater lift or the 618 AOC (TACC), for coordination of inter-theater airlift and AE crew and/or specialized team tasking according to the clinical requirements dictated by the PMRC. When an AE mission has been tasked by the AECT or 618 AOC (TACC), the PMRC manifests patients and patient attendants on the mission according to mission number.

3.4.2.2. Supporting Patient Movement. When an ERPSS is not present to support patient movement between the MTF and servicing airfield, the AELT should ensure a safe and successful patient transition. Patients assigned to an AE mission should be prepared for movement, to include litters, equipment, meals and medications, in accordance with AFI 48-307V1 and Air Force Instruction (AFI) 11-2AEV3, *Aeromedical Evacuation (AE) Operations Procedures*. Patients should be transported to the airfield in the safest manner available, preferably by ambulance. A clinician should accompany patients until handoff to the AE crew. A designated clinician should provide a clinical report on each patient to the AE crew before relinquishing responsibility of the patient(s). The originating medical facility should also provide the AE crew with proper patient records and any other pertinent clinical documentation. If mission details such as patient load, flight path, or times have changed since the mission began, provide updated mission paperwork to the AE crew. Transport should be timed to minimize the time patients spend between the MTF and AE aircraft.

3.4.2.3. Reference AFI 48-307V1 and AFI 48-307V3, *En Route Care Documentation*, for important patient preparation and documentation information.

3.4.2.4. AELTs should be aware of small mobile surgical teams operating in their AOR that may need their support. United States Air Force Ground Surgical Teams consist of only six personnel and U.S. Army Forward Surgical Teams have reduced configurations of ten personnel. These small mobile teams will rely heavily on rapid AE to remain mission capable.

3.4.3. Training Medical Elements. Training user services on AE operations is a significant portion of the AELT mission. As the on-site AE experts, AELT personnel should fully engage with the MTF's command, clinical, and operations staff in order to ensure a strong working knowledge of AE requirements.

3.4.3.1. The AELT is responsible for supporting the component service patient evacuation requirements even if the medical capability is not located near the airfield. In this case, the AELT should advise the user service on the safest and most appropriate mode of transportation based on patient criteria. The component service's need for collocated Air Force AELT consultation and support services is critical to executing an effective fixed-wing AE system.

3.4.3.2. Component services must organize, train and equip themselves to submit and transmit patient movement requirements to the PMRC, and to transport validated patients to the aircraft on the Commander, Air Force Forces certified airfield. The AELT should provide assistance with access to TRAC2ES and other mission-related information systems in addition to delivering training on operating these systems. When possible, the

AELT should work with the MTF and Patient Movement Clinical Coordinator to develop continuity documentation such as operating instructions or standard operating procedures related to patient movement in the AE system.

3.4.3.3. The Patient Movement Clinical Coordinator should specifically work with the medical, nursing and ancillary support staff regarding patient preparation for AE such as documentation, patient safety, equipment, medications, flight physiology, and physician's orders.

3.4.3.4. The AE Operations Officer should work with the Patient Administration Director or Medical Regulating Officer to ensure proper patient documentation, patient movement records, litter carrying, patient transport, aircraft loading and other logistical support.

3.4.3.5. A primary goal of the AELT personnel is to ensure the user service MTF can effectively accomplish all the above tasks independently and hand-off medically and administratively prepared patients to the AE crew at the aircraft (e.g., sufficient meals, medicines, proper paperwork, and anti-hijacking in accordance with AFI 13-207-O, *Preventing and Resisting Aircraft Piracy (Hijacking)*, AFI 48-307V1 and Federal Aviation Administration (FAA) directives). Other patient preparation and anti-hijacking resources include AFTTP 3-42.57, *En Route Patient Staging System.*

3.5. DSCA or HA/DR Operations. The AELT may be tasked to support a DSCA or HA/DR event. The fundamental AELT task, to support the organization(s) requesting evacuation assistance, remains the same. However, additional coordination and support may be required. The servicing PMRC enforces the evacuation policy dictated by the Unified Command Surgeon. Operation-specific patient movement policies and requirements, such as civilian patient documentation, will be provided through the PMRC and AECS. AELT personnel should be aware of any socio-political factors that have an effect on patient movement operations. Familiarization with all civilian and/or coalition agencies involved in the operations is highly recommended to providing appropriate support. Patient movement support may involve personnel and assets from US or international military forces, government, or non-governmental organizations. **Note:** This section applies only to Title 10 forces, and not to DSCA operations for ANG members in a Title 32 or State Active Duty status.

3.6. AE Operations in Chemical, Biological, Radiological, and Nuclear (CBRN) Environments. Refer to AFI 11-2AEV3 for current AE instructions related to the transportation of patients, personnel, or casualties with known or suspected contamination from chemical, biological, or nuclear warfare agents. Other useful guidance regarding movement of contaminated and/or contagious casualties include JP 3-11 and Army Techniques Publication (ATP) 4-02.7, *Multi-Service Tactics, Techniques and Procedures for Health Support in a Chemical Biological, Radiological, and Nuclear Environment*.

3.7. Redeployment.

3.7.1. Once the user service medical facility is able to communicate with the PMRC and regulate its patients for AE, the AELT should be redeployed within the AOR to provide continued support of AE operations, or back to home station for reconstitution. The AELT should coordinate all preparation and movement with the AECT.

3.7.2. During redeployment, equipment should be inventoried, cleaned, repackaged and prepared for Joint Inspection processing and transportation by UTC personnel. If there is CBRN contamination, prior to striking, the equipment should be certified decontaminated from nuclear, biological, and chemical hazards by the designated agencies responsible for this activity at the deployed location. For completion of the Joint Inspection process, at least one AELT member should be Hazardous Material Certified to complete and sign the Shippers Declaration of Dangerous Goods Forms and should be trained and certified in pallet building procedures in accordance with, Defense Transportation Regulation (DTR) 4500.9-R-**Part II**, *Cargo Movement*, May 2014, to help direct the palletizing and shipping of AELT equipment. Refer to AELT Mission Essential Task Lists for Joint Inspection process requirements found on the MEFPAK website at ht**https://usaf.dps.mil/teams/12956/default.aspx**.

3.7.3. If AELT personnel are redeploying and the equipment is remaining, it should be inventoried and turned over to oncoming personnel in good condition.

Chapter 4

PLANNING AND SUPPORT CONSIDERATIONS

4.1. Introduction. Medical and AE planners should consider many factors when projecting AELT employment. The unique capability of each medical unit and airfield should be considered. The AE planner should include the AELT as part of the AE support requirements to the combatant commander.

4.2. Theater Patient Movement Policy. The theater patient movement policy is executed by the Geographic Combatant Commander. The theater PM policy delineates the maximum number of days that patients may be held within the command for treatment prior to further movement or return to duty. Patients who cannot return to duty within the specified number of days are evacuated to the next higher level of care for further treatment. Shorter movement policies within the theater reduce theater bed requirements and increase the number of beds required elsewhere. Shorter movement policies also increase movement requirements. The theater PM policy is flexible and can change as the tactical situation dictates. (JP 4-02, *Joint Health Services*)

4.3. AELT Associated UTCs. Air Force War planners use UTCs to document total manpower and logistics capabilities needed to support the national military strategy during operational planning and execution activities (AFI 10-403). Each UTC has a MISCAP which simply states the capabilities of each UTC. Air Mobility Command Surgeon General (HQ AMC/SG) is the MEFPAK responsible agency for AE UTCs and is responsible for constructing and monitoring AE MISCAPs (OPR HQ AMC/SGXM). For the most up-to-date information on UTC capabilities and requirements, please refer to the MEFPAK website at **https://usaf.dps.mil/teams/12956/default.aspx**.

4.3.1. UTC FFQL1 – Medical Liaison Team Equipment Package. The AELT deploys with the FFQL1 UTC. The following requirements are in accordance with the current MISCAP.

4.3.1.1. FFQL1 should be stored as War Reserve Materiel containing sufficient supplies and equipment to operate 30 days without re-supply.

4.3.1.2. FFQL1 should deploy as a rolling stock package; therefore, one UTC UFMVE, High Mobility Multipurpose Wheeled Vehicle (HMMWV), should also be tasked.

4.3.1.3. FFQL1 can pack out on one HMMWV or one aircraft pallet and includes organic supplies, communications equipment (with man-portable mode capability), billeting, and power equipment (example pack-out guides with photographs may be found on the AE MEFPAK website under UTC FFQL1 Allowance Standard).

4.3.1.4. FFQL1 takes up 700 square feet of operating space and 100 square feet for antenna. 100 square feet operating space should be requested for man-portable teams.

4.3.1.5. Allowance Standards. The most up-to-date Allowance Standards information is available on the Air Force Medical Logistics web page: **https://medlog.us.af.mil/** (account necessary). Copies may also be found on the MEFPAK website at **https://usaf.dps.mil/teams/12956/default.aspx**.

4.3.1.6. References.   Important publications for management, resupply, and redeployment of FFQL1 equipment include: AFTTP 3-42.8, *Expeditionary Medical Logistics (EML) System*; Air Force Manual (AFMAN) 41-209, *Medical Logistics Support*; AFI 24-301, *Ground Transportation*; and AFI 24-302, *Vehicle Management*.

4.3.1.7. Resupply. AELT resupply requirements not included in the FFQL1 allowance standard, which cannot be provided by base operating support, should be requested through the AECT.

4.3.2. UTC FFQCR – Communication Team (personnel only).

4.3.2.1. The AELT deploys with the AE Communications Team (FFQCR) comprised of a Radio Frequency Transmission Systems Craftsman and Radio Frequency Transmission Systems Journeyman (3D173 and 3D153 respectively).

4.3.2.2. FFQCR does not deploy independently. It provides communication capability to any AE UTC when mission-needed communications are unavailable.

4.3.2.3. FFQCR has no associated communications equipment since it is organic to the AE medical equipment UTCs (including the UTC FFQL1).

4.3.2.4. FFQCR should hand carry when deployed, 90 days' worth of communications security (COMSEC) material. Refer to the FFQCR MISCAP on the MEFPAK website for specific requirements at **https://usaf.dps.mil/teams/12956/default.aspx**.

4.4. Physical Location. Base, wing, group, or user service commanders should ensure appropriate real estate is available for the AELT to operate. However, AELT personnel should fully engage appropriate leaders to inform and advocate for AELT requirements.

4.5. Expeditionary Combat Support. Air Force base civil engineers (or user service equivalent) should be responsible for major maintenance of non-medical equipment (e.g., generators, heaters, air conditioning). Other support services such as billeting, food service, sewage and waste disposal, potable water, power, transportation, POL, and vehicle maintenance should be coordinated and provided by the user service to support AELT needs.

4.5.1. Electrical Power. FFQL1 allowance standard includes a diesel generator. If available and arranged, deployed base electrical power systems can provide primary and backup power for AELT facilities and equipment.

4.5.2. Coordinate and plan to provide power for computers, a PRC-117 Radio, a Broadband Global Area Network (BGAN) radio, a Land Mobile Radio base station, and handheld charging station. A PRC-117 Radio will require 2.5 Amps Max, 85-260 voltage (AC) and 47-440 Hz frequency. A BGAN will require 0.5 Amps Max, 100-240 voltage (AC), and 47-63HZ frequency. A Land Mobile Radio charger requires 2 Amps, 100-240 voltage (AC), 50/60 Hz frequency with the base station requiring 7 amps max, 100-240 voltage (AC), and 50/60 Hz frequency.

4.6. Patient Movement Items-Asset Tracking System (PMI-ATS). Refer to AFI 48-307V1, for a thorough review and requirements of the PMI-ATS system. Patient Movement Item (PMI) equipment (e.g., IV pumps, suction pumps, sequential compression devices) should be supplied by the sending MTF. However, if the MTF does not typically use equipment approved for the AE system, the AELT can help coordinate the acquisition of approved equipment or request and obtain a waiver for use of non-approved equipment in accordance with AFI 11-2AEV3 as

required. AFMAN 10-2909, *Aeromedical Evacuation Equipment Standards* and the *HQ AMC Aeromedical Evacuation Medical Equipment Compendium*, are located at the AMC/A3V SharePoint (see **Attachment 2**, "Additional Resources").

4.6.1. The source for PMI durable equipment such as litters, backrests, pads, and litter straps is the theater source of supply. PMI Centers and the PMI Cell, if a Cell is stood up, should recycle litters to the greatest extent possible. Shortfalls of durable items should be ordered from the supply chain. PMI operations are found in AFMAN 41-209, JP 4-02, and Commander, United States Transportation CommandCDRUSTRANSCOM) BPLAN 9008-18.

4.6.2. AE medical equipment in accordance with AFI 41-201, *Managing Clinical Engineering Programs*, should be continuously checked for AE certification standards and affixed with the AF Form 4033, *PMI/AE Certification Label*. Additionally, it should be within the current preventive maintenance and calibration certification standard and should be affixed with DD Form 2163, *Medical Equipment Verification/Certification*, or most current and approved label.

4.7. Threat Environment. The Air Force core mission of Rapid Global Mobility charges UTCs with rapidly deploying to anywhere in the world. Because of the wide variety of possible operating locations and potential adversaries, there exists a broad range of potential threats.

4.7.1. Major threats expected during small scale contingencies include terrorism and Information Warfare. With the high probability of US Forces engaging in some form of small scale contingencies, deployed AELT personnel should plan for force protection against terrorist and Information Warfare type threats.

4.7.2. Diseases, Non-Battle Injuries, & Unique Threats to AELT Personnel. The medical community is exposed to a unique class of threats. Personnel and patients from high threat areas may show signs of exposure to suspected or known highly infectious agents. Additionally, AELTs may be vulnerable to environmental threats due to food and water borne pathogens, insect disease vectors, and heat and cold stress. While AELT personnel do not normally provide direct patient care, team personnel should be aware of possible signs and symptoms of these diseases as well as the appropriate public health response. Proper emphasis on infection control practices should keep this threat to a minimum, but may require firm and sustained enforcement. Potential threats or inadvertent spread of infection exists if infection control practices are not followed. Safety is paramount in an environment where minor injuries can become serious due to austere conditions. Appropriate training of medical personnel during peacetime should mitigate these potential threats.

Chapter 5

TRAINING

5.1. Introduction. The home station AE Squadron Commander should ensure their personnel are trained prior to deployment. Sufficient training is challenging without the benefit of operating in the full TAES environment that can be provided by DOD, Air Force-Level, and Major Command-level exercises.

5.2. Contingency Training. AE Squadron members have the potential of being tasked to deploy in an AELT position regardless of UTC assignment and should be properly trained and prepared. The Aeromedical Evacuation and Patient Staging Course provides hands-on experience with the AELT equipment package and trains personnel on all components of the TAES (Refer to AFTTP 3-42.5). All AELT personnel should complete initial training and maintain Aeromedical Evacuation and Patient Staging Course sustainment training in accordance with AFI 10-2912 and any in-force HQ AMC/A3/10 policy letters.

5.3. Requirements. It is essential that AE ground support personnel have a firm knowledge of AE operations including, but not limited to, launch and recovery procedures, AE medical equipment, mission management, C2 systems, En Route Critical Care team operations, and mission documentation. These skills are not a part of the Comprehensive Medical Readiness Program or Air Force Specialty Code training. AELT members should be trained to meet current FFQLL Mission Essential Task Lists. Formal local training programs and AE training missions should be utilized to train, test, and reinforce the needed deployed knowledge base.

5.4. UTC Sustainment Training. UTC training should cover deployed AE operations pertinent to patient movement coordination and all phases of deployment, employment, and re-deployment. The Comprehensive Medical Readiness Program employed by AF SG, although required for all personnel with medical Air Force Specialty Codes, should be supplemented with UTC specific training. Readiness training should be conducted in conjunction with sponsored or local training exercises, or operational deployments as authorized with proper coordination. Joint training is encouraged to foster relationships as it enhances capabilities of each service. Personnel tasked to the AELT UTC should have required training and access to the following applications (specifics identified in reporting instructions, line remarks, and obtained prior to a member's deployment):

- Global Decision Support System and/or Single Mobility System
- TRAC2ES
- Joint Patient Safety Reporting system
- Medical Logistics Allowance Standard Management **https://medlog.us.af.mil/**
- Secure communications
- PMI Program
- Weapons and ammunition storage and management
- HMMWV training
- Hazardous Materials (HAZMAT) and Pallet Building

5.5. Mobility Operations Training. Many courses are available for airlift operations training. The United States Air Force Advanced Distributed Learning Service application offers multiple courses to give personnel insight into air mobility operations. Training programs which provide

tactical training scenarios, load-out training, and joint C2 relationships are highly recommended. This cannot be overemphasized as AELT personnel may deploy far forward. Pre-deployment combat skills training (reference deployment-specific line remarks) may also be required.

5.6. Primary Source Guidance. The small-unit nature of the AELT requires assigned personnel to have an in-depth knowledge of patient movement operations, governing regulations, policies, and guidance. AELT personnel should also have a strong cross-functional knowledge as well as policies that apply to AMC and the specific AOR.

5.7. Intelligence. During the pre-deployment phase, AELT personnel should obtain a detailed medical intelligence assessment for pre-deployment briefings and inclusion in the force protection plan. Sources for this information may include Major Command Aerospace Medical and Readiness divisions, host base and theater intelligence, Air Force Office of Special Investigations, National Center for Medical Intelligence, Medical Environmental Disease Intelligence and Countermeasures CD-ROM data base, airfield surveys reports, previous after action reports, Joint Lessons Learned Information System (and other published lessons learned), Department of State, and any in-country US embassy or consulate.

Chapter 6

COMMUNICATIONS AND INFORMATION SYSTEM SUPPORT

6.1. General. The AELT should deploy with organic communications equipment (included in FFQL1) as a primary resource to provide secure and unsecure voice and data communications links capable of sustaining command and control, patient movement data and general message traffic capabilities.

6.1.1. The AELT communications system is established, using this organic equipment, to process and track requests for AE, follow mission progress, and maintain situational awareness. Secondary communications links, such as a Local Area Networks, are obtained upon arrival in theater depending on the maturity of the theater communications infrastructure and the availability of commercial or military service-provided circuits. Communications capabilities need to be reliable and capable of supporting AELT operations for any theater along with the full spectrum of contingencies.

6.1.2. Some of the variables that affect the establishment of an AELT communication system include the intensity of the conflict, governing laws of the host nation regarding spectrum and communication management, climate and geography, electromagnetic environment, propagation conditions, and real estate (on-site) availability. AELT communication systems planning and implementation procedures contained in the Operation Plan Annex K must be thoroughly presented and widely disseminated among element Officer In Charge, Non-Commissioned Officer in Charge and communication operators.

6.1.3. The AELT currently uses satellite communications for its primary C2 system. With this media, the AELT establishes a closed, directed communications net and performs as the Net Control Station to ensure proper net procedures, protocols, and radio operator discipline as stated in applicable directives, such as Allied Communications Publication (ACP) 125, *Communications Instructions Radiotelephone Procedures* and ACP 130, *Communications Instructions Signalling Procedures in the Visual Medium*. The Net Control Station also designates an alternate to assure continuity of mission requirements in contingencies affecting the net.

6.2. Message Precedence. All message traffic transmitted is assigned precedence. It serves as a guide to communication personnel to indicate the order of handling and notifies the addressee of the significance or urgency of the content of the message. All messages are sent as soon as possible, however, the one with the higher precedence is sent first.

6.2.1. Flash. This precedence is reserved for alerts, warnings, and other emergency actions having immediate bearing on national, command, or area security. Flash messages are hand carried, processed, transmitted, and delivered immediately ahead of all other messages.

6.2.2. Immediate. This precedence is reserved for vital communication having immediate operational effect on tactical operations; communication directly concerning safety or rescue operations; and communication affecting the intelligence community operational role.

6.2.3. Priority. This precedence is reserved for calls that require prompt completion for national defense and security, the successful conduct of war, or to safeguard life or property.

Normally, priority is the highest precedence that may be assigned to administrative matters for which speed of handling is of vital importance. Maximum delivery time is 24 hours.

6.2.4. Routine. This precedence is reserved for all official communications to which all of the above listed precedence does not apply. Routine messages are handled in the order received and after all messages of a higher precedence have been sent. Maximum delivery time is 72 hours.

6.3. Message Traffic.

6.3.1. There are four basic message types in use in the AE system. They are PMRs, AE mission messages, AE operations reports, and general messages. AE operational reports consist of the Situation Report (SITREP) and any other, as requested, reports or messages. SITREPs are used to report the status of readiness of an element to the chain of command within the theater. Refer to AFMAN 10-206, *Operational Reporting (OPREP)*, and specific Joint Task Force and/or Commander, Air Force Forces guidance.

6.3.2. When computer network capabilities are available, the AELT can assist the user service with PMR inputs until the user service is capable to perform this function on their own. When patients are manifested on an assigned AE mission, the mission's information should be entered into TRAC2ES by the PMRC. Patient and mission information can also be transmitted through secure telephone systems such as Secure Voice over Internet Protocol. AELT communication should always adhere to patient privacy and Operations Security (OPSEC) regulations and policies.

6.4. Communications Systems Operations.

6.4.1. The AE system uses organic Very High Frequency, Ultra High Frequency and Satellite Communication radio assets as a means of providing communications capability to the AE system. Trained AE Radio Frequency Transmission personnel are assigned to set up and initiate communications between elements.

6.4.2. Secure and non-secure systems may be available during contingencies. The mode of transmission is dependent on availability and the classification or sensitivity of the information being passed. The degree to which the information needs to be protected will dictate the type of system that should be utilized.

6.5. Communication Equipment.

6.5.1. Secure/Non-secure Communication. Any classified information should be transmitted by secure means. SITREPs, medical surveillance, site locations, and compiled patient data are all examples of information that can be classified and will need safeguarding. The types of secure communication equipment usually available include secure telephone equipment and various other encryption devices. Medical or casualty information becomes an OPSEC issue when linked to a particular military mission or operation. While medical information itself is not normally classified, in the context of a mission, it should be protected as part of the theater overall OPSEC program to deny information to the enemy. Radio equipment, COMSEC, and classified material should be destroyed in accordance with current COMSEC Radio Equipment Destruction directives.

6.5.2. Computer systems. The AELT deploys with organic computer hardware and software which provide word-processing, database management, and graphics. If available, Local

Area Network connectivity such as the Non-classified Internet Protocol Router Network and Secure Internet Protocol Router Network may be obtained through the user service. If Local Area Network capable, the AELT should use TRAC2ES to maintain oversight for regulated patient needs, and the Global Decision Support System for mission tracking and visibility. SITREPs should be transmitted by secure means or in accordance with local communications policy. Access to both secure and non-secure communication networks will allow the team a direct connection to obtain operational, administrative, and clinical input from the AOC, C2 authorities and geographically separated units, PMRC access, and secure internet sites for publications, forms, and operating instructions.

6.5.3. Telephones/Radios. The AELT may be required to maintain radio communication and 24-hour operations using satellite radios and phones.

6.5.4. Iridium Phone with secure sleeve. An Iridium phone is a handheld satellite phone that can be utilized anywhere in the world. It is larger than a typical mobile phone, but still small enough to carry in a backpack, and is very simple to use. It provides secure and unsecure voice telephone capabilities through satellites. For secure communications, a secure sleeve must be attached to the phone handset. Each unit should use their local Program Designator Code (PDC) for the purchase and activation of Subscriber Identity Module cards for training and exercises. War Reserve Materiel Subscriber Identity Module cards should not be used for unit training or exercises. When iridium phones are deployed, the War Reserve Materiel Subscriber Identity Module card should be activated using the appropriate contingency operation consolidated PDC.

6.5.5. Broadband Global Area Network (BGAN). Portable and easy to setup, the BGAN is another satellite phone that uses satellites located around the earth for worldwide telephone capabilities. This system can also interface with the secure telephone equipment to provide secure communications. Each unit should use their local PDC for BGAN terminal activation to support training or exercise operations. Upon deployment, the PDC should need to be switched to the operations consolidated PDC.

6.5.6. PRC-117 Multiband Manpack Radio. Provides breakthrough wideband data performance and legacy narrowband interoperability in one lightweight package. Covering the 30 MHz to 2 GHz frequency range, this single-channel radio is 30% smaller and 35% lighter than currently fielded multiband manpack radios and operates off a single standard battery. This device can be used to pass secure information as well as data transfer of sensitive material and documents such as PMRs and SITREPs.

6.6. Communications and Operations Security (OPSEC). It is vital to protect and secure all classified information. AE C2 should be capable of processing classified information up to and including SECRET. All aircraft mission information is considered classified in the theater of operations. All aspects of COMSEC and OPSEC should be fully implemented and rigidly enforced. AE Communications Teams (FFQCR) should deploy with the current month COMSEC material plus a 90 day supply. The AE Operations Team should establish a COMSEC account within the AOR if the operation will require secure communications beyond 90 days.

JOSEPH T. GUASTELLA Jr., Lt Gen, USAF
Deputy Chief of Staff, Operations

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

Secretary of the Air Force, (10 U.S.C. § 9013)

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DTR 4500.9-R-Part II, *Cargo Movement*, 1 May 2014

JP 3-11, *Operations in Nuclear, Biological, Chemical, and Radiological (CBRN) Environments*, 29 October 2018

JP 3-17, *Air Mobility Operations*, 5 February 2019

JP 4-02, *Joint Health Services*, 11 December 2017

AFI 10-2912, *Aeromedical Evacuation Readiness Programs*, 20 June 2018

AFI 10-401, *Air Force Operations Planning and Execution*, 7 December 2006

AFI 10-403, *Deployment Planning and Execution*, 17 April 2020

AFI 11-2AEV3, *Aeromedical Evacuations (AE) Operations Procedures*, 15 August 2014

AFI 13-207-O, *Preventing and Resisting Aircraft Piracy (Hijacking)*, 5 February 2019

AFI 24-301, *Ground Transportation*, 22 October 2019

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AFTTP 3-4, *Airman's Manual*, 11 January 2019

AFTTP 3-42.5, *Aeromedical Evacuation*, 23 July 2019

AFTTP 3-42.57, *En Route Patient Staging System*, 10 August 2016

AFTTP 3-42.8, *Expeditionary Medical Logistics (EML) System*, 16 November 2018

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Air Force Doctrine Annex 3-17, *Air Mobility Operations*, 28 June 2019

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ACP 130, *Communications Instructions Signalling Procedures in the Visual Medium,* July 2005

ATP 4-02.7, *Multi-Service Tactics, Techniques, and Procedures for Health Service Support in Chemical, Biological, and Radiological, and Nuclear Environments*, 15 March 2016

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Prescribed Forms

None

Adopted Forms

AF Form 4033, *PMI/AE Certification Label*

AF Form 847, *Recommendation for Change of Publication*

DD Form 2163, *Medical Equipment Verification/Certification*

Abbreviations and Acronyms

AE—Aeromedical Evacuation

AECS—Aeromedical Evacuation Command Squadron

AECT—Aeromedical Evacuation Control Team

AELT—Aeromedical Evacuation Liaison Team

AF—Air Force

AFI—Air Force Instruction

AFMAN—Air Force Manual

AFPD—Air Force Policy Directive

AFR—Air Force Reserve

AFTTP—Air Force Tactics, Techniques and Procedures

AMC—Air Mobility Command

AMCI—Air Mobility Command Instruction

ANG—Air National Guard

AOC—Air and Space Operations Center

AOR—Area of Responsibility

ATP—Army Techniques Publication

BGAN—Broadband Global Area Network

C2—Command and Control

CBRN—Chemical, Biological, Radiological, and Nuclear

CDRUSTRANSCOM—Commander, United States Transportation Command

COMSEC—Communications Security

DOD—Department of Defense

DSCA—Defense Support of Civil Authorities

DTR—Defense Transportation Regulation

ERPSS—En Route Patient Staging System

FAA—Federal Aviation Administration

FN—Flight Nurse

HA/DR—Humanitarian Assistance/Disaster Response

HMMWV—High Mobility Multi-purpose Wheeled Vehicle

HQ AMC—Headquarters Air Mobility Command

HQ AMC/SG—HQ AMC Command Surgeon General

HQ AMC/SGXM—HQ AMC Command Surgeon/Medical Readiness/Logistics and MEFPAK

JP—Joint Publication

MEFPAK—Manpower & Equipment Force Packaging

MISCAP—Mission Capabilities Statement

MSC—Medical Service Corps

MTF—Military Treatment Facility

OPREP—Operational Reporting

OPSEC—Operations Security

PDC—Program Designator Code

PMI—Patient Movement Item

PMI-ATS—Patient Movement Items-Asset Tracking System

PMR—Patient Movement Request

PMRC—Patient Movement Requirements Center

RegAF—Regular Air Force

SG—Command Surgeon/Surgeon General

SITREP—Situation Report

TACC—Tanker/Airlift Control Center

TAES—Theater Aeromedical Evacuation System

TO—Technical Order

TRAC2ES—TRANSCOM Regulating Command & Control Evacuation System

TTP—Tactics, Techniques and Procedures

USC—United States Code

UTC—Unit Type Code

Attachment 2

ADDITIONAL RESOURCES

Aeromedical Evacuation References
AFI 10-2501, *Emergency Management Program*, 10 March 2020
AFI 10-301, *Managing Operational Utilization Requirements of the Air Reserve Component Forces*, 20 December 2017
AFI 10-402, *Mobilization Planning*, 8 March 2018
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AFI 44-102, *Medical Care Management*, 17 March 2015
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AFI 48-307V2, *En Route Critical Care*, 10 January 2017
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AFPD 10-3, *Operational Utilization of the Air Reserve Component Forces*, 29 November 2017
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Air Force Doctrine Annex 4-02, *Health Services*, 12 November 2019
JP 3-0, *Joint Operations*, 17 January 2017
Aeromedical Evacuation Resources
847 Central (AMC/A3V, Mobility AF lead command, change recommendations to aircrew publications): **https://cs2.eis.af.mil/sites/12797/SitePages/847%20Central.aspx**

HQ AMC Aeromedical Evacuation Medical Equipment Compendium, 26 June 2020, and Medical Equipment Manuals may be found at the HQ AMC, Aircrew Standardization & Evaluation, Aeromedical Airlift (A3VM) SharePoint site.
AEF Online Personal Deployment Preparedness Tool (PDPT) (e-deployment folder, e-readiness tracker [After signing in, click "PDPT," populates information from ADLS, ASIMS, MILPDS]):
https://aefonline.afpc.randolph.af.mil/personalprep.aspx
AF Combat Support Tactics, Techniques, and Procedures (TTP) Repository:
https://cs2.eis.af.mil/sites/10070/default.aspx
AF Doctrine: **http://www.doctrine.af.mil/**
AF E-Publishing: **http://www.e-publishing.af.mil/**
AF Medical Readiness Decision Support System (MRDSS-Ultra):
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AF Medical Service Knowledge Exchange: **https://kx.health.mil/Pages/default.aspx**
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DOD Dictionary and Terminology Repository (Military Acronym Finder):
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DOD Directives Division (DOD Publications and Forms): **http://www.esd.whs.mil/DD/**
Education & Training Course Announcements (ETCA) (*use email certificate* May have to go to IE Options, Content, clear SSL State): **https://app10-eis.aetc.af.mil/etca/SitePages/Home.aspx**
HQ AMC, Aircrew Standardization & Evaluation, Aeromedical Airlift (A3VM) "Master_Library_Verified AE" SharePoint:
https://cs2.eis.af.mil/sites/12679/aircrew%20pubs%20library/forms/better.aspx
HQ AMC, Aircrew Standardization & Evaluation, MAF Aircrew Information Site, Flight Crew Information File (FCIF)/Special Interest Item (SII) Library (Select "…" to filter for AE, SII, etc.): **https://cs2.eis.af.mil/sites/10370/SitePages/Home.aspx**
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Safe to Fly Matrix: **https://www.wpafb.af.mil/stf/**
Safe to Fly SharePoint: **https://cs2.eis.af.mil/sites/10567/sitepages/home.aspx**
TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES):
https://www.trac2es.transport.mil/

USAF Individual Medical Readiness (IMR) Status: **https://imr.afms.mil/imr/myIMR.aspx**