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Aerospace Medicine

FLIGHT AND OPERATIONAL
MEDICINE PROGRAM (FOMP)

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SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Major changes include AOME policy changes, comprehensive fatigue management program oversight, aeromedical dispositions, aerospace and operational medicine training of personnel, Base Operational Medicine Clinic (BOMC) guidance, guidance for Aeromedical Physician Assistants (APA) and Aeromedical Nurse Practitioners (ANP), Flight and Operational Medicine Clinic (FOMC) empanelment, changes in Formal Aerospace Medicine Training Courses at United States Air Force School of Aerospace Medicine (USAFSAM) and changes in Integrated Operational Support (IOS) to include Squadron Medical Element (SME) and Operational Medical Elements (OME). New mandatory training for additional Personnel Reliability Assurance Program (PRAP) personnel has been updated. Special Warfare (SW) Human Performance (HP) Support language has been added which outlines human performance support by the SW HP Support Group. Other major changes in this manual include the reduced use of acronyms and lower level tiering.

Chapter 1

PROGRAM OVERVIEW

1.1. Overview. This manual is consistent with the policy in AFPD 11-4, *Aviation Service* and highlights responsibilities at wing-level and below to support the overall AOME. It focuses specifically on elements that are required, delineated by directive language such as "will," "shall," and "must." Supplemental information that focuses on best practices and "how to" processes related to the AOME can be found on the Air Force Medical Service (AFMS) Knowledge   Exchange   (KX)   at **https://kx.health.mil/kj/kx4/FlightMedicine/Pages/operationalmedhomeapril2012.aspx**.

1.2. The Aerospace & Operational Medicine Enterprise (AOME). The AOME consists of all health capabilities and activities that directly support execution of the Air Force mission. These include aviation medicine; occupational, environmental, and operational medicine; industrial hygiene; public health; force health readiness and protection; medical support to the nuclear enterprise; human performance sustainment, optimization, and enhancement and medical response to aviation and operational mishaps and to chemical, biological, radiological, or nuclear events.

Chapter 2

ROLES AND RESPONSIBILITIES

2.1. The AF Surgeon General/Deputy Surgeon General.

2.1.1. Provides strategic guidance, policies and procedures to execute the AOME.

2.1.2. Advocates for resources to execute the AOME.

2.2. The Director, Medical Operations (AF/SG3).

2.2.1. Provides policy and regulatory guidance necessary to successfully execute the AOME.

2.2.2. Oversees strategic planning and programming activities.

2.2.3. Maintains liaison with Department of Defense (DoD) agencies for aircrew and special operations (SO) personnel's health, disease prevention, occupational health, environmental quality and crew performance issues.

2.2.4. Sets policy for utilization of operational medicine assets.

2.3. Chief, Aerospace Medicine Policy and Operations (AF/SG3P).

2.3.1. Develops policy, plans, and programs to enable AOME execution.

2.3.2. Ensures integration and coordination of AOME initiatives and policy with Headquarters Air Force agencies.

2.3.3. Maintains liaison with AF/A3O on issues concerning all line embedded medical personnel to include SME and Operational Medical Elements (OME). Works with AF/A3O to determine line embedded utilization, capabilities and requirements to be sourced appropriately.

2.3.4. Provides consultation on all AOME issues to Defense Health Agency (DHA), Headquarters Air Force, MAJCOM, and other agencies.

2.3.5. Provides programming recommendations to support strategic guidance of the AF/SG.

2.3.6. Maintains liaison with sister Services and Federal agencies in order to enable AOME execution.

2.3.7. Serves as the AF subject matter expert on medical standards and physical qualifications.

2.3.8. Serves as the AF subject matter expert on the medical waiver of disqualifying medical conditions.

2.3.9. Serves as the OPR for BOMC program as set forth in **Chapter 4**.

2.3.10. Serves as the AF medical subject matter expert on the PRAP.

2.3.11. Serves as the AF subject matter expert on the AOME initiatives supporting high-reliability-organization principles.

2.3.12. Interfaces with 711 HPW/USAFSAM and all MAJCOM/SGPs to facilitate successful execution of the AOME.

2.3.13. Develops and maintains standardized medical training for all AOME personnel.

2.3.14. Develops objective metrics to measure the success of the AOME.

2.4. Director, SW HP Operations (AF/A3S/SG). Provides strategic guidance and policies to execute SW HP program.

2.5. MAJCOM/SG.

2.5.1. Assists with organizing and training personnel to support AOME execution within their command.

2.5.2. Coordinates with DHA to assign a supporting military medical treatment facility (MTF) for AOME components at limited scope medical treatment facilities, geographically separated units and medical aid stations.

2.6. MAJCOM/SGP (Chief of Aerospace Medicine).

2.6.1. Ensures execution of guidance for subordinate installation medical units to properly execute the AOME.

2.6.2. Ensures Operational Medicine personnel are appropriately trained in executing the AOME objectives. Development of courses and training for all operational medicine personnel occurs at the 711 HPW.

2.6.3. Ensures MTF level 48X contracts conform to standard performance work statement minimums as provided by the AF/SG Aerospace Medicine Consultant. Base level contracts may include additional requirements but must contain the minimum knowledge, skill, abilities. This will be enforced by the MAJCOM.

2.6.4. Functions as a liaison between the MTF, Total Force Integration units, medical squadrons or medical groups, and Air Force Medical Readiness Agency (AFMRA).

2.6.5. Executes MAJCOM/SG waiver authority for aeromedical waivers within delegated authority in accordance with AFI 48-123 *Medical Examinations and Standards*. **Note:** ARC/SGP functions as MAJCOM-level authority.

2.6.6. Identifies locations requiring manpower support to operate as secondary establishments in support of TFE Title 10 missions. **Note:** TFE includes both Total Force Integration units and stand-alone ARC units executing a Title 10 mission.

2.6.7. Identifies TFE medical manpower requirements and incorporates them into business case analysis and program objective memorandum processes or negotiates for Title 10 resources (military personnel appropriation days) to meet the operational medicine support requirements.

2.6.8. Consults with MAJCOM/A3 counterparts when implementing individual MAJCOM programs in the use of fatigue countermeasure medications (Go and No-Go Pills).

2.6.8.1. Air Combat Command (ACC)/SGP shall be the medical lead for all MAJCOM SGPs that support Combat Air Forces (CAF) aircraft.

2.6.8.2. Air Mobility Command (AMC)/SGP shall be the medical lead for all MAJCOM SGPs that support Mobility Air Forces (MAF) aircraft.

2.6.8.3. Air Force Special Operations Command (AFSOC)/SGP shall be the medical lead for all MAJCOM SGPs that support SW Airman.

2.7. Military MTF/CC or equivalent will: Note: Air Force Reserve Component (AFRC) equivalent is a Reserve Medical Unit Commander (RMU/CC) and the ANG equivalent is a Guard Medical Unit Commander (GMU/CC).

2.7.1. Utilizes resources and personnel to ensure successful execution of the AOME at their installation. **(T-2).**

2.7.2. Ensures operational medicine personnel are trained and resourced to successfully execute the AOME at deployed locations. **(T-2).**

2.7.3. Ensures execution of Occupational and Environmental Health (OEH) Program in accordance with AFI 48-145, *Occupational and Environmental Health Program*. **(T-2).**

2.8. MTF/SGP (Chief of Aerospace Medicine). Note: This individual must be credentialed as a Flight Surgeon (FS) 48X and must receive Flight Medicine privileging at the MTF (RMU/GMU).

2.8.1. Oversees the AOME programs (directly supports the line of the Air Force mission), coordinates aerospace medicine activities, and maintains operational oversight for operational medicine personnel. **Note:** The SGP will be appointed in accordance with AFI 48-101, Aerospace Medicine Enterprise. These programs directly support the line of the Air Force mission.

2.8.2. Serves as the installation subject matter expert on types of medical examinations, medical standards and physical qualifications. Also serves as the signature authority in Physical Exam Processing Program (PEPP), Aeromedical Information Management Waiver Tracking System (AIMWTS) and Aeromedical Electronic Resource Office.

2.8.3. Ensures quality and timeliness of the initial flying class medical examination process.

2.8.4. Serves as the local aeromedical certification and waiver authority when so designated by the MAJCOM/SGP.

2.8.5. Provides oversight for the DoD separation history and physical exam program. **Note:** Not applicable to ARC.

2.8.6. Serves as the installation focal point in handling matters of medical standards application and resolving problems associated with conducting assessments, documentation and required follow-up of all cases, and other matters that may call for resolution.

2.8.7. Ensures assigned 48X, APAs, ANPs, and operational medicine technicians are trained on military physical exams, standards, aircrew waivers, and BOMC processes.

2.8.8. Serves as the subject matter expert for BOMC execution. Serves as the senior advisor, maintaining operational oversight of BOMC and designates the BOMC Team Lead.

2.8.9. Ensures assigned 48X personnel, APAs, and ANPs complete and maintain required training to ensure they are fully mission qualified and ready to deploy.

2.8.10. Ensures contract and civilian 48X hires meet contract and/or job description requirements.

2.8.11. Assigns duties and monitors duty performance of AOME personnel, 48Xs, 42GXPs, 46YXFs, and 4N0X1Fs including in-garrison SMEs.

2.8.12. Serves as the Air Force's senior profile officer and chairs the Deployment Availability Working Group (DAWG). **Note:** See AFI 48-133, *Duty Limiting Conditions* for further information regarding the DAWG.

2.8.13. Serves as the OPR for administrative-support oversight of the Deployment-Related Health Assessment Program in accordance with AFI 48-122, *Deployment Health.*

2.8.14. Coordinates with Chief of Medical Staff (SGH), Public Health (PH), Physical Evaluation Board Liaison Officer, and BOMC to ensure a clear process exists for deployment medical waivers and that it is briefed to Professional Staff annually.

2.8.15. Develops a local prioritized list of Mission Essential Tasks and Activities for Line Support (METALS) and an annual execution and monitoring plan. See **Attachment 2** for additional details about METALS.

2.8.16. Engages with line commanders regarding in-garrison SME requirements to function within the medical group. The SGP and line commander will work together to optimize the clinic schedule of the SMEs ensuring both the line medical support and MTF in-garrison medical missions are fully supported.

2.8.17. Acts as A liaison between embedded medics and the local MTF. The SGP will work with line units to ensure needed support for DAWG, Airmen Medical Readiness Optimization (AMRO) Board functions and medical evaluation board (MEB) actions are provided by line medics.

2.8.18. Provides expert advice and training as needed to embedded providers. This will cover all aspects of aerospace medicine, occupational assessments, and consults on quality control for all aspects of care provided to aircrew and special operation duty personnel.

2.9. Aerospace Medicine SQ/CC or Equivalent (e.g., operational medicine readiness squadron (OMRS)/CC).

2.9.1. Establishes clear objectives and goals for the AOME.

2.9.2. Defines tasks and responsibilities necessary to achieve the objectives of the AOME.

2.9.3. Manages the personnel, including SME, and activities in support of the AOME.

2.10. Flying or Operational SQ/CC.

2.10.1. The SQ/CC shall retain administrative control over subordinate SME/OME personnel, with respect to administration and support, including organization of service forces, control of resources and equipment, personnel management, logistics, individual and unit training, readiness, discipline and other matters not included in the operational missions of the subordinate organization. **(T-3).** Day-to-day oversight and supervision is normally delegated by the Flying or Operational SQ/CC to the SGP while in-garrison. (**Exception:** May include AFSOC assigned personnel, combat search and rescue medical element, and IOS personnel assigned or organic to line units).

2.10.2. Reporting to Credentials Function and Medical Leadership. It is imperative that all concerns of potentially inappropriate professional and/or medical conduct noted by line

leadership be immediately reported to MTF (RMU/GMU) leadership for appropriate quality review IAW DHA-PM 6025.13. **(T-2).** This is to ensure the quality of medical care and the integrity of the Military Health System. The Operational Squadron/CC will immediately report all conduct concerns as well as all concerns of possible deficiencies in the provision of care to the MTF/SGH. **(T-2).**

2.11. Chief of Medical Staff (SGH).

2.11.1. Oversees the professional staff management program, professional practice review, patient safety, infection prevention, health risk management and performance improvement activities that occur within line units.

2.11.2. SGH should be consulted by the embedded line clinical leadership to work with the MTF Medical Information Systems staff, in coordination with MTF quality office staff, to provide data to embedded clinical leadership regarding unsigned orders, incomplete encounters, results pending review, and other quality items in the electronic health record deemed necessary by the SGH.

2.12. Chief Nurse (SGN).

2.12.1. Peer Review: MTF/SGN consulted by the embedded line clinical leadership to ensure peer review activities are being completed on embedded nursing personnel. The optimal peer review program integrates line nursing personnel into the appropriate MTF clinical area peer review process.

2.13. Line Embedded Clinical Leadership.

2.13.1. Line embedded clinical leadership defaults to the senior embedded medical functional(s) appointed by the line commander. At times this embedded clinical oversight is provided at the squadron level but is more often at the group or wing level. This clinical leader works closely to ensure all guidance for the provision of care is followed. Ensures that clinical oversight, quality of care, and nonmedical services are appropriate and adequate. (**T-3**).

2.13.2. Develops embedded supplemental guidance for day-to-day management of embedded clinical staff.

2.13.3. Determines optimal processes for utilization of embedded clinical resources.

2.13.4. Monitors clinical performance of embedded clinical staff and coordinates with local MTF SGH and SGN to enhance quality of care and ensures appropriate remediation if there is concern regarding quality of care (in accordance with DHA-PM 6025.13, *Defense Health Agency Procedures Manual (DHA-PM) 6025.13, Clinical Quality Management in the Military Health System,* and AFI 44-119, *Medical Quality Operations*) **(T-0).**

2.13.5. Monitors and addresses privileged providers' response to applicable MTF directives and medical staff bylaws.

2.13.6. Ensures electronic health record (EHR) access for embedded medical personnel.

2.13.7. Ensures embedded provider representation at MTF grounding management activities and DAWG and AMRO Board functions.

2.13.8. Coordinates with the BOMC to ensure embedded providers have the information necessary to complete preventive health assessment (PHA) activities in accordance with AFI 44-170, *Preventive Health Assessment*.

2.14. AFMRA/SG3P.

2.14.1. Creates strategic guidance for the medical support of an AF fatigue management program.

2.14.2. Serves along with the MAJCOM SG office as the medical liaison to A3.

2.14.3. Defines tasks and responsibilities necessary to achieve the objectives of the program.

Chapter 3

AEROSPACE AND OPERATIONAL MEDICINE PROGRAM

3.1. Objectives and Desired Effects. The AOME consists of all health services and activities that directly support execution of the AF mission. The AOME focuses on the readiness, availability, and lethality of all Airmen for employment and deployment. The AOME aims to promote and sustain a healthy and fit force, prevent illness and injury, restore health, and optimize and sustain HP in support of the operational mission of the AF. The program supports the major operational medicine divisions which include General Operational Medicine, Occupational Medicine (OM), Flying and Special Operational Medicine, IOS, and Reliability Medical Support. The AOME provides care to populations which require special administrative and operational controls to certify fitness for duty on a daily basis for regular employment. Populations covered by this program include Flying class I, II, III, remotely piloted aircraft (RPA), operational support flyer (defined in AFMAN 11-402, *Aviation and Parachutist Service*) and non-flight populations that fall under the special operational duty (SOD) categories such as air traffic control (ATC), SW, explosive ordnance disposal, missile operator duty, personnel reliability program (PRP), presidential support duties, fire fighters, and others as assigned by the DHA.

3.2. Organization, Training, and Functions of the Flight and Operational Medicine Clinic.

   3.2.1. Empanelment/population served. **Note:** Not applicable to ARC.

      3.2.1.1. The FOMC empanels personnel who require maintenance of a DD Form 2992, *Medical Recommendation for Flying or Special Operational Duty*, and non-flight populations which fall under the SOD categories. Explosive ordinance disposal personnel and fire fighter personnel may be empaneled to FOMC with the approval of the MTF/CC. **Note:** Even though 13Sx and 1C6xx Air Force Specialty Code (AFSC) do not require a DD Form 2992, they may be empaneled to the FOMC.

      3.2.1.2. Empanelment capacity is in accordance with Defense Health Agency-Procedural Instruction (DHA-PI) 6025.11, *Processes and Standards for Primary Care Empanelment and Capacity in Medical Treatment Facilities (MTFs)*. **(T-0).**

      3.2.1.3. See AFI 31-117, *Arming and Use of Force By Air Force Personnel*, for the empanelment guidance regarding Arming and Use of Force personnel.

      3.2.1.4. The BOMC will see, but not empanel the following categories:

         3.2.1.4.1. Civilian federal employees for occupational health exams, unless there is a stand-alone OM clinic. **(T-2).**

         3.2.1.4.2. RegAF that require occupational health exams as determined by the Occupational and Environmental Health Working Group (OEHWG), unless there is a stand-alone OM clinic. **(T-2).**

         3.2.1.4.3. Individuals requiring initial flying class exams in accordance with AFI 48-123 for familiarization flight physical exams or operational support flyer. **(T-2).**

      3.2.1.5. MTF/CC, with consultation from the MTF/SGP, must approve or disapprove any empanelment additions that deviate from this AFI. **(T-3).** Deviations may include

enrollment of other operational support groups such as personnel with specific occupational exposures determined by the SGP or personnel whose duties are critical to successful completion of local aeromedical or installation missions.

3.2.2. If sufficient FSs, APAs, or ANPs are not available, contract and/or civilian operational medicine providers may be utilized in the FOMC. Granting and maintenance of credentials require approval and review in accordance with DHA-PM 6025.13, volume 4, *Credentialing and Privileging*. **(T-0).** SGPs will recommend to the credentials function that requested privileges be granted/denied as part of the review process. **(T-0).**

3.2.3. FOMC Training and Development.

3.2.3.1. Objectives and Desired Effects. FOMC personnel are required to deliver aeromedical and operational support in-garrison and while deployed. It is critical that FOMC personnel are skilled and proficient in their roles. MTF (RMU/GMU) leadership should allocate time and resources to ensure FOMC personnel are adequately trained.

3.2.3.2. FOMC AFSC Qualification Training

3.2.3.2.1. Independent duty medical technician (IDMT) (4N0X1C) assigned to FOMC must complete the Flight and Operational Medicine Technician Course to obtain the 470 SEI and gain the knowledge base of aerospace medical programs and procedures. **(T-2).**

3.2.3.2.2. Initial Qualification Training (IQT). Physicians, PAs and Family Nurse Practitioners (FNP) working in aerospace medicine must successfully complete all required modules of the formal aerospace medicine training course (which includes the Air Force Operational Medicine (AFOM) courses and Aerospace Medicine Primary (AMP) Courses provided by USAFSAM. **(T-2).**

3.2.3.2.3. Formal Aerospace Medicine Training Courses:

3.2.3.2.3.1. AFOM 101: All AF 4-year Heath Professions Scholarship Program and Uniformed Services University of Health Sciences students must attend AFOM 101. **(T-1).** AF medical corps (MC) physicians, PAs, and FNPs are approved to attend AFOM 101, this includes MC residents in training as permitted by their program. AF Reserve FNPs and PAs must receive AFRC/SGO approval prior to enrollment. **(T-2).** PAs and FNPs must have 24 months current experience in an appropriate general adult primary care setting before attending AFOM 101. **(T-2).** AFOM 101 attendance may be waived only by the aerospace medicine consultant.

3.2.3.2.3.2. AFOM 102: AF FSs who have been designated to serve in a FOMC within the next 2 years are required to attend AFOM 102. Residents who have been selected to serve in a FOMC clinic upon graduation are expected to attend AFOM 102 training during their 2nd or 3rd year electives as scheduled by their program. Uniformed Services University of Health Sciences and Health Professions Scholarship Program medical students who were not selected or elect not to attend a full residency upon graduation may attend training during their fourth year as a medical student or during their internship as scheduling permits. Credentialed FS physicians, including contractors, crossing over to the AF from

sister services must attend AFOM 102 prior to receiving credentials as a FS in the AF. **(T-2).** FSs (48G or 48R), Aeromedical PAs (APA) or Aeromedical NPs (ANP) who have not served as an aeromedical provider within the previous five years must repeat AFOM 102 prior to receiving full privileges in aerospace medicine. **(T-2).** AFR/ANG FNPs and PAs must receive prior approval from AFRC/SGO to attend. **(T-2).** PAs and FNPs must have 24 months of clinical primary care experience before attending AFOM 102. **(T-2).** AFOM 102 attendance may be waived only by the aerospace medicine consultant.

3.2.3.2.3.3. AMP 201 and 202: Those members obtaining the 48X AFSC (to include fourth year medical student and residents as mentioned above) must attend AMP 201 and 202 prior to logging flight hours. **(T-2).** Credentialed aeromedical providers crossing over to the AF from sister services should attend AMP 201 and 202 prior to logging flight time in the AF. This training can be waived based upon prior operational medicine experience and with concurrence of the AF aerospace medicine consultant. AF credentialed providers who have been designated to serve in a FOMC or BOMC within the next 2 years are required to attend before being credentialed as an aeromedical provider.

3.2.3.2.4. Mission qualification training (MQT). After assignment to an aerospace medicine billet and prior to deployment, the 48R1 or 48G1P FS, 46Y1F ANP, and 42G1P APA must complete MQT to become fully mission capable and receive the 48R3, 46Y3F, and 42G3P AFSC upgrade. **(T-2).** MQT may be initiated immediately upon completion of the AFOM/AMP courses or at a later date if not immediately assigned to work in a flight medicine clinic. MAJCOM/SGP must verify the certification upgrade. Refer to **Table 3.1** and **Table 3.2** for FS, APA, and ANP requirements for MQT.

3.2.3.2.5. FS requirements for MQT. MTF/SGP must endorse and MAJCOM/SGP must approve FS for MQT.

Table 3.1. Mission qualification training requirements: Flight Surgeon.

Basic Requirements	Minimum Number for SGP Certification
SERE (Combat Survival)[1] and Water Survival[2]	Maintain
Advanced Trauma Life Support (ATLS)	Maintain
Advanced Cardiac Life Support	Maintain
Unrestricted FS privileges[3]	Obtain/Maintain
FS sorties/flying hours	Sorties (4) & Hours (6)[1]
SGP oversight for 6 months w/ peer review[4, 5]	Once
Application of Standards	
Aeromedical Dispositions	Thirty-Five (35)[5]
Occupational Exams	Five (5)[5]
Annual flight physical examinations (Fly PHA)	Five (5)[5]
Initial flying class physicals	Five (5)[5]

Aircrew waiver packages	Four (4)[5]
Occupational health shop visits	Two (2)[5]
Public Health sanitation/food inspections	Two (2)[5]
Shop visits (AFE required to be one visit)	Two (2)[5]
In-flight Emergency responses (tabletop acceptable)	Two (2)
Aerovac (AF Form 3899, *Aeromedical Evacuation Patient Record*) Review (tabletop acceptable)	Two (2)
Flight & Operational Medicine Working Group (FOMWG)	Four (4)[5]
Aeromedical Council Meetings	Two (2)[5]
DAWG	Four (4)[5]
OEHWG	Two (2)[5]
Profile reviews as Profile Officer	Thirty-Five (35)[5]

Notes:
1. Combat Survival, training should always apply to current AFI 16-1301, *Survival, Evasion, Resistance, and Escape (SERE) Program.*
 Initial or refresher training must be current within three years. One of the following is acceptable to complete the initial training requirement: 1) SS20: Level-C, (SERE Training, S-V80-A); 2) United States Air Force Academy (USAFA) Course MT-220 (1994 or earlier) or MT-220 + S-V80-A Top-off (after 1994); 3) (July 2017 or earlier) ECAC (S-V88-AL) + Combat Survival Training (SS02) + Emergency parachute Training (SS06); or 4) USAFSAM SERE course (prior to 1 Oct 2009).
Refresher Training:
One of the following is acceptable to complete the refresher training requirement: 1) SS02 (Combat Survival Training—CST) or 2) SS03 (Conduct After Capture—CAC)." Initial or Refresher Training must be current within 3 years
2. Water Survival, training should always apply to current AFI 16-1301Initial or refresher training must be current within three years. One of the following is acceptable to complete the initial training requirement: 1) SS31: Emergency parachute Training/Water Survival Training (S-V85-A) (for ejection seat/bailout aircraft) or 2) SS32: Water Survival Training, Non-parachuting (S-V90-A) (for ditching aircraft). One of the following is acceptable to complete the refresher training requirement: 1) SS05 (Water Survival Training) and 2) SS06 (Emergency parachute Training)
3. ARC FSs must obtain/maintain the FS portion of their unit training assembly privilege list. **(T-3).**
4. This requirement refers to a minimum of 6 months while functioning as a FS assigned to a Regular Air Force MTF flight medicine clinic. This ensures familiarity with application of standards. The SGP may delegate oversight to another experienced FS. For ARC members who also have and hold current clinical privileges in 44E, 44F or 44M AFSCs, this requirement can be met by serving as a FS in RMU or GMU. Other ARC FSs must meet this requirement in an AD flight medicine clinic, or by serving as RMU/GMU FS and obtaining and

demonstrating equivalent proficiency in general adult primary care in another setting. **(T-2).**
5. MTF (RMU/GMU) SGP may certify with less than minimum observed if the individual demonstrates the requisite knowledge and skills to perform the function. MAJCOM/SGP must still approve the certification upgrade. **(T-3).**

   3.2.3.2.6. MTF/SGP must endorse and MAJCOM must approve APA and ANP for MQT. ANPs MQT will be in consultation with MTF Chief Nurse.

Table 3.2. MQT Requirements APA & ANP.

Basic Requirements	Minimum Number for SGP Certification
Unrestricted Aeromedical PA/NP privileges[1]	Obtain/Maintain
APA/ANP flying sorties[2]	Three
SGP oversight for 6 months w/ peer review[3, 4]	Once
Application of Standards:	
Aeromedical dispositions	Thirty-Five (35)[4]
Occupational exams	Five (5)[4]
Annual flight physical examinations (excluding pilots/ATCs)	Five (5)[4]
Initial flying class physicals (excluding pilots/ATCs)	Five (5)[4]
Aircrew waivers	Four (4)[4]
Occupational health shop visits	Two (2)[4]
Public Health sanitation/food inspections	Two (2)[4]
Shop visits (AFE required to be one visit)	Two (2)[4]
In flight emergency response with FS (tabletop exercise acceptable)	One (1)
FOMWGs	Four (4)[4]
Aeromedical Council Meetings	Two (2)[4]
DAWG	Four (4)[4]
OEHWG	Two (2)[4]
Profile reviews as Profile Officer	Thirty-Five (35)[4]

Notes:
1. ARC APA/ANP must obtain/maintain the Aeromedical portion of their unit training assembly privilege list. **(T-2).**
2. APA and ANP can participate in aircraft flights as observers on a noninterference basis in accordance with AFMAN 11-402. There is no minimum number of flights after completion of MQT but there should be no more than 3 flights per month.
3. This requirement refers to a minimum of 6 months while functioning as an APA or ANP assigned to an AD MTF flight medicine clinic. The SGP may delegate to another experienced FS. This ensures familiarity with application of standards.

4. MTF (RMU/GMU) SGP may certify with less than minimum observed if the individual demonstrates the requisite knowledge and skills to perform the function. MAJCOM/SGP must still approve the certification upgrade.

3.2.3.2.7. Aeromedical providers and Aerospace Operational Physiologists assigned to fighter/attack aircraft are encouraged to attend the Top Knife course within one year of assignment as mission permits and on a space-available basis. Top Knife is a course offered to aeromedical providers and physiologists to learn about fighter pilot tactics.

3.2.3.2.8. Medical support for Installation Safety Program. All aeromedical providers and Aerospace and Operational Physiology Training (AOPT) personnel must have access to the AF safety automated system. **(T-3).**

3.2.3.2.9. Intermediate level training for aeromedical providers. After completion of MQT aeromedical providers should work towards completing the intermediate level training listed in the Tables.

Table 3.3. Intermediate Level Flight Surgeon Training.

Intermediate Level Training (future consideration)
Aircraft Mishap Investigation and Prevention Course
Occupational Symposium
PRAP course in accordance with Department of Defense (DoD) 5210.42_AFMAN 13-501, *Nuclear Weapons Personnel Reliability Program (PRP)*
Aerospace and Operational Medicine Executive Development Symposium, formerly the SGP Symposium
Tropical Medicine Symposium
Global Medicine Symposium
Top Knife (RPA & Intelligence, Surveillance and Reconnaissance (ISR) Operations and/or High Performance Aircraft)
Public Health Emergency Officer (PHEO) Course
Advance Clinical Concepts in Aeromedical Evacuation Symposium
Medical Review Officer Certification

Table 3.4. Intermediate Level APA/ANP Training.

Intermediate Level Training (future consideration)
Occupational Symposium
PRAP course in accordance with DoD 5210.42_AFMAN 13-501
Global Medicine Symposium
Tropical Medicine Symposium
Top Knife (RPA & ISR Operations and/or High Performance Aircraft)

3.3. Execution of the Aerospace and Operational Medicine Program.

   3.3.1. Aeromedical Dispositions.

      3.3.1.1. In order to render a timely aeromedical disposition, aeromedical providers must review all medical and dental care provided outside the FOMC. **(T-2).** ARC aeromedical providers, in-garrison, should render the disposition as soon as possible but no later than their next duty/drill day. Timely aeromedical dispositions should occur so that operators do not carry out their operational duties with an aeromedically significant medical condition.   Aeromedical provider must document signed and dated aeromedical dispositions in the member's medical record. (**T-2**).   Aeromedical provider must communicate a member's status changes on a DD Form 2992 to the member's SQ/CC and squadron aviation resource manager. (**T-3**).

      3.3.1.2. Healthcare providers making aeromedical dispositions to include return to fly must be credentialed and privileged in flight/aerospace medicine at the examining facility and can be of any branch of the military service or Coast Guard. **(T-2).**

      3.3.1.3. AF civilian employees or contractors may perform medical examinations and make aeromedical dispositions on flying and/or SOD personnel only if credentialed and privileged in flight/aerospace medicine. Contract and/or job description requirements approved by AFMRA/SG3P must also be met. **(T-2).**

      3.3.1.4. APAs and ANPs may evaluate and treat aircrew and SOD personnel. They may render aeromedical dispositions if they meet the following criteria in order to become an aeromedical provider.

         3.3.1.4.1. PAs (42G3) and NPs (46Y3H) must have 24 months of clinical primary care experience before being identified to become aeromedical providers. **(T-2).** APAs and ANPs assigned to FOMC or BOMC must complete AFOM 101, AFOM 102, AMP 201, and AMP 202 at USAFSAM. **(T-1).**

         3.3.1.4.2. APA and ANPs will complete training before being assigned to Flight and Operational Medicine, but if not, will be accomplished within 6 months of assignment. **(T-3).** Aerospace medicine privileges for APA/ANPs are dependent on completion of this training.

         3.3.1.4.3. APA/ANPs will require oversight with timely peer reviews and spot checks, targeted to the aeromedical disposition, by the local SGP or most experienced FS. **(T-3).** Oversight will be for a period of time determined by the local SGP before upgrading privileges in the Joint Centralized Credentials Quality Assurance System (JCCQAS) to fully qualified in accordance with DHA-PM 6025.13, *Clinical Quality Management in the Military Health System,* volume 3*, Healthcare Risk Management.* **(T-0).**

         3.3.1.4.4. Healthcare Risk Management. Once awarded, aeromedical disposition privileges should be added to the APA/ANPs master privilege list in accordance with DHA-PM 6025.13V4.

         3.3.1.4.5. APA/ANPs will not be assigned to a location without a FS present for oversight and will not be assigned to a SME. **(T-1).**

3.3.1.4.6. APA/ANPs should practice within the scope of their training and privileges and seek physician consultation when appropriate. Any condition that requires a flying waiver for flight safety critical AFSCs needs to be coordinated with a FS (see the Medical Standards Directory on the Knowledge Exchange for a list of flight safety critical AFSCs). Only a FS can issue a medical certificate for flight safety critical AFSC's after an approved waiver. **(T-0).** Flight safety critical AFSC aircrew members are required to have initial and annual medical certification exams accomplished by a FS in accordance with the Code of Federal Regulations, Title14 CFR Part 61, *Certification: Pilots, Flight Instructors, and Ground Instructors*, Title 14 CFR Part 91, *General Operating and Flight Rules*, Title14 CFR Part 141, *Pilot Schools,* and the International Civil Aviation Organization Doc 8984 AN/895, *Manual of Civil Aviation Medicine*. **(T-0).** FSs are required to validate all Standard Threshold Shifts in accordance with Department of Defense Instruction (DoDI) 6055.12, *Hearing Conservation Program (HCP).* **(T-0). Exception:** AFSOC APAs and ANPs working independently in support of SO Command missions may be granted aeromedical disposition privileges when deployed and without reasonable access to a FS preceptor IAW authority delegated by AF/SG. **(T-1).**

3.3.1.4.7. APAs and ANPs may be profiling officers but not the senior profiling officer. Only FSs will be the senior reviewer for all flying waivers and initial flight qualifications in AIMWTS and PEPP. **(T-1).**

3.3.1.4.8. Telehealth technology should be considered for healthcare providers working independently in a deployed or remotely located setting in support of combat or operational missions and without reasonable access to FS preceptors. Telehealth technology may be used as an aid for making aeromedical assessments and aeromedical dispositions. Treating provider must appropriately document medical decision-making of the healthcare team in the medical record. (**T-2).**

3.3.2. Aerospace and Operational Medicine Program and Personnel:

3.3.2.1. Personnel will complete all professional, paraprofessional, and clinical components of flying and SOD exams. **(T-2).** This includes occupational health assessments and/or examinations unless a separate OM Clinic is located at the MTF.

3.3.2.2. Aeromedical providers should plan and schedule operational site visits (shop, food facility, aircrew flight equipment (AFE), etc.) to meet METALS operational requirements.

3.3.2.3. Personnel will track and review aeromedical data from clinics outside of the FOMC (e.g., dental, optometry, mental health (MH), women's health, physical therapy, and any others deemed necessary by the SGP). **(T-2).**

3.3.2.4. MQT FSs are the local clearance authority when determining whether patients are clinically stable and physiologically ready to air transport. **(T-2).** FSs should ensure proposed en-route treatment is appropriate and compatible with flight. Due to differences in the type of evacuation assets used and their effect on the patient's medical condition, the theater validating FS must validate evacuation requests to transport patients via the USAF AE system. **(T-1).**

3.3.2.5. The SGP will develop a local prioritized list of METALS and an annual execution and monitoring plan which must be submitted annually to the MAJCOM/SGP for review (see **Attachment 2** for METALS list). **(T-2).** This plan will ensure all aeromedical providers meet both clinical and non-clinical requirements to include METALS and squadron operational support activities. This plan carries the intent that approximately 50% of the FS's time is spent covering clinical workload and 50% accomplishing METALS and squadron operational support activities. Not all operational support activities exist or are of the same importance at each base due to different mission requirements, this should be reflected in the SGP's annual plan. It is recommended the METALS list is completed as a matrix based on manning levels, e.g., lists with METALS would be planned to be complete if manned at 100%, 75%, 50% or 25% of aeromedical provider manning. This allows everyone from the MAJCOM SGP to the base level aeromedical provider to understand the priority of effort.

3.3.2.6. All aeromedical providers will conduct operational inspections of agencies whose mission is support of aircrew such as: AFE, control tower, alert facilities, radar approach control and parachute units. **(T-3).** These inspections should ensure aeromedical providers are familiar with aircrew support facilities on their installation. They should observe the working environment of DD Form 2992 holders to make better informed aeromedical decisions. The MTF/SGP will determine which agencies require inspection. **(T-3).** The frequency of visits is tailored to mission requirements as determined by the MTF/SGP unless directed by regulation or other instruction.

3.3.2.7. Personnel will provide preventive medicine services to mitigate travel-related health risks in empaneled populations. **(T-3).** ARC aeromedical providers will provide appropriate medical prophylaxis and deployment counseling. **(T-3).** ARC aeromedical providers do not serve as travel medicine consultants except as related to deployments. ANG GMUs in Title 32 USC status do not provide routine medical care.

3.3.2.8. All personnel of the Aerospace and Operational Medicine Program should have access to the KX and should use the website resources to supplement this AFI. (**https://kx.health.mil/kj/kx4/FlightMedicine/Pages/operationalmedhomeapril2012.aspx**)

3.3.3. The FOMWG will:

3.3.3.1. Review weekly (monthly for ARC) the AF Form 1041, *Medical Recommendation for Flying or Special Operations Duty Log*, in Aeromedical Services Information Management System (ASIMS), and recommend action on cases as needed. **(T-2).**

3.3.3.2. Review routinely the AIMWTS or equivalent electronic waiver system workflow data including new waivers, waiver renewals, and waivers requiring interim follow-ups. **(T-2).** Interim evaluations should be performed and tracked by the FOMC or BOMC team or health systems technician for the ANG. The MTF/SGP must request extensions for expiring waivers through the MAJCOM/SGP. **(T-2).**

3.3.3.3. Review all open initial physical examinations. **(T-2).**

3.3.4. Aerospace and Operational Medicine Program personnel are required to attend/chair and provide expertise to the following functions:

3.3.4.1. The DAWG will be conducted in accordance with AFI 48-133.

3.3.4.2. The AMRO will be conducted in accordance with AFI 48-133.

3.3.4.3. Threat working group. The PHEO must be a member of the installation threat working group and should sit on the Emergency Management Working Group in accordance with AFI 10-2519, *Public Health Emergencies and Incidents of Public Health Concern.* **(T-3).**

3.3.4.4. Population Health Working Group (PHWG). The SGP is a member of the PHWG which must be conducted in accordance with AFI 48-103, *Health Promotion* and AFI 44-173, *Population Health*. **Note:** not applicable for the ANG.

3.3.4.5. The OEHWG will be conducted in accordance with AFI 48-145.

3.3.4.6. Installation environment, safety and occupational health council will be conducted in accordance with AFI 90-801 and AFI 48-145.

Chapter 4

READINESS

4.1. Base Operational Medicine Clinic.

4.1.1. The AOME is intentionally and systematically standardizing workflows and management activities in pursuit of a highly reliable system of health and operations. The BOMC is responsible for the execution of the PHA, Initial flying class exam, mental health assessment, deployment related health assessment, occupational exams and medical clearance (overseas, retraining, professional military education, etc.) workflows. The BOMC serves to protect and promote Airmen's health in-garrison and while deployed. Integral to the BOMC is timely and accurate identification and characterization of duty limiting conditions, medical clearances, and fitness for duty throughout the deployment process.

4.1.2. Organization and Functions.

4.1.2.1. The FOMC will provide medical services to all flight and SOD personnel as assigned. **(T-3).**

4.1.2.2. PHA: FOMC clinic staff will follow existing guidance in AFI 44-170. **(T-2).** Required examinations for personnel requiring a DD Form 2992 should be in sync with current PHA and individual medical readiness reporting business rules. FOMC (GMU for ANG) will manage PHAs for those on flying status. **(T-3).**

4.2. IOS.

4.2.1. IOS is an AF/SG focus area and is executed by AFMS personnel delivering medical expertise within operational USAF units/organizations (outside Medical Groups/MTFs, the SG's Office, AFMRA or medical training units). IOS aims to increase the operational effectiveness and readiness, and to protect and enhance the health of Airmen as they execute their mission specific duties. Key objectives include maximizing Airman performance and sustaining Airman capabilities during mentally and/or physically challenging circumstances. Types of IOS include Aeromedical Evacuation, SMEs, SO Medical Elements, OME supporting Cyber and Intelligence/Surveillance/Reconnaissance Units, Education & Training (E&T) Units, Guardian Angel Pararescue Squadrons, Contingency Response Groups, Air Operations Squadrons and Base Operational Support Teams.

4.2.2. IOS involves a wide range of support activities from medical providers involved in the direct provision of clinical services, provision of services by non-privileged medical providers, and services which support performance but do not involve medical services. There are a growing number of roles and locations where IOS function to improve readiness, enhance mission effectiveness, and improve the quality of life for Airmen.

4.2.3. The goal of IOS is to decrease the overall impact to AF personnel from the unique occupational stressors Airmen face. IOS is differentiated from the overall Defense Health Program as IOS is designed to mitigate the impact from military specific operations and address the stressors specific to military occupations. An example of military specific stressors includes the extreme physiologic stress placed on fighter aircrew involved in fighter operations. Another example includes the unique mental health stress involved during in-garrison combat operations experienced by operators of RPA. Although IOS personnel

perform some routine healthcare activities the purpose and need for IOS is to directly support the mission of the AF. This support is directly addressing the challenges due to occupations in support of the AF mission.

4.2.4. A better understanding of the stressors of AF occupations and the development of better prevention and treatment modalities are employed will result in more effective IOS countermeasures.

4.2.5. Funding for IOS originate from different sources. Some services are provided through line operations and maintenance funding (MFP 4 and 11) and some embedded services are provided through medical funding (MFP 8). Provision of clinical medical care can at times be funded through operations and management funding. This occurs when the clinical care is needed as a direct result of a military specific mission. Examples of this include the use of FSs in a SME or embedded (MH) providers in an ISR unit. MAJCOM SG and Air Staff will work together to determine the most appropriate funding process for new embedded support activities.

4.3. IOS Guidance.

4.3.1. IOS operations cover the spectrum from clinical care to readiness support services which do not constitute healthcare. While IOS assets embedded in operational units are removed from traditional MTF oversight, clinical IOS operations must adhere to MTF policies regarding the provision of care. Clinical IOS operations will adhere to all policies regarding the provision of care. **(T-3).**

4.3.2. Process for Adding New/Additional IOS operations. It is necessary to ensure all new embedded support activities, particularly medical support activities, occur in a manner that ensures compliance with all appropriate procedures and guidance. Further for any new medical activities, such additional resources must be entered into service in a manner which ensure the highest degree of quality of care. All new/additional embedded medical services must be proposed to and approved at no lower than the MAJCOM level. For medical services these new services must be approved by the MAJCOM/SG or a designee duly appointed for this function. Proposals for new embedded services must include information on the need the services will fill. It must include a plan for the allocations of positions for the IOS activity and a plan for the working interactions with other support, typically the MTF.

4.3.3. Provision of Care. Only licensed and privileged providers who have completed appropriate MTF in-processing activities will provide medical care. (**T-3).**

4.3.3.1. Regardless of the background and skills of the IOS team member the level of services appropriate for each setting should be determined based on need and the level of services appropriate to the setting. Embedded providers need to be trained on what the scope of their services can be in the embedded unit. Implicit in IOS operations is the understanding that whenever the level of care needed for a particular patient exceeds what is authorized and appropriate for that embedded clinical setting the care of the member will be transitioned to a higher echelon of care.

4.3.3.2. All credentialing and privileging for IOS personnel will be in accordance with DHA-PM 6025.13, volume 4. **(T-0).** All providers must be up to date with regard to privileging actions. **(T-0).** Embedded medical providers will be privileged. **(T-2).**

4.3.3.2.1. Minimally invasive procedures may be performed in the embedded setting (e.g., dry needling, acupuncture, immunizations, etc.) when consistent with local guidance and in compliance with the provider's contract, where applicable. More invasive procedures will not be performed in the embedded setting. This includes (but is not limited to) suturing, local anesthetics, lesion removal or destruction, pap smears, closed reduction of fractures and nail removal.

4.3.3.2.2. Embedded IDMTs will meet all certification, rotational, and medical skills maintenance training required for continued IDMT certification in accordance with AFI 44-103, *The Air Force Independent Duty Medical Technician Program.* **(T-2).** A Memorandum of Agreement should be created and maintained between organizations with embedded IDMTs and the medical group (MDG) to outline the roles and responsibilities of all parties involved.

4.3.3.2.3. All enlisted personnel will function in compliance with CFETPs and will maintain currency on all appropriate trainings. **(T-2).**

4.3.3.2.4. Embedded nursing service personnel will provide care consistent with that provided by the local MTF and will maintain currency on all appropriate training. **(T-2).**

4.3.3.3. Accreditation. Line embedded medical assets described here will follow accreditation in accordance with DHA-PM 6025.13V5. **(T-0).**

4.3.3.4. Clinical Oversight. Day-to-day embedded clinical oversight is delegated to a full-time senior medic (typically active component & line-owned) designated by the chain of command, in coordination with the local MTF SGH and SGP. If the line unit has no medical personnel assigned, appropriate to provide clinical oversight, the line unit will seek assistance from the MTF to determine the most appropriate provider to provide clinical oversight over embedded medical care. **(T-3).**

4.3.3.5. Non-clinical Oversight: The services provided by the non-medical embedded personnel is overseen by the line chain of command. The MTF/CC, SGH, SGP, or other MTF personnel have neither oversight authority nor responsibility for the actions or results of these non-medical embedded services. The line commander may find that embedded medical assets are appropriate for oversight of some non-medical embedded support such as strength and conditioning coaches.

4.3.3.6. Embedded privileged providers should attend Professional Staff and High-Interest (HI) meetings with MH and Aerospace Medicine meetings as appropriate and in accordance with DHA-PM 6025.13. They should also attend other MTF meetings and committees as appropriate to the maximum extent practical. Although embedded providers' duties are separate from MTF clinical activities, embedded providers will be responsible for all applicable Professional Staff content. **(T-3).**

4.3.3.7. Embedded providers will adhere to all guidance applicable to AF providers to include local Medical Staff Bylaws. **(T-2).**

4.3.3.8. In the embedded setting embedded medics will provide clinical services only to military personnel. **(T-2).**

4.3.3.9. Empanelment: All patients will remain empaneled to MTF providers and will not be empaneled to embedded providers. **(T-2).**

4.3.3.10. Embedded providers can receive restricted reports of sexual assault and domestic violence and must handle these in association with Air Force and DoD policy, including, but not limited to, DoDI 6495.02, *Sexual Assault Prevention (SAPR) Program Procedures*. DoDI 6310.09, *Health Care Management for Patients Associated With Sexual Assault* and DoDI 6400.06, *Domestic Abuse Involving DoD Military and Certain Affiliated Personnel*

4.3.3.11. Embedded mental health providers often have conversations with Airmen for a variety of reasons. These conversations include, but not limited to, individual or group education and skills coaching, individual or group problem-solving, and clinical services, such as limited scope counseling. Embedded providers shall ensure that Airmen understand the limits of confidentiality, particularly in education and coaching sessions or when delivering non-clinical services. Only communications made for the purpose of facilitating diagnosis or treatment of a patient's mental or emotional condition are privileged under Military Rule of Evidence 513.

4.3.3.12. Embedded medics are responsible for clinical documentation in the EHR and will document all clinical care performed to include DD Form 2992, AF Form 469, *Duty Limiting Condition Report*, medical quarters reporting, and ASIMS requirements. **(T-3).** Medical management activities, to include care coordination, require documentation in the EHR.

4.3.3.13. Protected health information of Service members may be used and disclosed to appropriate military command authorities for activities deemed necessary to assure the proper execution of the military mission. DoDM 6025.18, *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DoD Health Care Programs,* and AFI 41-200, *Health Insurance Portability and Accountability Act (HIPAA),* further describe how such information is used or disclosed. Only the minimum amount necessary is disclosed, and such disclosures must be accounted for **(T-0).** DoDI 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members,* creates a presumption that a command authority is not notified when a Service member obtains mental health services, substance abuse education services, or both. **(T-0).** Command notification is prohibited unless the presumption is overcome by one of the notification standards listed in Enclosure 2 of DoDI 6490.08. **(T-0).**

4.3.3.14. A new Defense Medical Information System (DMIS) will be created for each base on which embedded medical services are provided. This single DMIS will be used for all embedded clinical services on that base. At locations where the AF is not the lead for the base, the embedded medics should work with the local MTF to have a new DMIS generated. The DMIS for the host MTF will be used until the new DMIS is generated. **(T-3).**

4.3.3.15. Embedded medical personnel must use medical expense and performance reporting system (MEPRS) and DMIS. **(T-3).** Embedded medics will use the MEPRS codes. Although there is no MEPRS workload targets for embedded medics all clinical care is tracked through MEPRS.

4.3.3.16. Infection Prevention and Control activities should be in accordance with DHA-PM 6025.13, volume 2, *Patient Safety*. **(T-0).**

4.3.3.17. Pharmacy: Embedded providers will preferentially use the local MTF pharmacy when open or an AF-approved medication dispensing device (MDD), when available. **(T-3).**

4.3.3.17.1. Only when these sources cannot reasonably meet the needs for an individual prescription will a prescription be written and filled at a civilian pharmacy. The embedded providers will ensure these off-base prescriptions will not include refills. **(T-3).** Embedded personnel will ensure any prescriptions written to be filled off base are appropriately documented in the EHR. **(T-3).** This does not preclude the use of the Tricare Mail Order Pharmacy.

4.3.3.18. Prescription of any medication, to include over-the-counter medicine and supplements, should be documented in the Assessment/Plan module in the EHR. Embedded providers must accomplish medication reconciliation at every clinical encounter. (**T-2).** Embedded medics should follow local MTF procedures for medication reconciliation

4.3.3.19. Embedded medical personnel leadership will ensure HIPAA training is completed for all IOS medical personnel and anyone with authorized access to medical records systems. **(T-3).** Access to medical records systems for other than the provision of health care must be approved by DHA. When the need for access to the medical record system and HIPAA training is not clear, line leadership for the embedded services should work with the MTF SGH and SGP to help determine the correct actions. If there remains a disagreement, the HIPAA Privacy Officer and servicing legal counsel should be consulted. All medical personnel will adhere to all applicable HIPAA policies and guidance. **(T-0).**

4.3.3.20. Operational use of stimulants, sedatives, and nutritional supplements should be in accordance with MAJCOM supplements to this AFI (ACC for CAF and AMC for MAF) and the *Official AF Aerospace Medicine Approval Medication List* on the KX, under Operational/Flight Medicine. (**https://kx.health.mil/kj/kx4/FlightMedicine/Pages/operationalmedhomeapril2012.aspx**) The designated MAJCOM/NGB will coordinate guidance revisions with AF/SG3P. Guidance on the KX remains the primary program resource unless MAJCOM supplemental guidance is approved.

4.3.3.21. Ancillary services: Embedded medical leadership will ensure lab and radiology services needed in conjunction with care provided in the embedded setting are performed at the local MTF or appropriate civilian facility if such services are unavailable at the MTF. **(T-3).**

4.3.4. Scope of Services: Embedded support includes medical care providing office-based, medical and limited scope MH care, as well as spiritual, life skills, and physical support services within designated squadrons, groups, and wings.

4.3.4.1. Immunizations: Immunizations may be performed in the embedded setting by medical personnel but must be in compliance with local guidance regarding training,

storage, quality assurance, documentation, and emergency procedures related to providing immunizations. **(T-3).**

4.3.4.2. Procedures: Embedded providers must hold privileges for procedures they perform. **(T-2).** Procedures beyond what is appropriate for the embedded setting, should be exercised within the MTF.

4.3.4.3. MH:

4.3.4.3.1. Embedded mental healthcare. There is a growing need for embedded mental healthcare. This increased need is due to the unique occupational stressors and barriers to care (e.g., sustained combat engagement, compartmented classification, and shiftwork) involved in deployed-in-place combat operations. The intent is not to replace base MH services but to augment it. Embedded mental healthcare helps develop a better understanding of the MH challenges resulting from the military mission and the complex challenges faced by AF Airmen.

4.3.4.3.2. MH providers embedded in line units may deliver Limited Scope Counseling (LSC). LSC is a capability currently provided only to AD members. Not all IOS programs have this capability. If this capability is within a program's concept of operations, then the scope of care is usually determined by the program. Generally, LSC is limited to low acuity concerns for patients that are low risk. The number and length of sessions may be limited, and the therapeutic techniques are usually limited as well. LSC is a form of healthcare and as such will follow all guidance and procedures in association with local guidance or DHA. **(T-0).**

4.3.4.3.3. The IOS MH Team also provides individual or group educational trainings and skills coaching to unit members. Topics should be relevant to duty performance, resiliency, work-life balance, relationships, sleep hygiene, fatigue prevention, pre-exposure preparation, stress management training and other topics. The team provides consultation to individuals, groups, and leaders regarding methods and options to solve problems in these and other HP areas. Consultation may include "psychological first aid" or emotional support to facilitate decompression and effective problem-solving. Unit members who may need or desire MH, medical, or other services will be educated regarding resources available in the area. **(T-3).**

4.3.4.3.4. When providing clinical services, regardless of the setting, the MH provider will ensure appropriate clinical documentation is entered in the patient's medical record in the EHR. **(T-3).**

4.3.4.3.5. Any embedded MH care will be provided to uniformed members only; no care or counseling with dependents will occur in the embedded setting. **(T-3).**

4.3.4.3.6. The embedded MH provider has a uniquely challenging responsibility to ensure the transition of MH services to the MTF when the level of services or the diagnosis require the care be moved to the MTF MH clinic. Whenever there is uncertainty regarding this decision, care should be transitioned or consideration of transition should be discussed with a senior MH provider and documented appropriately.

4.3.4.3.7. The following services are excluded in the embedded setting, but may be provided by properly trained and privileged embedded MH assets when working in an MTF MH specialty clinic: forensic evaluations; command directed evaluations; sanity boards; MEBs; and independent treatment of patients who should be referred to mandated DoD/AF programs (e.g., Alcohol and Drug Abuse Prevention & Treatment, Family Advocacy).

4.3.4.4. Clinical Emergencies:

4.3.4.4.1. Embedded medics should be trained in basic life support. Contractors should refer to guidance in their contract to determine the requirements for life support training. Line embedded medics will provide basic life support (or higher level care when available) for patient emergencies while seeking patient transport through the 9-1-1 system as appropriate. **(T-3).** All buildings with embedded medical services will have an automated external defibrillator immediately available. **(T-1).** This automated external defibrillator will be part of the base public access defibrillation program. **(T-1).** This level of response may be different from the level of emergency response at the local MTF.

4.3.4.4.2. Management of Patients in Crisis (during duty and after-duty hours). Per AFI 44-172, *Mental Health*, if emergency evaluations cannot be delivered by close of normal business hours, arrangements should be made for the patient to be seen at an emergency medical facility. In an outpatient setting, MH assessments should be performed during regular duty hours, when both security and other support is available. The MTF emergency department, when available, is the safest and most appropriate venue for conducting after-hours emergency mental health assessment, including suicide risk assessments. In MTFs without an Emergency Department, these emergencies should be handled in a similar fashion to other acute medical emergencies, using community medical resources.

4.3.4.4.3. Suicidal/Homicidal Patients. Patients who have been assessed as at low risk for suicide/homicide or other safety concerns may be treated by the embedded MH providers within the scope of LSC. Patients at a higher risk should be referred to MH Clinics and managed in accordance with HI procedures. The provider should document the determination as to whether the patient is low risk or high risk.

4.3.4.5. Staffing: Staffing for embedded medics is requested by the MAJCOM/SG and line leadership with input, if required, from the host MTF Commander. Exact composition of the embedded clinical functions will vary based on unit and mission.

4.3.4.6. The scope of healthcare in an embedded setting is often significantly more limited than the scope of an embedded medic's MTF privileges. While embedded medics must abide by any restrictions on scope of care in the unit, they are not restricted from providing unit members care at the MTF consistent with the full range of their privileging, where appropriate.

4.3.4.7. Licensing and maintenance of certifications are the responsibility of the IOS embedded personnel.

4.3.4.8. E&T: Embedded medical leadership will ensure all embedded medical providers will be tracked by the MTF E&T function. **(T-3).** Embedded providers will provide E&T with proof of training currency. **(T-3).**

4.3.4.9. Medical Readiness Training: The comprehensive medical readiness program is described in AFI 41-106, *Medical Readiness Program Management*. All medical readiness training is documented in medical readiness decision support system and unit-level training and reporting application for AD providers. The readiness training is tracked by associating their unit's personnel accounting system code with the MTF within medical readiness decision support system unit-level training and reporting application. Embedded medical provider's medical readiness tasks will be monitored by their line unit. **(T-3).** Each embedded AD member is responsible for ensuring their own Readiness Training currency. The responsible G-series commander is ultimately responsible to ensure readiness requirements are completed.

4.3.5. Biomedical equipment technicians support for medical equipment: Embedded medical equipment used in line units will be maintained by biomedical equipment technicians in the same manner as for equipment in the MTF. **(T-3).**

4.3.6. Types of Embedded Services: The range of services noted below for each type of medic may be further limited by the contract covering the service, local guidance, medical staff bylaws, other policies of the base, MAJCOM, or higher level guidance. The decision to embed medical services is an important and sometimes challenging decision. The unit must weigh the value of using one of their positions to be filled with a medic or other support person. The medical community must weigh the value in using a limited resource to fill a specific need for one unit in which the medic is providing services to a smaller number of patients.

4.3.6.1. MH. Embedded MH providers may include: Clinical Psychologists, Operational Psychologists, and Licensed Clinical Social Worker (LCSW) with support from mental health technicians (4Cs). MH providers functioning in the embedded setting need to be cognizant of the level of care appropriate for that embedded location. The level of services in the embedded setting typically reflects LSC and nonmedical services. Appropriate patient selection for embedded MH care, following the LSC type model and timely referral to the MTF when appropriate, are important to ensure patient and staff safety and whether the provider will be able to maintain clinical proficiency.

4.3.6.1.1. Clinical Psychologists. Clinical psychologists will provide limited scope MH care consistent with their clinical discipline, their privileges as awarded by the MTF, and the guidelines outlined in this chapter. **(T-3).** When providing services within an MTF specialty clinic, clinical psychologists (or LCSW) may provide full spectrum MH care in association with DHA-PM 6025.13, AFI 44-172, and other applicable policies.

4.3.6.1.2. Operational Psychologists: Although much of what Operational Psychologists do falls outside of traditional MH care, they may also provide traditional MH care. Other activities of an operational psychologist are not within the scope of clinical psychology and will consequently not require privileging or medical documentation. These activities may include assessment and selection, performance

enhancement, SERE training/interventions, aircraft mishap investigation, and Military Information Support Operations.

4.3.6.1.3. LCSW will provide limited scope MH care consistent with their clinical discipline, their privileges as awarded by the MTF, and the guidelines outlined in this chapter. **(T-3).** When providing services within an MTF specialty clinic, LCSW may provide full-spectrum MH care in accordance with DHA-PM 6025.13 and AFI 44-172. **(T-0).**

4.3.6.2. Primary Care Providers: There are select groups of Airmen whose specific primary care needs, related to occupational barriers to accessing care and specific occupational medical needs, require embedded primary care providers. These factors include security requirements, difficulty in accessing care due to work schedules, and the need for the provider to understand the specific needs of these operational communities. These providers include FSs, family medicine physicians, general medical officers, PAs, NPs, and others. These providers should work closely with the host MTF to ensure the full range of needed services are available to the unit's members and ensure the medical readiness of the unit members. Embedded primary care providers attend to the primary care needs of their units, mitigate occupational stressors encountered by unit members, and advise unit leadership on medical readiness issues.

4.3.6.3. Physical Therapists (PTs): Patient treatment modalities may include: ice, heat, ultrasound, myofascial manipulation, range of motion and weight training. Other clinical activities may be provided as per the individual PT's privilege list. PTs assigned to line units may function within a line unit and/or within an MTF. PTs provide general musculoskeletal prevention education, which does not require clinical documentation. But, PTs also provide the full scope PT services allowed within an embedded unit. This includes assessment, diagnosis, developing a treatment plan, and carrying out a treatment plan. These clinical activities must follow all of the requirements for the provision of medical care. **(T-3).**

4.3.6.4. Athletic Trainers (ATs) may independently provide prevention services through strength and conditioning and exercise guidance to address musculoskeletal health. However, ATs may not provide clinical services independently; they must perform any clinical services under the direct supervision of a privileged provider, such as a physician or physical therapist. **(T-2).** There should be a credentials verification done of ATs, and there needs to be a close working relationship with the MTF staff to ensure there is clear communication with precepting providers.

4.3.6.5. Strength and Conditioning Coaches (SCCs) are being utilized in several settings to improve performance and help prevent injury. There should be a credentials verification done of SCCs, and there needs to be a close working relationship with the MTF staff to ensure the SCCs do not negatively impact the treatments of physical therapy and other providers.

4.3.6.6. Chaplains are providing an increasing level of embedded support to line units. Chaplains provide a range of services. Chaplains may be integrated into the overall embedded support activities. Also, chaplains should have a close working relationship with embedded medical staff. This will ensure communications and information sharing

occurs within the confines of the privileged confidentiality of the chaplaincy, applicable mental health privilege, and the protections afforded to health information under HIPAA.

4.3.6.7. Other embedded support personnel: There is a growing understanding of services which may be needed to support line operations. These services should be assessed for the benefit versus the cost. The services should be assessed to ensure appropriate guidance for the embedded support is followed. Embedded medical leadership will ensure all embedded services which are either clinical or border on clinical activates are overseen by the line clinical leadership and must establish appropriate ties to the MTF. **(T-3).**

4.3.7. MTF Responsibilities:

4.3.7.1. Chief of Medical Staff (SGH):

4.3.7.1.1. Clinical Performance Improvement: Clinical Performance Improvement activities include peer review and clinical oversight by the line senior medic. Other Clinical Performance Improvement initiatives may be directed by the senior line medic in consultation with the MTF. Senior embedded medic will track clinical performance improvement activities to completion and report to the MTF. **(T-3).**

4.3.7.1.2. Peer Review:

4.3.7.1.2.1. Embedded medical leadership are responsible to ensure peer review activities are being completed on embedded providers in accordance with DHA-PM 6025.13, volume 1, *General Clinical Quality Management*. **(T-0).** Failure of the embedded medics to ensure completion of quality assurance activities, such as peer review, is elevated to the embedded medical leadership. The optimal embedded peer review program integrates embedded medics into the appropriate MTF clinical area peer review process. The embedded medical leadership should forward monthly peer review results to the local MTF/SGH or SGH designee. This should be arranged by senior embedded medical leadership in consultation with the MTF.

4.3.7.1.2.2. Embedded medical leadership should ensure peer review activities are being completed on embedded nursing personnel in consultation with the MTF/SGN. Failure of the line embedded nursing personnel to ensure completion of quality assurance activities, such as peer review, is elevated to the embedded medical leadership. The optimal peer review program integrates line nursing personnel into the appropriate MTF clinical area peer review process. Embedded medical leadership should forward peer review results to the MTF/SGN or SGN designee. This should be arranged by senior embedded medical leadership in consultation with the MTF.

4.3.7.1.3. The embedded medical leadership should work with the MTF/SGH to ensure Patient Safety Reporting (PSR) is available to embedded providers. MTF Patient Safety assists with PSR training, reporting, and tracking, and may also assist with other patient safety initiatives for embedded medics.

4.3.7.2. Risk Management: The embedded medical leadership should work with the local Healthcare Risk Manager (RM), in consultation with the SGH, in providing a review of

embedded clinical activities. The RM should be encouraged to submit a report of findings to the senior line medic and the MTF/SGH. The RM reviews should take place within three months of the initiation of provision of care at the line location and annually thereafter in consultation with the MTF/SGH. RM reviews and Ambulatory Care Unit (ACU) senior FS responses to findings should be forwarded to the SGH, and the embedded clinical leadership.

4.3.8. Line Embedded Clinical Leadership:

4.3.8.1. The senior embedded medic will work with the local MTF to ensure compliance with the intent for embedded providers to attend Professional Staff and other appropriate MTF functions. **(T-3).** The senior embedded medic will ensure that the MTF has an active list of embedded providers. **(T-3).**

4.3.8.2. The senior embedded medic should work with embedded medical personnel to determine a list of computers and the primary users of these computers, which will require EHR access. The intent is to balance access for users against the expense and risk inherent with excessive installation of the EHR. The senior embedded medic should forward the access requests to the individual designated by the local MTF for action regarding EHR access.

4.4. Range of IOS: below is a summary of line integrated services but is not all inclusive.

4.4.1. SME Operations.

4.4.1.1. The SME is a line funded medical support team package, comprised of a FS and one or two medical technicians, assigned or attached to a qualifying aviation unit. The SME is integrated into MTF FOMC operations, while in-garrison is available for deployment/exercise to the line commander. The SME is an advisor to the unit commander to optimize health, performance, and resilience.

4.4.1.2. A qualifying unit includes all aviation units with a deployment unit type code. Other selected aviation units are subject to MAJCOM SGP and AFMRA/SG3P validation.

4.4.1.3. SMEs provide limited outpatient care, clinical care, emergency medical care (trauma and cardiac stabilization), aerospace medicine support, and In-Flight Emergency (IFE) coverage to deployed flying units in a myriad of operations. SMEs collect, assess, and provide medical intelligence information. They recommend strategies to the deployed commander to reduce and/or prevent aerospace, occupational, environmental, and PH risk factors from having a detrimental impact on mission effectiveness.

4.4.1.4. SME composition is determined by the unit manpower document.

4.4.1.5. SME FSs hold the AFSC 48XX and are certified as medically qualified/acceptable for Flying Class II duties. FSs holding categorical waivers must be medically acceptable for the restricted assigned mission design series airframe. **(T-2).** FSs must also be medically qualified for worldwide duty. **(T-2).** FSs who have not completed MQT upgrade training and verified by the MAJCOM/SGP will not deploy. **(T-2).**

4.4.1.6. SME enlisted composition (4NOX1F, 4NOX1C) should meet training requirements prior to SME assignment. At a minimum, the SME FS will ensure enlisted SME attend the in-residence Flight and Operational Medicine Technician Course. **(T-2).**

4.4.1.7. ARC: SME billets should only be filled by FSs who are fully qualified for deployment. Line leadership will ensure physicians who have not completed all AMP increments and been awarded 48X1 AFSC will NOT be placed in SME billets. **(T-2).** If MQT and upgrade to 48X3 has not been completed, the MTF SGP will ensure a written plan is completed detailing timely accomplishment. **(T-2).** The MTF SGP will present the written plan to ARC/SGP for approval. **(T-2).**

4.4.1.8. SME enlisted composition (4NOX1F, 4NOX1C) will be deferred to MAJCOM SGP, MAJCOM 4N functional manager and Wings (OG, SGP) to determine appropriate SME package. This will be based on specific unit mission, subject to a validation process involving AF/SG consultants and Career Field Managers (CFM) in coordination with stakeholders. SME medical technicians must be medically qualified for worldwide duty. **(T-2).**

4.4.1.9. AFMRA SG3P and MAJCOMs (SGP, manpower and equipment force packaging planners, and A3) will work together to develop validation for existing and future SME composition and positions.   This will be validated with AF/A3, MAJCOM/SG and Wing CC. Validation will take into consideration each units current deployment rate, future projected deployment frequency, duration of deployments, deployment locations, and mission capabilities.

4.4.1.10. Performance Reporting for SMEs.

4.4.1.10.1. The reporting official for the SME FS will be the operational squadron commander. **(T-3).** An SME FS's officer performance reports will flow up the operational review chain. If MTF (RMU/GMU) and line commanders concur, the rater can be the immediate MTF (RMU/GMU) supervisor. The OPR would return to the line chain for first and second level review/endorsement. The MTF SGP/SGH will review draft officer performance reports for content and provide career progression feedback to the line commander. **(T-3).**

4.4.1.10.2. The reporting official of enlisted SMEs will be the senior SME technician and/or SME FS. **(T-3).** An SME technician's Enlisted Performance Report flows up the operational chain for review/endorsement. The MTF 4N0 functional manager must review draft enlisted performance reports for content and provide career progression feedback to the line commander/superintendent. **(T-3).** Enlisted performance reports reflect the technician's duty performance supporting the line unit, AOME, and duties within the MTF (RMU/GMU). The MTF SGP, Operational Medical Readiness Squadron/CC, Aerospace Medicine/CC, or equivalent is responsible for ensuring the above process occurs.

4.4.1.11. MAJCOM SGPs will be familiar with all SME deployment taskings. **(T-2).** This will provide awareness of current deployed medical assets and determination of the need for SMEs at the deployed location.

4.4.1.12. In-Garrison Operations.

4.4.1.13. SME personnel must be fully integrated with the MTF (RMU/GMU) and work under clinical supervision of the SGP. **(T-2).** SGPs should coordinate with line commanders to ensure that sufficient time is spent covering MTF responsibilities which include clinical workload (initial flying class exams, waivers, initial review in lieu of (IRILO), MEBs, PHAs, etc.), METALS, and squadron operational support activities. **Note:** MAJCOM SGPs can intervene and modify time requirements for specific subsets to meet operational needs.

4.4.1.14. SME providers will maintain credentials with the MTF (RMU/GMU) and perform duties within the MTF (RMU/GMU) sufficient to warrant award and maintenance of privileges. **(T-2).**

4.4.1.15. Deployed SME Operations. SMEs deployed to locations with a fixed MTF must identify themselves to the MTF commander (or equivalent) or SGP (Chief of Aerospace Medicine). **(T-3).** Clear lines of communication should be established and support requirements for SMEs identified. SMEs using fixed MTF services (pharmacy, lab, or other services) will be required to submit a credentials transfer brief and complete other administrative procedures in accordance with DHA-PM 6025.13V4. **(T-0).**

4.4.2. OME.

4.4.2.1. Background: New and emerging technologies and the classified nature of some operations create work domains with unique HP challenges. The communities of RPA, ISR, and others have experienced high workload demands with barriers to medical services and opportunities for HP enhancement which ultimately affect readiness. The OME consists of specially trained medical and MH personnel with the needed security clearance who provide augmented medical, mental, and occupational health support to certain operations.

4.4.2.2. One goal of the OME is to identify medical concerns of operators early in order to intervene at a level before symptoms become clinically significant.

4.4.2.2.1. OME at non-AF locations: Some AF embedded assets are located on non-AF installations or in data-masked environments. At these locations the lead medic at the squadron, wing, numbered AF, or MAJCOM/SG(P) should work with the MTF in support of OME activities.

4.4.2.2.2. OME personnel typically do not deploy in support of the unit, but may in some circumstances. Embedded medical and MH personnel will perform duties within the MTF sufficient to warrant award and maintenance of privileges. **(T-3).** Personnel will build and maintain knowledge and relationships with MTF providers and services for coordination of care. Other duties will include interacting with assigned operator personnel, performing health assessments and advising line commanders. Other duties include designing and implementing organizational interventions to improve the organization's overall readiness. ARC/OME must be in an active Title-10 status to take part in the provision of care. **(T-1).**

4.4.3. Special Operations Embedded Support. For many years, Special Operations Forces (SOF) have utilized embedded medical assets to work in close proximity to the warriors. Due to high operations tempo and unique physical and emotional stressors, Special Operations Command established an initiative called Preservation of the Force and Family

(POTFF).   The course of action guided by the POTFF initiative is an expansion of the embedded medical assets as well as the creation of several new non-privileged, non-medical positions.   These positions assist the SOF in managing the stressors particular to their profession.

4.4.3.1. Structure of SOF Embedded Medical Assets:

4.4.3.2. ACU: ACUs, AFSOC's embedded clinical activities, are located in Special Operation Squadron (SOS) and Special Tactics Squadrons.   The types of providers assigned to each ACU vary based on need.   The intent of the ACU is to provide resiliency resources in the form of medical and mental healthcare to SOF where the operators are located.

4.4.3.3. Special Operations Forces Medical Element (SOFME):   SOFME is an element of the Operational Support Medical (OSM) and functions to support the SOS.   SOFME personnel provide aerospace medicine, primary care, and preventive medicine for AFSOC personnel in deployed and in-garrison environments.   SOFME medics may also provide care in ACUs while in-garrison.   POTFF assets in this situation are part of the ACUs and are members of the SOS but are not part of the OSM.   Therefore the OSM providers, functioning in the SOS ACU, will have operational control over the POTFF ACU providers but not administrative control. **(T-2).**

4.4.3.4. Special Tactics (ST) ACU: ST ACUs are designed to provide in-garrison embedded medical care to SOF ST units.   ST ACU assets are funded from Defense Health Program sources and non-DHP sources (through POTFF/Major Force Program, 11).   The Special Tactics Squadron has administrative and operational control for all ST ACU providers.

4.4.3.5. Clinical leadership for AFSOC embedded support is provided by the senior physician overseeing the embedded operations.   The senior physician may be at the squadron, group, or wing level.

4.4.3.6. AFSOC Embedded Guidance: AFSOC/SG has developed guidance in support of AFSOC embedded medical assets with the coordination of AF/SG3. (AFSOCI 48-1010, *Aeromedical Special Operations*)

4.4.3.7. The local AFSOC Line Commander should supply space suitable for embedded operations.

Chapter 5

MEDICAL STANDARDS AND SPECIAL POPULATIONS

5.1. PRAP.

5.1.1. The PRAP is governed by DoDM 5210.42_AFMAN 13-501 and AFI 31-117.

5.1.2. PRAP medical staffing will be in accordance with the current established AFMS manpower standard.

5.1.3. PRAP medical support staff should be assigned for a minimum of 24 months in the PRAP clinic to obtain proficiency. The SQ/CC shall coordinate with the Lead Competent Medical Authority (CMA) and the functional manager prior to the premature removal of PRAP medical support staff. **(T-3).**

5.1.4. The MTF (RMU/GMU) will provide CMA contact information to units with PRAP personnel and to the wing command post. **(T-3).**

5.1.5. All active PRP recommendations by the CMA at the MTF should be made in accordance with DoDM 5210.42_AFMAN 13-501. The PRP module in ASIMS should be used to document PRP notifications to the certifying officer.

5.1.6. All active Security Forces personnel (DAFSC 31P or 3P0) "Do Not Arm" recommendations by the provider at the MTF should be made in accordance with AFI 31-117. The Arming and Use of Force module in ASIMS should be used to document these recommendations. In addition, AF Form 469 is used to document the duty restriction "Do Not Arm" recommendation to the line Commander in accordance with AFI 48-133.

5.2. Training Requirements.

5.2.1. All medical staff that directly support the PRAP will accomplish AF standardized training in accordance with DoD 5210.42_AFMAN 13-501. **(T-1).**

5.2.2. The Lead CMA will ensure that all designated medical personnel are trained to their appropriate level as directed by the AF/A10 PRAP training matrix which can be found on the Air Force Portal. **(T-1).**

5.2.3. The Lead CMA, alternate Lead CMA, and MTF (RMU/GMU) PRAP monitor will attend the USAFSAM Medical PRAP Course for certification within six months of being assigned to the position. **(T-1).** IDMTs assigned to a munitions support squadron will also attend the USAFSAM Medical PRAP Course. **(T-1).** This training is required prior to permanent change of station for members going to outside contiguous United States locations. The requirement for training before permanent change of station may be waived by the MAJCOM/SGP, but the member will still require this training within 6 months of assignment to duty supporting PRAP. **(T-2).** The lead provider at the MTF managing the Arming and Use of Force program will also attend the one-time USAFSAM Medical PRAP Course within six months of being assigned to the position. **(T-2).** The lead provider for the Arming and Use of Force program will train other providers and medical personnel that treat security force members under the PRAP program. **(T-2).**

Chapter 6

HP OPERATIONS

6.1. Objectives and Desired Effects. HP operations focuses on the service member's physical, mental, and emotional health to achieve the best performance over time. It provides a combination of approaches and techniques to help airmen optimize their performance. It helps them carry out their duties safely and effectively with the goal of reducing injury rate, improving health, enhancing performance and increasing operational readiness. Flight medicine providers and AOPT personnel work together in evaluating and sustaining baseline HP for all flyers and SOD personnel.

6.2. USAF Comprehensive Fatigue Management Program.

6.2.1. Fatigue and drowsiness are common to all humans and can only be eliminated by restorative sleep. Sleep may be affected by personal or work schedules that conflict with circadian rhythms or environmental conditions. Sleep is affected by light, noise, ingestion of caffeine, tobacco, alcohol, medications, or the timing of meals, naps, and exercise. Reduced sleep can decrease reaction time and vigilance, create cognitive distortions, and ultimately degrade performance. The AOME endorses a comprehensive fatigue prevention and control program that contains 6 essential elements which are required for an effective program. 1) Management Leadership, 2) Employee Involvement, 3) Hazard Identification and Assessment, 4) Hazard Prevention and Control, 5) Personnel Training, and 6) Measurement of Effectiveness.

6.2.2. Aeromedical providers and AOPT personnel should be familiar with AFMAN 11-202V3, *Flight Operations,* Chapter 3, General Flight Rules. In addition, several platforms have guidance in V3 of their respective AFI or AFMAN 11-2 series operational procedures which can be found in Air Force e-publishing.

6.2.3. Education of workers and supervisors is a critical component of fatigue management. Unit supervisors and employees participating in the program should receive standardized training from the local MTF on the following topics:

6.2.3.1. Normal sleep to include sleep cycles, cues for sleep, and the importance of REM sleep.

6.2.3.2. Abnormal sleep effects including the demonstration of the impairment equivalency between fatigue and alcohol and other medical conditions associated with fatigue.

6.2.3.3. Sleep hygiene and the importance of adequate sleep.

6.2.3.4. Supervisory fatigue management such as how to perform a risk assessment, use of sleep, activity, fatigue and task effectiveness fatigue avoidance scheduling tool (SAFTE FAST), and identification and disposition of the fatigued worker.

6.2.4. AOPT and aeromedical providers can provide training to participating units on SAFTE FAST. SAFTE FAST is a web-based fatigue modeling system that can integrate with any scheduling system for proactive and reactive analysis of fatigue. It can provide efficient modeling of aircrew fatigue at every stage in the schedule planning and execution

process. This program can be used to mitigate risk by avoiding excessive fatigue in future planning. Each MAJCOM and AFMRA has an administrator that can sign up individuals for an account.

6.2.5. Aeromedical providers and/or AOPT personnel should be involved in mission planning on missions and operations where fatigue is likely to be a factor.

6.2.6. Program effectiveness should be measured by the unit and reported to the local SGP in terms of reduction in mission cancellation, degradation, or errors.

6.2.7. Fatigue Countermeasure Medications. Pharmacologic interventions are authorized but intended to be a last resort when all other measures have been exhausted.

6.2.7.1. Approved fatigue countermeasure medications (Go and No-Go Pills). AFMRA/SG3P will publish the list of authorized stimulants (Go pills) and sedatives (No-Go pills) that have proven to be effective and have the least risk with their use. They will be used to mitigate fatigue and used in accordance with the Official Air Force Aerospace Medicine Approved Medications List. This does not constitute approval to use these medications without prior authorization from the MAJCOM/NGB (or higher) AND approval from the local SGP and Wing/CC (or equivalent).

6.2.7.2. MAJCOM Specific Guidance. Per AFMAN 11-202V3, MAJCOMs/NGB will develop guidance on the use of fatigue countermeasure medications, specifically situations, exercises and contingencies where "Go Pills" could be authorized. This guidance will list situations where "Go Pills" could be authorized for use, but will still need local approval. All tenant units will follow guidance of the host MAJCOM. **(T-2).**

6.2.7.3. Operational use of stimulants (Go Pills) and sedatives (No-Go Pills) are in accordance with MAJCOM supplements to this manual (ACC for CAF, AMC for MAF and AFSOC/CV guidance letter for SW Airmen) and the Official AF Aerospace Medicine Approved Aircrew Medications list. The designated MAJCOMs will coordinate supplement development and revisions with AF/SG3P. Caution: There is potential for Airmen using Go and No-Go Pills to become dependent on their use to the exclusion of all other non-pharmacological interventions. Aeromedical providers must clinically supervise the use of any Go and No-Go medications and exercise careful judgment before dispensing. **(T-3).** They are not intended to be a solution to manning shortages or to support a lifestyle of poor sleep habits or inappropriate prioritization of work and play activities.

6.2.7.4. Local Approval. If AF policy and MAJCOM guidance allow the use of "Go Pills" for a given situation, then the local Wing/CC or equivalent can make an operational risk management decision about whether to authorize their use. The local authority should consult with the SGP to ensure other risk mitigation strategies have been considered.

6.2.7.5. Flight Medicine will establish a program to ground test, dispense, and control pharmacological agents for fatigue management in accordance with AFI 48-123, AFMAN 11-202V3, and current AF policy. **(T-2). Note:** For ARC: Written plans should address the security, storage and distribution of controlled substances in accordance with AFMAN 41-209, *Medical Logistics Support.* Contact MAJCOM/SGP for further guidance.

6.2.7.6. The SGP advises the Wing or deployed commander (Go Pill approval authority), regarding the medical utility of using Go Pills for a particular mission or mission set. The aeromedical provider and operational squadron leadership should emphasize utilization of appropriate non-pharmacological fatigue preventions strategies and operational countermeasures prior to SGP concurring with operational Go-Pill use.

6.2.7.7. Eligibility for the operational use of pharmacologic sedatives (No-Go) requires appropriate ground testing and approval of the local aeromedical provider. Aircrew will declare themselves DNIF after use of sedative for the specified time as annotated in the Official AF Aerospace Medicine Approved Aircrew Medications list and as instructed by the aeromedical provider. **(T-1).** (see **Figure A2.1**: Operational Medication Request form example)

6.2.7.8. Go and No-Go pill ground testing and operational use is voluntary. The aeromedical provider offers ground testing for Go and No-Go pills to select eligible aircrew prior to use in an operational setting. Documentation of successful ground testing or deferral is entered in the medical record of eligible aircrew. All aircrew are DNIF while ground testing both Go and No-Go pills.

6.2.7.9. Aeromedical providers provide eligible aircrew counseling regarding off label use of Go Pills as an operational countermeasure, and obtain informed consent as required prior to prescribing them in accordance with DoDI 6200.02, *Application of Food and Drug Administration (FDA) Rules to Department of Defense Force Health Protection Programs.* **(T-0).** ANPs and APAs will prescribe controlled substances in accordance with their state licensing organization. **(T-0).** Informed consent is required only once for each Go Pill medication and dosage and the aeromedical provider must ensure it is documented in the Airman's medical record. **(T-3).** **Note***:* References and tools to provide this counseling can be found at the "Go Pills" link on the KX under Operational   &   Flight   Medicine (**https://kx.health.mil/kj/kx4/FlightMedicine/Pages/operationalmedhomeapril2012.aspx**). The local SGP will report operational use of Go Pills including adverse reactions during operational use to MAJCOM/SGP (home station MAJCOM if deployed). **(T-2).** A sample format to accomplish this can be found on the "Go Pills" link at the KX.

6.2.7.10. Aeromedical providers and other healthcare providers transporting controlled substances on temporary duty or deployment.

6.2.7.10.1. Aeromedical providers and other healthcare providers may transport controlled substances issued by the MTF pharmacy in the context of operational support to line units (e.g., SME FS and GO pills) in coordination with DHA guidance. Such providers should only transport controlled substances on temporary duty or deployment when pharmacist or pharmacy technician is not traveling or deploying.

6.2.7.10.2. When transporting controlled substances, the aeromedical providers or other healthcare provider will:

6.2.7.10.2.1. Be issued an AF Form 579, *Controlled Substances Register*, by the local MTF pharmacy. **(T-3).**

6.2.7.10.2.2. Possess a signed memo by the MTF SGP authorizing transport of controlled substances. **(T-3).** This memo should address the qualification of the

aerospace medicine provider or other healthcare provider; rationale for transporting controlled substances; validation that controlled substances were issued by the local MTF pharmacy and documented on the AF Form 579; any limitation on dispensing controlled substances; and a MTF POC.

6.2.7.10.2.3. Possess copies of individual medical license and DoD drug enforcement administration certificate. **(T-3).**

6.3. Aircrew chemoprophylaxis testing. Chemoprophylaxis is the use of drugs to prevent disease. Antimalarial medication chemoprophylaxis is often taken when deployed to an area where there is a malaria risk. Operational medicine personnel should offer rated and career enlisted aircrew ground testing with operationally required prophylactic medications per the Official AF Aerospace Medicine Approved Medications List. This will occur under the supervision of an aeromedical provider. Ideally this will be accomplished prior to the aircrew completing initial training or as mission requires. Results of medication testing (whether cleared for operational use or not) or a member's refusal to test, will be documented in ASIMS by the FOMC team. **(T-3).**

6.4. Night Vision Device (NVD) Support Program.

6.4.1. AFMAN 11-202V1, *Aircrew Training*, defines AF-wide training requirements for use of NVDs. AOP officers must become certified NVD instructors as part of the training team and assist in initial and refresher training. **(T-3).** Aeromedical providers, AOP technicians, optometrists and ophthalmologists may become certified NVD instructors. Weapons-specific training and operational requirements are in accordance with applicable AFI or AFMAN 11-2 series.

6.4.2. Aeromedical providers and/or AOPT personnel should be knowledgeable on basic visual issues (e.g., contrast, ambient lighting, color vision, etc.), and work with local aircrew flight equipment technicians and aircrew on laser eye protection, high contrast visor, ballistic eye protection, and aircrew spectacle equipment optimizing performance of war fighters. This will be in accordance with MAJCOM and local mission requirements that is outlined annually using the local prioritized list of METALS and execution plan per **paragraph 3.3.2.7**

6.5. G-Awareness Continuation Training.

6.5.1. Aeromedical providers and AOP officers who support high G aircraft must have adequate training (to include centrifuge qualification in accordance with AFMAN 11-404, *Fighter Aircrew Acceleration Training Program*) and be familiar with G-awareness continuation training requirements. **(T-3).** Units who support sustained high G aircraft should reference AFMAN 11-202V1 for anti-G straining maneuver requirements, to include heads-up display (HUD) reviews. They should work with flying squadron leadership for execution of G-awareness training.

6.5.2. AFMAN 11-404 describes the initial qualification, refresher centrifuge training requirements, and guidance and procedures for handling aircrew that do not satisfactorily complete this training program.

6.6. SW HP Support.

6.6.1. HP support is essential to building and maintaining the Special Warfare (SW) Airman as required by AFPD 10-35, *Battlefield Airmen*. HP support should ideally be available throughout all phases of an operator's career.

6.6.1.1. The HP Enhancement enables special operators to go beyond currently achievable and sustainable performance thresholds. It may be accomplished through science and technology initiatives that range across the spectrum from intra-human (e.g., biotechnology, cognitive, refueling, pharmacologic, physiologic monitoring) to extra-human (e.g., hardware, software, artificial intelligence, cloaking, body armor).

6.6.1.2. HP Optimization in special warfare hinges on the special operator being able to successfully execute skillsets and tactics and meet the physical demands of sustained operations in both overt and covert operations to mission completion and success.

6.6.2. The Special Warfare or Operations Wing SG will serve as the lead for clinical guidelines and Wing policies for human performance and POTFF related matters. **(T-3).**

6.6.3. The supporting MTF commanders are responsible for credentialing, medical documentation, IT support and professional oversight functions for SWTW, AFSOC, or Special Operations Command line owned and contracted medical and HP licensed providers. This authority may be delegated to supporting MTF SGH or equivalent.

6.7. Medical Support for Jump Operations. Reference AFI 11-410, *Personnel Parachute Operations*, for medical requirements in support of jump operations.

Chapter 7

OCCUPATIONAL AND ENVIRONMENTAL HEALTH

7.1. Operational Environmental Health operations: OEH operations protect AF personnel (RegAF, ARC, and civilian employees) from inherent health hazards associated with AF industrial activities. OEH promotes a healthy, fit work force to enhance performance of mission essential functions. OEH operations should comply with applicable federal, state, and local laws and requirements.

7.2. Organization and Functions: OEH is executed in accordance with AFI 48-145, AFI 48-127, *Occupational Noise and Hearing Conservation Program,* and AFMAN 48-146, *Occupational and Environmental Health Program Management*.

7.2.1. FOMC personnel will brief the MTF Professional Staff annually at a minimum on local installation industrial health hazards. **(T-3).** This requirement is not applicable to the ARC.

7.2.2. Laser accidents and incidents.

7.2.2.1. FOMC personnel should provide medical evaluation and aeromedical disposition following suspected ocular directed energy exposure. Personnel should be familiar with the AF Research Lab and USAFSAM Laser Injury Guidebook located on the AFMS KX (**https://kx.health.mil/kj/kx4/FlightMedicine/Pages/operationalmedhomeapril2012.aspx**) Installation Laser Safety Officer must coordinate all suspected ocular directed energy exposures and report such exposures using the DoD Tri-Service Laser Injury Hotline at 1-800-473-3549, (937) 938-3764, or DSN 798-3764. **(T-2).**

7.2.2.2. Aircrew with symptoms should be placed on DNIF and referred to an eye specialist.

7.2.2.3. Confirmed ocular directed energy exposures must be reported as a Class E physiologic event as a minimum by the aeromedical provider. **(T-3).** AFI 91-204, *Safety Investigations and Hazard Reporting,* should be referenced as a higher reporting class may be required.

7.2.2.4. Operational medicine personnel must also notify the Installation Laser Safety Officer (LSO), usually the Bioenvironmental Engineer, of any accident or incident involving a suspected laser, broadband or other optical radiation overexposure. **(T-3).** They should notify the Installation LSO of any visible laser illumination that negatively impacts mission operations or a laser exposure causing personal injury to personnel and material damage to AF equipment, systems or sensors. The LSO have a requirement to investigate and document per AFI 48-139, *Laser and Optical Radiation Protection Program.*

7.2.3. Electromagnetic Field (EMF) Accidents and Incidents.

7.2.3.1. Operational Medicine Clinic personnel may provide medical evaluation and aeromedical disposition following suspected EMF overexposure. Personnel should be familiar with the EMF overexposure medical format. Injury and Overexposure Hotline at 1-888-232-3764, commercial (937) 938-3764, or DSN 798-3764. **(T-3)**

7.2.3.2. Personnel operating in high EMF areas who are suspected of being overexposed, or who exhibit symptoms of EMF overexposure such as unexplained heating, burns, heat-related illnesses, etc. should be referred to the nearest medical provider for evaluation.

7.2.3.3. Confirmed EMF overexposures must be reported as a Class E physiologic event as a minimum by the aeromedical provider. **(T-3).** AFI 91-204 should be referenced as a higher reporting class may be required.

7.2.3.4. Operational medicine personnel must also notify Bioenvironmental Engineering of any accident or incident involving a suspected EMF overexposure or active EMF emitters that negatively impact mission operations. **(T-3).** They should also notify Bioenvironmental Engineering of EMF exposures causing personal injury to personnel and material damage to AF equipment, systems or sensors. They have a requirement to investigate and document per AFI 48-109, *Electromagnetic Field Radiation (EMFR) Occupational and Environmental Health Program.*

7.2.4. Custom Hearing Protection. Standard ear impression technique (SEIT) for attenuating custom communication earpiece system (ACCES) and similar devices. **Note:** All logistic support, ordering, receipt, routine maintenance and associated costs for training and materials remain the responsibility of the requesting flying squadron, group, or wing.

7.2.4.1. Operational Medicine is the OPR for oversight of SEIT procedures for the ACCES and similar programs and will appoint a program manager to oversee SEIT if the wing supports such a program. **(T-3).** The program manager will either be an aeromedical provider or an audiologist. **(T-3).**

7.2.4.2. Only individuals who have completed appropriate SEIT training may create SEIT impressions and assess fit and comfort of ACCES or similar devices provided by the manufacturer. In order of preference, the following individuals should perform these duties: Audiologist, Aeromedical Provider, IDMT (4N0X1C, 4N0X1F, or 4E0X1), Nurse, Dentist, or AOP personnel (43A3 or 4M0X1). All personnel except audiologists must complete the manufacturer's SEIT training before performing these duties. **(T-3).**

Chapter 8

COMMUNITY HEALTH PROGRAMS

8.1. Community Health Programs. These programs are managed by public health (PH) and may be clinically executed by all primary care manager teams, but primarily the FOMC. Unless otherwise directed in applicable DoD, DHA, or Air Force policy, follow methods for controlling and preventing disease described in the Centers for Disease Control and Prevention publication, *Morbidity and Mortality Weekly Report*, and supplements.

8.2. Community Health Program Regulating. Community health program activities are regulated in accordance with: AFI 48-110*, Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases*; AFI 48-117, *Public Facility Sanitation;* AFI 48-116, *Food Safety Program*; AFMAN 48-105, *Public Health Surveillance Program* which outlines communicable disease surveillance for prevention and control, sexually transmitted infection, surveillance for prevention and control, latent tuberculosis infection management, and the Animal Bite Program; AFI 44-108, *Infection Prevention and Control Program*; AFI 48-144, *Drinking Water Surveillance Program*; AFMAN 10-246, *Food and Water Protection Program* and AFI 44-178, *Human Immunodeficiency Virus Program* which guides the AF and DHA policies.

Chapter 9

EMERGENCY RESPONSE AND DISASTER MANAGEMENT OPERATIONS

9.1. Organization and Functions. The MTF (RMU/GMU) Medical Contingency Response Plan (MCRP) supports an Installation Emergency Management Plan (IEMP) in accordance with AFI 10-2501, *Emergency Management Program,* and AFMAN 10-2502, *Air Force Incident Management System (AFIMS) Standards and Procedures*. FOMC personnel will be familiar with the MCRP and their roles within the plan. **(T-3). Note***:* Not all ARC units will have their own MCRP, but must be familiar with their role to support their host MCRP.

9.2. Essential Functions. Note: This is not applicable to the ARC.

9.2.1. First Responders. The FOMC will maintain emergency responder capability supporting installation flying operations and coordinate with other available first response capabilities. **(T-3).**

9.2.2. First responders provide initial on-scene command. The most experienced medical responder will coordinate with fire or police commanders or Incident Commander (IC) as the Medical Advisor (MA) and be clearly recognizable. **(T-3).** Further medical personnel arriving on scene should report to the MA for instructions if not previously communicated. The MA should be the most experienced aeromedical provider (usually the most senior) medical person on-scene. The role of the MA should be transferred upon the arrival of a more experienced medical responder depending on the circumstances of the incident and the expertise required.

9.2.3. Transport. FOMCs support airfield operations responding to a variety of IFEs and airfield incidents. Vehicle configuration and response plans should be tailored to the type of aircraft assigned and the spectrum of aircraft that visit the airfield. Installation location, mutual-aid response capability, and proximity to definitive care are factors that should be considered. These parameters form the basis of a risk assessment conducted by the SGP to determine level and adequacy of emergency medical response. Emergency Transport response time should meet the requirements in DoDI 6055.06, *DoD Fire and Emergency Services (F&ES) Program.*

9.2.4. A transport vehicle must be able to transport a minimum of two first responders, one aeromedical provider, and medical equipment supply packs to any crash site within a 10 mile radius of the airfield over rough terrain. **(T-2).**

9.2.5. Medical vehicle drivers responding to IFEs and airfield incidents should have a valid flight line drivers permit and be proficient with flight line driving during both day and night operations in accordance with AFI 13-213, *Airfield Driving*.

9.2.6. First Receivers: Some remote locations require the FOMC to have first receiver capability. This must be staffed with medical personnel, provider at minimum, with ATLS or pre hospital trauma life support qualifications and knowledge of the hospital incident command system. **(T-2).**

9.3. Specialized Response. Note: ARC RMU/GMUs are not treatment facilities. RMU/GMU personnel should immediately direct injured or ill patients who are brought to the RMU/GMU to

the appropriate medical facility for care. Use 911 for transport where appropriate. Staff may provide supportive care only while the individual awaits transportation.

9.3.1. Aeromedical providers provide medical oversight and emergency response to physiological and/or medical incidents resulting from hypoxia (e.g., altitude chamber or reduced oxygen breathing device) and/or centrifuge training as applicable for units with this training mission. During all scheduled training events, a designated aeromedical provider must be able to continuously respond by telephone and get to the training facility in the timeliest manner possible. **(T-3).**

9.3.2. Chemical, Biological, Radiological, Nuclear, Explosive and Hazardous Materials Response. FOMC personnel must have correctly fitting personal protective equipment (PPE) and individual protective equipment appropriate for their specific team responsibility. **(T-3).** Prior to responding, they are required to have experience wearing the equipment while performing their duties. **(T-3).**

9.3.3. Disaster Response. FOMCs should develop relationships and demonstrate familiarity with all disaster response plans. This includes coordination with local emergency services and an understanding of integration with these agencies to support their missions under the IEMP and MCRP. Familiarity with the National Incident Management System (NIMS) methodology is fundamental in coordination with civilian agencies and aligns with AFI 10-2501 and AFMAN 10-2502.

9.3.4. Aircraft Mishap Response. FOMCs should review AFI 91-204 and the Aircraft Mishap portion of the MCRP. This will ensure they are able to execute their responsibilities per IEMP and MCRP. Critical elements include:

9.3.4.1. Initial Response: Includes site safety, treatment of injured, initial collection and preservation of evidence. **Note:** Strongly consider sending an aircrew member who has undergone an ejection seat sequence to a local Emergency Room or Trauma Center despite his/her minimization of injuries.

9.3.4.2. Evidence preservation and collection is directed by the Interim Safety Board (ISB) President, usually a member of Wing Safety. Obtain required toxicology and other relevant tests in accordance with AFI 91-204. Extent of testing depends on the nature of the mishap. Consult SGPs, Armed Forces Medical Examiner System, and the AF Safety Center FSs as needed.

9.3.4.3. Identify an aeromedical provider for the ISB, per base plan. The aeromedical provider's primary duty is based on ISB requirements until released.

9.3.4.4. Sequester associated hardcopy healthcare records (medical, dental, MH) and preserve a certified copy of the EHR until requested by the ISB or follow on safety investigation board.

9.3.4.5. Obtain 72-hour and 14-day histories from each aircrew member involved in the mishap.

9.3.4.6. The FOMC ensures proper aeromedical dispositions are accomplished for mishap personnel on flying or SOD.

9.3.4.7. Notify medical leadership (SGP, SQ/CC, MDG/CC) and MAJCOM/SGP.

9.3.4.8. The MTF/SGP must ensure mishap kits are developed, maintained, and appropriately resourced. **(T-3).** FOMC personnel should train and be familiar with the kit. FOMC personnel must review mishap response plans and inventory the mishap kit every six months at a minimum. **(T-3).** ANG- GMUs will only maintain a training mishap kit to facilitate FOMC personnel training. **(T-3).** Deploying SMEs must ensure there is a mishap kit at their deployed location or they must bring a (non-training) mishap kit with them on the deployment. **(T-3).**

9.3.5. IFEs. Aeromedical providers should be familiar with the management of routine IFEs, especially physiologic incidents. Aeromedical providers must meet aircraft after IFEs with a physiologic incident to identify causes of symptoms and assess and document the need for aircrew examination and/or treatment. **(T-3). Note:** This does not apply to ARC while in-garrison.

9.3.5.1. An aeromedical provider must be available (On-Call) for IFE coverage during scheduled flying hours. **(T-3). Note:** This is not applicable for ARC.

9.3.5.2. Aeromedical providers must respond to IFEs when requested by fire chief, wing safety, and supervisor of flying. **(T-3).** Aeromedical providers should respond where there is a risk for physiologic incident. Examples of physiologic incidents include G induced loss of consciousness, hypoxia, aircrew disorientation, altered mental status, loss of cabin pressure at >18,000 ft., rapid decompression, smoke and fumes, or other physical symptoms or injuries reported by the aircrew. ARC units without local full time aeromedical provider support may need to send the patient for civilian evaluation if there is no aeromedical provider available to evaluate the member. ARC aeromedical providers should be notified if a patient is transferred to a civilian institution for evaluation.

9.4. Training: First responders must be trained and equipped for immediate response to expected hazards and environmental conditions. **(T-3).**

9.5. Undersea & Hyperbaric Medicine.

9.5.1. Brooke Army Medical Center (BAMC) undersea & hyperbaric medicine (UHM) service: shall provide subject matter expertise to the AFMS and regarding the treatment of suspected decompression sickness (DCS) and arterial gas embolism. **(T-3).** BAMC will also provide guidance for other illnesses considered amenable to hyperbaric therapy. **(T-3).** The BAMC UHM service shall be consulted in all cases or suspected cases of DCS or arterial gas embolism if the treating provider is not privileged in the UHM. **(T-3).** The BAMC UHM hyperbaric physician will be consulted as soon as practicable, ideally prior to the initiation of any hyperbaric oxygen therapy. **(T-3).**

9.5.2. BAMC UHM contact information. For emergency referral or consultation (DCS, arterial gas embolism, CO poisoning) current on-call contact information is located on the Knowledge Exchange Hyperbaric Medicine webpage at **https://kx.health.mil/kj/kx2/HyperbaricMedicine**.

                                  DOROTHY A. HOGG
                                  Lieutenant General, USAF, NC
                                  Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

Title 32, U.S.C, *National Guard*

14 CFR 61, *Certification: Pilots, Flight Instructors, and Ground Instructors*

14 CFR Part 91, *General Operating and Flight Rules*

14 CFR Part 141, *Pilot Schools*

DoDI 6055.06, *DoD Fire and Emergency Services (F&ES) Program*, 3 October 2019

DoDI 6055.12, *Hearing Conservation Program (HCP)*, 14 August 2019

DoDI 6200.02, *Application of Food and Drug Administration (FDA) Rules to Department of Defense Force Health Protection Programs,* 27 February 2008

DoDI 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*, 17 August 2011

DoDM 5210.42_AFMAN 13-501, *Nuclear Weapons Personnel Reliability Program (PRP),* 19 September 2018

DoDM 6025.18, *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs*, 13 March 2019

AFPD 10-35, *Battlefield Airmen*, 5 June 2017

AFPD 11-4, *Aviation Service,* 12 April 2019

AFPD 48-1, *Aerospace & Operational Medicine Enterprise (AOME),* 7 June 2019

AFI 10-2501, *Emergency Management Program,* 10 March 2020

AFI 10-2519, *Public Health Emergencies and Incidents of Public Health Concern*, 10 December 2019

AFI 11-410, *Personnel Parachute Operations,* 4 August 2008

AFI 13-213, *Airfield Driving*, 4 February 2020

AFI 16-1301, *Survival, Evasion, Resistance, and Escape (SERE) Program,* 3 August 2017

AFI 31-117, *Arming And Use of Force by Air Force Personnel*, 2 February 2016

AFI 33-322, *Records Management and Information Governance Program,* 23 March 2020

DAFI 33-360, *Publications and Forms Management*, 1 December 2015

AFI 41-106, *Medical Readiness Program Management*, 9 June 2017

AFI 41-200, *Health Insurance Portability and Accountability Act (HIPAA)*, 25 July 2017

AFI 44-103, *The Air Force Independent Duty Medical Technician Program*, 30 August 2018

AFI 44-108, *Infection Prevention and Control Program*, 5 June 2019

AFI 44-119, *Medical Quality Operations,* 16 August 2011

AFI 44-170, *Preventive Health Assessment*, 30 January 2014

AFI 44-172, *Mental Health*, 13 November 2015

AFI 44-173, *Population Health*, 10 January 2019

AFI 44-178, *Human Immunodeficiency Virus Program*, 4 March 2014

AFI 48-101, *Aerospace Medicine Enterprise*, 8 December 2014

AFI 48-110, *Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases,* 7 October 2013

AFI 48-122, *Deployment Health,* 18 August 2014

AFI 48-123, *Medical Examinations and Standards,* 5 November 2013

AFI 48-133, *Duty Limiting Conditions,* 7 August 2020

AFI 48-145, *Occupational and Environmental Health Program,* 11 July 2018

AFI 48-103, *Health Promotion*, 21 June 2019

AFI 48-109, *Electromagnetic Field Radiation (EMFR) Occupational and Environmental Health Program*, 1 August 2014

AFI 48-116, *Food Safety Program,* 11 September 2018

AFI 48-117, *Public Facility Sanitation,* 11 September 2018

AFI 48-127, *Occupational Noise and Hearing Conservation Program,* 26 February 2016

AFI 48-139, *Laser and Optical Radiation Protection Program*, 30 September 2014

AFI 48-144, *Drinking Water Surveillance Program*, 21 October 2014

AFI 90-801, *Environment, Safety, and Occupational Health Councils*, 9 January 2020

AFI 91-204, *Safety Investigations and Hazard Reporting,* 27 April 2018

AFMAN 10-246, *Food and Water Protection Program*, 18 May 2020

AFMAN 10-2502, *Air Force Incident Management System (AFIMS) Standards and Procedures*, 13 September 2018

AFMAN 11-202V1, *Aircrew Training,* 27 September 2019

AFMAN 11-202V3, *General Flight Rules*, 10 June 2020

AFMAN 11-402, *Aviation and Parachutist Service*, 24 January 2019

AFMAN 11-404, *Fighter Aircrew Acceleration Training Program*, 27 November 2019

AFMAN 41-209, *Medical Logistics Support,* 4 January 2019

AFMAN 48-105, *Public Health Surveillance Program,* 26 June 2020

AFMAN 48-146, *Occupational and Environmental Health Program Management*, 15 October 2018

DHA-PI 6025.11, *Processes and Standards for Primary Care Empanelment and Capacity in Medical Treatment Facilities (MTFs)*, 9 October 2018

DHA-PM 6025.13, *Clinical Quality Management in the Military Health System,* 29 Aug 2019

V1: *General Clinical Quality Management*

V2: *Patient Safety*

V3: *Healthcare Risk Management*

V4: *Credentialing and Privileging*

V5: *Accreditation and Compliance*

AFSOCI 48-1010, *Aeromedical Special Operations*, 8 March 2016

International Civil Aviation Organization Doc 8984 AN/895, *Manual of Civil Aviation Medicine,* Third Edition - 2012

Adopted Forms

DD Form 2992, *Medical Recommendation for Flying or Special Operational Duty*

AF Form 469, *Duty Limiting Condition Report*

AF Form 579, *Controlled Substances Register*

AF Form 847, *Recommendation for Change of Publication*

AF Form 1041, *Medical Recommendation for Flying or Special Operational Duty Log*

AF Form 3899, *Aeromedical Evacuation Patient Record*

Abbreviations and Acronyms

ACC—Air Combat Command

ACCES—Attenuating Custom Communication Earpiece System

ACU—Ambulatory Care Unit

AD—Active Duty

AF—Air Force

AFE—Aircrew Flight Equipment

AFI—Air Force Instruction

AFMAN—Air Force Manual

AFMRA—Air Force Medical Readiness Agency

AFMS—Air Force Medical Service

AF/A3O—Director of Operations

AFOM—Air Force Operational Medicine

AFPD—Air Force Policy Directive

AFR—Air Force Reserve

AFRC—Air Force Reserve Component

AFSC—Air Force Specialty Code

AF/SG—Surgeon General

AF/SG3—Chief, Aerospace Medicine Policy and Operations

AF/SG3P—AFMRA Aerospace Medicine Branch

AFSOC—Air Force Special Operations Command

AIMWTS—Aeromedical Information Management Waiver Tracking System

AMC—Air Mobility Command

AMP—Aerospace Medicine Primary

AMRO—Airmen Medical Readiness Optimization

ANG—Air National Guard

ANPs—Aeromedical Nurse Practitioners

AOME—Aerospace and Operational Medicine Enterprise

AOPT—Aerospace Operational Physiology Training

APAs—Aeromedical Physician Assistants

ARC—Air Reserve Component (AFR, ANG)

ASIMS—Aeromedical Services Information Management System

ATC—Air Traffic Control

ATLS—Advanced Trauma Life Support

BAMC—Brooke Army Medical Center

BOMC—Base Operational Medicine Clinic

CAF—Combat Air Forces

CFETP—Career Field Education and Training Plan

CFR—Code of Federal Regulations

CM—Case Manager

CMA—Competent Medical Authority

DAWG—Deployment Availability Working Group

DCS—Decompression Sickness

DHA—Defense Health Agency

DMIS—Defense Medical Information System

DNIF—Duties Not Involving Flying

DoDM—Department of Defense Manual

DoD—Department of Defense

DoDI—Department of Defense Instruction

EHR—Electronic Health Record

EMF—Electromagnetic Field

FOMWG—Flight & Operational Medicine Working Group

FOMC—Flight and Operational Medicine Clinic

FOMP—Flight and Operational Medicine Program

FNPs—Family Nurse Practitioners

FS—Flight Surgeon

GMU—Guard Medical Unit

HIPAA—Health Insurance Portability and Accountability Act

HP—Human Performance

HPW—Human Performance Wing

IC—Incident Commander

IDMT—Independent Duty Medical Technician

IEMP—Installation Emergency Management Plan

IFE—In-Flight Emergency

IOS—Integrated Operational Support

ISB—Interim Safety Board

ISR—Intelligence, Surveillance and Reconnaissance

KX—Knowledge Exchange

LCSW—Licensed Clinical Social Worker

LSC—Limited Scope Counseling

LSO—Laser Safety Officer

MA—Medical Advisor

MAF—Mobility Air Forces

MAJCOM—Major Command

MC—Medical Corps

MCRP—Medical Treatment Facility Medical Contingency Response Plan

MDD—Medication Dispensing Device

MDG—Medical Group

MDG/CC—Medical Group Commander

MEB—Medical Evaluation Board

MEPRS—Medical Expense and Performance Reporting System

METALS—Mission Essential Task and Activities for Line Support

MH—Mental Health

MQT—Mission Qualification Training

MTF—Medical Treatment Facility

NVD—Night Vision Device

OEH—Occupational and Environmental Health

OEHWG—Occupational and Environmental Health Working Group

OM—Occupational Medicine

OME—Operational Medicine Enterprise

OMRS—Operational Medicine Readiness Squadron

OPR—Office of Primary Responsibility

OSM—Operational Support Medical

PEPP—Physical Exam Processing Program

PH—Public Health

PHA—Preventive Health Assessment

PHEO—Public Health Emergency Officer

POTFF—Preservation of the Force and Family

PPE—Personal Protective Equipment

PRAP—Personal Reliability Assurance Program

PRP—Personnel Reliability Program

PSR—Patient Safety Reporting

PT—Physical Therapist

RegAF—Regular Air Force

RM—Risk Manager

RMU—Reserve Medical Unit

RPA—Remotely Piloted Aircraft

SAFTE FAST—Sleep, Activity, Fatigue and Task Effectiveness Fatigue Avoidance Scheduling Tool

SEIT—Standard Ear Impression Technique

SG—Surgeon General

SGH—Chief of Medical Staff

SGN—Chief Nurse

SGP—Chief, Aerospace Medicine

SIB—Safety Investigation Board

SME—Squadron Medical Element

SO—Special Operations

SOD—Special Operational Duty

SOF—Special Operations Forces

SOFME—Special Operations Forces Medical Element

SOS—Special Operation Squadron

ST—Special Tactics

SW—Special Warfare

TFE—Total Force Enterprise

UHM—Undersea & Hyperbaric Medicine

USAFSAM—United States Air Force School of Aerospace Medicine

USC—United States Code

Terms

Aeromedical Nurse Practitioner (ANP)—A nurse practitioner who graduated from AMP and carries the AFSC or special identifier, privileged to provide health care to flight and special-operational-duty personnel in accordance with this AFI. They conduct shop visits and fly on a non-interference basis on airframes served by their clinic. They must maintain medical qualifications (meet operational support flyer standards) in order to fly.

Aeromedical Physician Assistant (APA)—A physician assistant who graduated from AMP and carries the AFSC or special identifier, privileged to provide health care to flight and special-operational-duty personnel in accordance with this AFI. They conduct shop visits and fly on a non-interference basis on airframes served by their clinic. They must maintain medical qualifications (meet operational support flyer standards) in order to fly.

Aeromedical Provider—A health care provider (physician, physician assistant or nurse practitioner) who graduated from AMP and carries the AFSC or special identifier. Aeromedical providers are privileged to provide health care to flight and special-operational-duty personnel in accordance with this AFI They conduct shop visits and fly on airframes served by their clinic.

Aerospace Medicine Information Management System (ASIMS)—Web-based computer system that houses key medical and duty data elements for Airmen concerning medical qualifications for duties, retention.

Air Reserve Component—Air Force Reserve and the Air National Guard

ARC SG—Air Force Reserve Component Surgeon General (AFRC/SG) for reservists; National Guard Bureau Chief of Aerospace Medicine (NGB/SGP) for guardsmen

ARC SGP—Chief of Aerospace Medicine for the appropriate Air Reserve Component, either Air Force Reserve or Air National Guard. When specific concerns are different for the AFR and ANG, specify the entity by name (e.g., AFRC/SGP and NGB/SGP).

Athletic Trainers—Athletic trainers encompasses the prevention, examination, diagnosis, treatment and rehabilitation of emergent, acute or chronic injuries and medical conditions. They are health care professionals who render service or treatment, under the direction of or in collaboration with a physician, in accordance with their education, training and the state's statutes, rules and regulations.

Fitness for Duty—Evaluation to determine if member is fit for duty (meets retention medical standards). In the case of ARC, an additional determination needs to be made to adjudicate whether the condition was in the line of duty. If it was, then the condition is eligible for the Integrated Disability Evaluation System considerations. If it was not found in the line of duty, the condition is not eligible for the Integrated Disability Evaluation System consideration.

Flight Surgeon—A physician who has graduated from AMP and carries the AFSC 48X. They are credentialed to provide health care to flight and special-operational-duty personnel in accordance with this AFI. They conduct shop visits and fly on airframes served by their clinic. They are rated aircrew and must maintain flying class II medical qualifications in order to fly.

Line Leadership—Line officers in operational/combat and combat support specialties that belong to non-medical units.

Limited Scope Counseling—Services provided for short-term counseling where a short-term model of therapy is utilized.

Medication Dispensing Device—A computerized drug storage device or cabinet used for healthcare settings to allow medications to be stored and dispensed near the point of care while controlling and tracking distribution.

Physical Examination Processing Program (PEPP)—Web-based computer system to record and store flight and special operational duty physical examinations.

Preventive Health Assessment (PHA)—A recurring assessment of an Airman's health status in accordance with AFI 44-170.

Professional Staff—Professional employees engaged in medical care and requiring knowledge of an advanced type in the field of medicine. This includes all medical providers.

Special Operational Duty (SOD)—Non-flight duties which require special administrative and operational controls to certify medical qualifications for duty on a recurring basis for regular employment. Special operational duty includes Ground Based Controllers (GBC), Special Warfare (SW), and Missile Operation Duty (MOD).

Special Warfare (SW)—The Special Warfare initiative includes: Combat Rescue Officers (CRO, 13DXA), Special Tactics Officers (STO, 13CXB), Tactical Air Control Party Officer (ALO, 13LX), Pararescue (PJ, 1T2XX), Combat Control (CCT, 1C2XX), Tactical Air Control Party (TACP, 1C4XX), and Special Operations Weather Team (SOWT, 1W0X2).

Top Knife—A course designed for aeromedical providers and physiologists to gain a firmer understanding on fighter and combat aircraft operations.

Attachment 2

AIR FORCE AEROMEDICAL PROVIDER METALS

A2.1. Flight Medicine Clinic related METALS.

A2.1.1. Waiver work-up, summary writing, and AIMWTS entry.

A2.1.2. MTF Profiling Officer: application of standards.

A2.1.3. ACSCL Program Management.

A2.1.4. PRAP Program Management and Chart Reviews (CMA activities).

A2.1.5. Participate in FOMWG.

A2.1.6. Aerospace Medicine Program Development.

A2.1.7. Aeromedical Dispositions for out of clinic consultations.

A2.1.8. Evaluate and prescribe PPE (e.g., malaria prophylaxis, TB eval/treat).

A2.1.9. Peer review.

A2.1.10. Aircrew Fatigue Management (GO/NO GO medications and all counter fatigue Management).

A2.1.11. Aircrew medication Ground Testing.

A2.1.12. Physical Standards: Application to individual conditions and defects.

A2.1.13. Travel Medicine: Interviews/medications.

A2.1.14. Pre-Placement/Occupational Examinations.

A2.1.15. Clinic Management.

A2.1.16. Fitness for duty and disability evaluations.

A2.1.17. Hyperbaric treatment and observation in consultation with ACS.

A2.2. Non Clinic related METALS.

A2.2.1. Flying (including brief and debrief).

A2.2.2. PH Facility Inspection (Food safety/sanitation).

A2.2.3. BEE shop visit (Industrial Hygiene).

A2.2.4. Aircrew Flight Equipment Shop Inspection.

A2.2.5. Pregnancy Evaluations for workplace exposures.

A2.2.6. Aeromedical advice to other PCM's and Specialist.

A2.2.7. Aircrew qualification training.

A2.2.8. In-flight Emergency and Physiological Incident Responses.

A2.2.9. Hearing Conservation Program (review and oversight).

A2.2.10. Fitness and Risk Evaluations.

A2.2.11. Aircraft mishap exercises and responses.

A2.2.12. SIB/AIB medical member and/or training (FSs only).

A2.2.13. Mass Casualty/MARE Exercises and Responses.

A2.2.14. Hazardous materials response exercises and responses.

A2.2.15. Chemical, Biological, Radiation, Nuclear, Explosive exercises and responses.

A2.2.16. Operational Readiness Exercise/Inspection.

A2.2.17. Safety/Performance Enhancement Briefings to the Wing or subordinate units.

A2.2.18. Aeromedical briefings to Medical Professional Staff.

A2.2.19. Participant in OEHWG, DAWG, and AMC (Working Group and Committees).

A2.2.20. Flying Squadron Visits.

A2.2.21. Epidemiological Public/Occupational Health Investigation.

A2.2.22. Supervision of subordinates (EPR's, OPR's, admin, clinic operations, etc).

A2.2.23. Pre/Post Deployment briefings, screening, and clearance.

A2.2.24. Oversea Medical Clearances.

A2.2.25. Aerospace Physiology Support (reduced oxygen breathing device, NVG, physiological incidents).

A2.2.26. Aeromedical evacuation Consultation/review/clearance.

A2.2.27. Develop/Refine emergency response plans.

A2.2.28. Disease/vector and other force protection issues.

A2.2.29. Inspection/inventory of emergency response equipment.

A2.2.30. Pregnancy Evaluations at Workplace (Exposure).

A2.2.31. Line consultant (medical, physiology, human factors, etc).

A2.2.32. MEB case work-up and summary writing.

A2.2.33. MEB review and approval in absence of SGP.

A2.2.34. Air Sickness Program Management.

A2.2.35. Provide OM advice to other providers and base leadership.

A2.2.36. Laser Injury Evaluations.

A2.2.37. Head-up Display (HUD) Tape Review.

A2.2.38. Combat Search and Rescue (CSAR) Support.

A2.2.39. Legal: Responding to Aeromedical legal issues.

A2.2.40. First Responder Training.

A2.2.41. Pre/Post Deployment Screening/Clearance.

Figure A2.1. Example Operational Medication Request Form.

EXAMPLE OPERATIONAL MEDICATION REQUEST FORM

For Official Use Only
Operational Medication Request
Flight Medicine: XXX-XXXX
(Please submit NLT 36 hrs prior to crew rest)

Date: _____

Requesting AC / Crew Member / POC: _____

Sortie Date: _____   Sortie Type/Airframe: _____

Show: _____ L   T/O: _____ L   Land: _____ L   Duration: _____ hrs

Other Reason for No-Go request: _____

Last Name, First	DoDID# Last 4	Medication Requested (# determined by aeromedical provider)		
		Ambien	Restoril	Sonata

Send request to all Aeromedical Providers listed below (provider on-call will address)
Chief, Aerospace Medicine: FS #1 (email)
XX AMDS/OMRS FS: FS #2 (email)
XX OMRS APA: Aeromedical Provider #3 (email)
XX OMRS ANP: Aeromedical Provider #4 (email)
NO GO PILLS: Use is voluntary/optional per individual.
Amount requested must be within reason, as determined by FS based on normal sleep cycle/ show time/ sortie duration/ land time/ etc.
Restoril: Take a dose not exceeding 30mg with a **minimum DNIF period of 12 hours** before the resumption of duties.
Ambien: Take a dose of 5mg or 10mg with a **minimum DNIF period of 6 hours** before the resumption of duties.
Sonata: Take a dose of 10mg with a **minimum DNIF period of 4 hours** before the resumption of duties.
Restoril and Ambien use is restricted to a maximum of 7 consecutive days and no more than 20 days in a 60-day period.
Sonata may be used for up to 10 consecutive days and no more than 28 days in a 60-day period.