

**BY ORDER OF
THE SECRETARY OF THE AIR FORCE**

**AIR FORCE TACTICS, TECHNIQUES, AND
PROCEDURES 3-42.51**



7 APRIL 2015

***Tactical Doctrine*
CRITICAL CARE AIR TRANSPORT TEAM (CCATT)**

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PURPOSE: The Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42 series of publications is the primary reference for combat support capability. This document, AFTTP 3-42.51, provides tactics, techniques, and procedures (TTP) for air transport of critically ill or injured patients across the range of military operations, from steady state/peacetime engagements through war-winning operations. This guidance is designed to assist commanders and planners in the successful integration of CCATT into Aeromedical Evacuation (AE) operations, and interface successfully with Air Force Expeditionary Medical Support (EMEDS) or equivalent component service medical support and AE ground medical operations. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of in accordance with Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS) located at <https://afrims.amc.af.mil/>. This publication applies to all Air Force personnel, including Air Force Reserve Command (AFRC) and Air National Guard (ANG). For the purpose of this TTP, ANG is included in the term Major Command (MAJCOM). The doctrine in this document is authoritative but not directive. The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force. This publication requires the collection and/or maintenance of information protected by the Privacy Act (PA) of 1974, 5 United States Code (USC) Section 552a. Forms affected by the PA have an appropriate PA statement.

SUMMARY OF CHANGES: The following is a summary of changes to the CCATT TTP: addition of paragraph in SCOPE to address possibility of CCATT being tasked/employed outside the traditional AE organization; deleted the following: *(Personnel nominated for assignment to a CCATT Unit Type Code (UTC) after 1 Sep 2006 are required to go through the validation process described herein. Members assigned to CCATT UTCs who successfully completed the CCAT Initial Course prior to 1 Sep 2006 will validate through attending the CCAT Advanced Course)* (paragraph 1.6.4.); 2.5 (Responsibility and Authority), adds a section that discusses the Theater En Route Critical Care Director (paragraph 2.5.2); deletes Communications & Computer

Support (formerly paragraph 2.5); adds further information/guidance on the requirement for an Official Passport (paragraph 3.5); addition of a section that defines CCATT Tasking & Employment (paragraph 3.7); expands guidance for CCATT on space-limited fixed-wing airframes (paragraph 3.7.3); provides guidance for operations on non-AE missions (paragraph 3.7.4); provides information on the definition of peacetime taskings (paragraph 3.7.5); CCATT Duty/Rest Cycle Day is updated (paragraph 3.8); updated information on Ground/Mission Support Operations (paragraph 3.10); additional documentation requirements for completion of the 3899L (paragraph 3.11); CCATT Quality Improvement/Performance Improvement (QI/PI) Process information is added (paragraph 3.12); Operational Support Flying information is broken out into a separate chapter (Chapter 4); adds information on body armor requirements for CCATT personnel (paragraph 4.2.2); Training chapter is re-numbered (Chapter 5); changed Air Reserve Component (ARC) training frequency for CCAT Advanced Course to every 24 months (paragraph 5.4.1.2.1.); and finally a paragraph that discusses the Operational CCATT Kit Program (6.9) is added.

SCOPE: United States Air Force (USAF) aeromedical evacuation provides a critical patient movement capability that cuts across traditional Service lines. Since World War II, the preponderance of AE patients generated during wars and contingency operations have come from Army and Marine Corps ground combat units. It is important that the en route care capabilities of all Services integrate well to support the care and movement of patients throughout the continuum. Moreover, during the past decade, it has become increasingly important that en route care capabilities continue to integrate with components of our nation's allies. Historically, in operational settings, CCATTs have typically been embedded in AE units. CCATTs will continue to be an integral component of USAF AE, however, in future operations there may be situations where CCATTs will be tasked to deploy and operate outside traditional USAF AE forces to provide critical care support in the en route care continuum. When tasked for a non-traditional CCATT role, the team would not be assigned to an AE unit or Operations Group but would be aligned under a different execution and command and control organization. CCATTs could also deploy in a Defense Support to Civil Authority (DSCA) scenario where the CCATTs may be assigned to the En Route Patient Staging System (ERPSS) to help prepare patients for evacuation at the Aerial Port of Embarkation (APOE) or at the Aerial Port of Debarkation (APOD) to facilitate movement of patients to the receiving hospitals. Unless specifically stated, this TTP will primarily address CCATT as an AE asset outlining specific roles and functions while operating within the AE organization. When CCATTs are assigned to an AE unit, they will follow the AE chain of command under the Operations Group. Air Mobility Command (AMC) is the Manpower and Equipment Force Packaging System (MEFPAK) responsible agency (MRA) for the CCATT.

Table of Contents

	Page
Chapter 1—CRITICAL CARE AIR TRANSPORT TEAM (CCATT)	
1.1. CCATT Mission	5
1.2. CCATT Concept	5
1.3. Range of Operations	5
1.4. CCATT Scope of Care	5
1.5. CCATT UTCs – Capabilities and Compositions	6
1.6. CCATT Candidate Selection & Validation	7
 Chapter 2—COMMAND AND CONTROL	
2.1. General	12
2.2. AE Integration in Air Mobility Operations	12
2.3. En Route Care Capability	13
2.4. Contingency AE Structure	13
2.5. Responsibility and Authority	13
 Chapter 3—OPERATIONS	
3.1. Scope	16
3.2. Force Health Protection	16
3.3. CCATT Relationship with Aeromedical Evacuation Crew Members (AECMs)	16
3.4. Support	16
3.5. Official Government Passport	17
3.6. Mission Essential Items	17
3.7. Tasking and Employment	17
3.8. CCATT Duty/Rest Cycle	21
3.9. Flight Operations	23
3.10. Ground Operations	24
3.11. Documentation	25
3.12. CCATT Quality Improvement/Performance Improvement (QI/PI) Program	26
3.13. Security	26
 Chapter 4—OPERATIONAL SUPPORT FLYING	
4.1. Operational Support Flier (OSF)	28
4.2. Flight Operations Protective Clothing & Equipment	28
4.3. Aeronautical Orders	29
4.4. Aviation Service Code/Flight Authorization Code	32
4.5. Flight Authorization	32
 Chapter 5—TRAINING	
5.1. Introduction	33
5.2. Unit CCATT Coordinator	33
5.3. Entry into CCATT Training	33
5.4. Training Pipeline	34

Chapter 6—LOGISTICS

6.1.	Allowance Standards	38
6.2.	Pre-Flight of Equipment	39
6.3.	Narcotics Accountability	40
6.4.	Aircraft Medical Equipment Operations	40
6.5.	Medical Equipment Waiver Protocol	40
6.6.	Medical Equipment Malfunction/Failure	40
6.7.	Base Operating Support	42
6.8.	Resupply and Patient Movement Items (PMI)	43
6.9.	Operational CCATT Kit Program	43

Attachment 1	– Glossary of References and Supporting Information	46
Attachment 2	– Validation Process Flowchart	51
Attachment 3	– Sample Cover Letter for Application Packages for CCATT Candidates	52
Attachment 4	– Sample Letter of Rebuttal	53
Attachment 5	– CCATT Candidate Application Package – Clinical Validation Committee Checklist Coversheet	54
Attachment 6	– CCATT Minimum Individual Protective Clothing & Equipment for Flight Operations (Initial)	55
Attachment 7	– CCATT Minimum Individual Protective Clothing & Equipment for Flight Operations (Deployed)	56
Attachment 8	– CCATT Requirements Matrix	57
Attachment 9	– Request for Waiver of Initial Aeromedical Evacuation Patient Staging (AEPS) Course	61

Chapter 1

CRITICAL CARE AIR TRANSPORT TEAM (CCATT)

1.1. CCATT Mission.

1.1.1. CCATTs assist in carrying out the global patient movement mission. They are a limited, rapidly-deployable resource available in selected situations to supplement en route care patient movement capabilities. CCATTs maintain/enhance the standard of care provided to critically ill/injured patients who require continuous stabilization and advanced care during transport to the next level of care utilizing a variety of aircraft platforms. They are typically engaged after a patient has received essential, stabilizing care by ground medical support personnel. CCATTs are able to continuously monitor and maintain stabilization of critically ill/injured patients during en route care in either an inter- or intra-theater mission support role.

1.2. CCATT Concept.

1.2.1. The addition of an intensive care unit (ICU) capability on aircraft has added a revolutionary dimension to AE missions and theater en route care capabilities. AE/CCATT serves as a distributive medical treatment facility – the aeromedical bridge between mobile and fixed medical facilities along a continuous en route system of ever-increasing medical capability. These specially-trained medical personnel care for critically injured/ill patients while in-transit by air to another medical treatment facility – usually one providing focused medical treatment and/or a higher level of medical care than the patient's originating facility. This capability ensures that the level of life-sustaining medical care for critically ill and injured patients during transport by air does not diminish. The CCATT UTC is a unique, capabilities-based mission platform. This specialized mission requires medical professionals distinctly skilled and experienced in the practice of critical care. Expert, knowledgeable professionals in critical care practice yield positive patient outcomes with fewer patient complications. These factors are decisive in the environment in which CCATTs perform their mission: aircraft at altitude – a situation that is hostile to providing the kind of highly-specialized patient care required in an ICU.

1.3. Range of Operations.

1.3.1. CCATTs are designed to be flexible in response and are employed across the spectrum of operations. This includes Aerospace Expeditionary Force (AEF) operations ranging from in-garrison care to homeland security, DSCA to worldwide humanitarian relief, small-scale contingencies through major theater war, and any other operational tasking where their unique patient care skill set is required.

1.4. CCATT Scope of Care.

1.4.1. CCATTs provide advanced, specialty medical capability to evacuate critically ill or injured patients requiring continuous stabilization or advanced care during transport to

the next level of care. Prior to transport, the role of the CCATT is to assess and prepare the critically ill patient for movement. The CCATT should normally originate with a patient from a nearby/co-located medical treatment facility (MTF) located at a theater AE hub. CCATTs may also be transported from an AE hub to forward locations to pick up patients for transport to higher levels of care. The CCATT will accompany the patient from the originating facility to the aircraft and continue to monitor and intervene during in-flight operations as required. The CCATT does not routinely provide primary stabilization and does not replace ground-based forward surgical, critical care, or other medical support team capabilities. These patients are usually in a state of dynamic, physiological flux, including patients whose resuscitation may still be in evolution. Patients designated for transport by CCATT usually are in need of supportive/resuscitative care of shock, hemorrhage, respiratory failure, and multi-system trauma. At the end of missions, CCATTs will accompany the patient from the aircraft to the destination facility, continuing to monitor and intervene as required until the patient is handed off to destination medical facility staff.

1.4.2. Each CCATT physician must verify the transport readiness of patients to be transferred based on the patient's clinical status. This must be communicated and coordinated with the controlling Patient Movement Requirements Center (PMRC) and tasking element. CCATT intervention normally begins at the originating MTF. If the patient is not stable enough to transport, the CCATT physician consults with the sending physician to cancel or suspend the Patient Movement Request (PMR) and remove the patient from the flight manifest.

1.4.3. Deviations from maximum CCATT patient loads, or combinations of high-acuity and lower-acuity patients, will be at the discretion of the CCATT team physician and based on patient acuity, resources required/available, mission requirements, and any other factors affecting team ability to provide patient care without degrading capability. Deviations from tasked patient loads will be coordinated with the theater validating flight surgeon and communicated to the medical crew director (MCD) prior to loading.

1.5. CCATT UTC Capabilities and Compositions.

1.5.1. Grade and skill level substitutions are authorized in accordance with AFI 10-403, *Deployment Planning and Execution*, and War Mobilization Plan (WMP-1), AFMS Supplement. Exceptions must be approved by the MEFPAC, AMC/SG.

1.5.2. UTC FFCCT, CCATT Personnel.

1.5.2.1. The CCATT UTC, FFCCT, in conjunction with equipment package, FFCC4, provides care for a maximum patient load of up to three high-acuity (e.g., ventilated) patients, or up to six lower-acuity (e.g., non-ventilated) stabilized patients. Introduction of untreated or unstable patients will degrade CCATT capability and deplete resources accordingly unless augmented. Consultation with the PMRC validating flight surgeon (VFS) and/or the Theater En Route Critical Care Director will be required prior to mission execution to determine the ideal provider mix to transport neonatal and pediatric critical patients.

1.5.2.1.1. A pediatric equipment augmentation kit, UTC FFCC2, is available to provide additional equipment/supplies to the FFCC4 equipment UTC to support FFCCT when the team is required to transport pediatric patients.

1.5.2.2. FFCCT consists of the following Air Force Specialty Codes (AFSCs)/skill levels and quantities:

(1) Critical Care Physician (044Y3) - Lt Col/O5

(1) Critical Care Nurse (046N3E) - Maj/O4

(1) Cardiopulmonary Technician (4H071)

AFSC substitutions for the critical care physician are authorized as follows: 044Y3A, 044M3 all shreds, 044E3A, 045A3, 045S3, 045S3A, 044F3, 048R3. 046N3E may be substituted with 046N3J. 4H071 must have respiratory equipment/ventilator experience. 4H071 may be substituted with 046Y3M. All candidates for assignment to this UTC must have completed validation screening of Readiness Skills Verification (RSV) tasks.

1.5.3. FFCC4, CCATT Equipment. This UTC provides advanced specialty medical equipment to support FFCCT teams, providing single mission support for up to 3 high-acuity or up to 6 lower-acuity adult patients.

1.5.4. FFCCB, CCATT Equipment Resupply. This UTC provides the re-supply package to support FFCC4; it provides 15 days support for one basic FFCC4.

1.5.5. FFCC2, CCATT Equipment – Pediatric Augmentation Kit. This UTC provides advanced specialty medical equipment/supply augmentation support to the FFCC4 equipment UTC specifically for transport of pediatric patients. This kit provides single mission support for a maximum of 2 pediatric patients weighing < 15 kg, and, a maximum of 2 pediatric patients weighing between 15 – 40 kg. Re-supply is provided within USAF AE at staging locations or supported element.

1.5.6. FFEC1, Expeditionary Support Package. This UTC provides basic shelter to CCATT members and AE crewmembers positioned at far-forward, secured airfields. Package is deployed with FFCCT or AE crewmembers (UTC FFQDE) when required to support a maximum of 30 personnel for 96 hours.

1.6. CCATT Candidate Selection & Validation.

1.6.1. Candidates for CCATT UTC assignment must be world-wide qualified and able to meet the requirements for physician, nurse, or cardiopulmonary technician positions as set forth in paras 1.6.6.1, 1.6.6.2, and 1.6.6.3 (respectively) below. They must meet physical standards for Operational Support Flier (OSF) status in accordance with (IAW)

AFI 48-123, *Medical Examinations and Standards*, Chapter 6. They must be able to obtain Operational Support Flier status IAW AFI 11-402, *Aviation and Parachutist Service, Aeronautical Ratings and Badges*, obtain an official government passport, and have a minimum of a Secret security clearance.

1.6.2. Medical unit commanders with CCATT UTCs assigned are responsible for selecting, training, and preparing members for assignment to CCATT. The CCATT validation process does not remove these responsibilities from the commander. The process is an enhancement to the medical UTC assignment system to ensure that only the most highly skilled medical professionals are assigned to CCATT.

1.6.3. All individuals selected as candidates for CCATT UTC assignment and duty will undergo a position-specific clinical skill validation process administered by the Air Force Expeditionary Medical Skills Institute (AFEMSI), under the authority of HQ AMC/SG as the MRA for CCATT.

1.6.4. The CCATT clinical validation process will assist MTF and ARC commanders in their responsibility to assign only those individuals with the requisite skills and experience to a CCATT UTC. The validation process is also designed to assist commanders in determining what further experience and training a prospective CCATT member must obtain in order to capably perform the CCATT mission.

1.6.5. Selection. Review packages must be prepared for each proposed CCATT member nominated by the unit commander. Forward packages to AFEMSI for review and evaluation prior to assignment to UTC positions. (Process flow chart is included as Attachment 2. Sample submission cover letter is included as Attachment 3.)

1.6.5.1. For ANG CCATT candidates, Clinical Validation Committee (CVC) packages should be scanned electronically and sent to ANG/SGX at: ANG.SGX@ang.af.mil. ANG CCATT CVC packages will be facilitated and forwarded to the USAF School of Aerospace Medicine (USAFSAM) by the ANG/SGX office.

1.6.5.2. For Air Force Reserve Command (AFRC) ERCC UTC candidates, application packages are reviewed by AFRC/SGP and SGX prior to unit submission to USAFSAM.

1.6.5.3. Complete packages (see paragraph 1.6.6.) should be scanned, compiled (in one document or file) and e-mailed to:

USAFSAM-CVC@WPAFB.AF.MIL

(Note: This org box is encryption capable)

1.6.6. Clinical Validation Committee. The CVC is composed of experienced CCATT members that review packages for recommended CCATT members. When reviewing candidates from AFRC or the ANG, a qualified physician, critical care nurse, or cardiopulmonary technician representative from the respective component, as applicable, will be a member of the CCATT clinical validation committee for the reserve member.

Members of the CVC will not be in a CCATT candidate's direct chain of command. Each package will be assigned to one lead CVC member for review and processing. A structured interview of the proposed member will be accomplished by the CVC lead. Two additional CVC members will review the package concurrently. Validation status will be assigned by a consensus of the three CVC members. The CVC is required to expeditiously conduct and complete their assessment in order to avoid a delay in the commander's ability to make timely personnel assignments to the CCATT UTC. AFEMSI will appoint a CVC Medical Director to lead the review process. The CVC Medical Director will be responsible for assigning CVC members and the clinical skills review process. Any irresolvable conflicts between the CVC members will be referred to the CVC Medical Director. The validation process will be completed within a 2-week period, with expedited review for ARC candidates to prevent a delay in the accession process. Based on the committee's decision, a candidate will be assigned one of the following:

1.6.6.1. Approved: Allows candidate immediate assignment to a CCATT UTC.

1.6.6.2. Provisional: Awaiting additional information on candidate or additional training/experience is required. This status will be changed to "approved" once additional verified information is received and/or additional training/experience is accomplished. If additional training is required, a training plan will be issued to the individual and his/her home unit by AFEMSI. Members may not be assigned to the UTC while in "provisional" status; all provisional items must be satisfactorily completed before "approved" status is designated. Once the training plan is completed, the candidate's home unit will forward documentation of completion to AFEMSI. AFEMSI will review the completed training plan prior to changing member status to "approved." Failure to complete provisional items within six months will result in "disapproved" status.

1.6.6.3. Disapproved: Candidate does not meet eligibility requirements for assignment to a CCATT UTC. AFEMSI will notify HQ AMC/SGK on all candidates disapproved for CCATT appointment. "Disapproved" applicants may appeal the decision through their unit commander to HQ AMC/SG (the CCATT MRA and appeal decision authority). The appeal package must include the original selection package, a letter of rebuttal to the disapproval, and any additional supporting documentation. (See Attachment 4 for sample letter of rebuttal).

1.6.7. Candidate Application Package Contents.

1.6.7.1. Physician application package requires (see Attachment 5 for package checklist):

1.6.7.1.1. Current curriculum vitae including a statement of attestation from the candidate affirming the total number of hours of critical care patient management for the past two years. (Critical care patient management experience is defined as patient care requiring continuous

cardiac and/or invasive hemodynamic monitoring and/or advanced airway support/management.) 800 hours of critical care patient management is the desired minimum requirement, however, personnel with less than 800 hours can apply for CCATT duties and should attest to the total number of critical care management hours they have at the time of application.

1.6.7.1.2. Current Hospital Privilege List (AF Form 1562 or equivalent).

1.6.7.1.3. Current copies of medical license(s), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS). One-time Advanced Trauma Life Support (ATLS) course and on-going contemporary clinical experience is required. Current ATLS course is desired; current Pediatric Advanced Life Support (PALS) course is desired for UTC FFCCT.

1.6.7.1.4. Current copy of 44Y3 RSV checklist for UTC FFCCT position.

1.6.7.2. Nurse application package requires (see Attachment 5 for package checklist):

1.6.7.2.1. AFSC: 46N3E, 46N3J, or 46Y3M with current critical care experience.

1.6.7.2.2. Current curriculum vitae including a statement of attestation from the candidate affirming the total number of hours of critical care patient management for the past two years. (Critical care patient management experience is defined as patient care requiring continuous cardiac and/or invasive hemodynamic monitoring and/or advanced airway support/management.) 800 hours of critical care patient management is the desired minimum requirement, however, personnel with less than 800 hours can apply for CCATT duties and should attest to the total number of critical care management hours they have at the time of application.

1.6.7.2.3. Current nursing job description and 2 references.

1.6.7.2.4. Proof of primary source verification or copy of nursing license, BLS, and ACLS. (PALS, Adult Critical Care Nursing {CCRN}, Trauma Nursing Core Course {TNCC}, and Advanced Trauma Care for Nurses {ATCN} certification is recommended, but not required. If certification in these areas is held, please include as applicable.)

1.6.7.2.5. Current copy of 46N3E RSV checklist for UTC FFCCT position. 46Y3M will submit current copy of RSV checklist for that AFSC.

1.6.7.3. Cardiopulmonary technician application package requires: (see Attachment 5 for package checklist):

1.6.7.3.1. Documentation of current 5-skill level or higher.

1.6.7.3.2. Current curriculum vitae including a statement of attestation from the candidate affirming the total number of hours of critical care patient management for the past two years. (Critical care patient management experience is defined as patient care requiring continuous cardiac and/or invasive hemodynamic monitoring and/or advanced airway support/management.) 800 hours of critical care patient management is the desired minimum requirement, however, personnel with less than 800 hours can apply for CCATT duties and should attest to the total number of critical care management hours they have at the time of application.

1.6.7.3.3. Certified Respiratory Therapist (CRT) required.

1.6.7.3.4. Current copies of respiratory license, BLS, and ACLS.

1.6.7.3.5. Current copy of RSV checklist.

Chapter 2

COMMAND AND CONTROL

2.1. General.

2.1.1. HQ Air Mobility Command (AMC) is the lead command for USAF aeromedical evacuation. HQ AMC Office of the Command Surgeon (AMC/SG) is the MRA for critical care air transport (CCAT) capabilities. HQ AMC/SG establishes, in coordination with other major commands, the principles for system wide organization, equipment, training, and clinical standards for the air transport of critically injured/ill patients – en route critical care air transport. Total Force, multi-command coordination ensures standards for system wide en route critical care personnel and training requirements, mission support requirements, clinical and in-flight care, team and individual performance, and CCAT process improvement. Examples of En Route Critical Care (ERCC) capabilities include, but are not limited to: CCATT, Lung Teams, Neonatal ICU (NICU) Team, Joint Medical Attendant Transport (JMATT) Teams, and Tactical Critical Care Evacuation Team (TCCET).

2.1.2. HQ AMC Office of the Command Surgeon, Aeromedical Evacuation Clinical Operations and Training Division (AMC/SGK) is the executive agent and primary point of contact for overall program administration and development of Air Force CCAT capability(ies), maintaining integration and synergy within AE operations, providing coordination and interaction with other service branches, coalition and allied forces, and directing clinical oversight and standards development for CCAT to ensure a unified, system wide, en route critical care capability. HQ AMC/SGK is the central manager for the CCAT OSF Program. HQ AMC/SGK maintains the AF Portal CCATT webpage; URL: <https://www.my.af.mil/gcss-af/USAF/ep/globalTab.do?channelPageId=s6925EC13493A0FB5E044080020E329A9>

2.1.3. HQ AMC/SG, Medical Plans and Readiness Division (AMC/SGX), serves as the MEFPAK Manager. HQ AMC/SGXM coordinates the development of TTPs, Mission Capability Statements (MISCAPS), and Mission Essential Task Lists (METLs). These documents and other information are available on the Air Mobility Command SG MEFPAK SharePoint website, maintained by AMC/SGX; URL: <https://cs3.eis.af.mil/sites/27468/default.aspx>

2.1.4. HQ AMC/SG, through AETC/SG, has designated the 59th Medical Wing as the Pilot Unit for UTC FFCCT. The Pilot Unit provides clinical, technical, manpower, and operational expertise and consultation in the development and enhancement of the CCATT capability.

2.2. AE Integration in Air Mobility Operations.

2.2.1. Command and control (C2) functions exercised over AE missions are consistent with those for all air mobility missions and are conducted in accordance with the C2 processes described in Joint Publication 3-17, *Air Mobility Operations*. In contingency

operations, AE-specific items will be outlined in the operation orders (OPORD) in Annex C, Appendix 30; and general patient movement guidance will be in Annex Q. AE assets are integrated within the inherent mobility structure established to support airlift operations through the Air Mobility Division (AMD) to the wing and down to the assigned expeditionary AE squadron/unit.

2.3. En Route Care Capability.

2.3.1. (Ref: Joint Publication 4-02, *Health Service Support*). The purpose of an en route care capability is the continuation of care during movement (evacuation) within the military health service support (HSS) continuum of care without clinically compromising the patient's condition. Patient movement involves transitory medical care, patient holding, and staging capabilities during transport from the site of injury or onset of disease, through successive capabilities of medical care, to a medical treatment facility that can meet the needs of the patient. Each Service component has an organic patient movement capability for evacuation from point of injury to initial treatment at a health care facility.

2.3.2. En route care capability can take three forms. Casualty evacuation (CASEVAC) involves the unregulated movement of casualties aboard opportune ships, land vehicles, or aircraft. Medical evacuation (MEDEVAC) is unregulated patient movement using pre-designated tactical or logistic aircraft (both fixed-wing and rotary-wing), boats, ships, and other watercraft equipped and staffed with medical attendants (MAs) for en route care. Aeromedical evacuation refers to the regulated patient movement to and between medical treatment facilities. Air Mobility Command is the lead command for USAF AE as tasked by United States Transportation Command (USTRANSCOM).

2.3.3. Today's lethal battlefield, the reduced medical footprint forward, and the "evacuate and replace" philosophy place a high demand on the en route care capabilities of all Services. Consequently, patient movement capabilities are even more critical than in the past and Service medical elements must integrate with lift operations, as well as with the associated capabilities of our Nation's allies and coalition partners.

2.4. Contingency AE Structure.

2.4.1. Deployed expeditionary air and space forces are organized to ensure unity of command. Deployed AE forces are organized within the constructs of the Air and Space Expeditionary Task Force (AETF) and are tailored based on the size and scope of the operation. C2 of theater AE forces in contingency operations is defined in the warning/execution/OPORD. AE assets may be under the operational control (OPCON) of the Joint Force Commander (JFC) through the Joint Force Air Component Commander (JFACC) and, when not appointed as the JFACC, the Commander, Air Force Forces (COMAFFOR) for administrative control (ADCON). The AE commander is authorized to communicate directly with the joint forces surgeon (JFS) who is assigned to the staff of the JFC.

2.5. Responsibility and Authority.

2.5.1. When CCATTs are deployed for contingency operations in support of a geographic combatant commander (GCC), the CCATTs may fall under the OPCON and Tactical Control (TACON) of the JFACC/COMAFFOR exercised through the Director of Mobility Forces-Air (DIRMOBFOR-AIR), and may be assigned to a deployed aeromedical evacuation element. When deployed in support of AMC AE operations, CCATTs fall under the OPCON or TACON of the 618 Air Operations Center (618 AOC). 618 AOC coordinates the management and expectation of CCATTs with the 18 AF/SG. In turn, OPCON or TACON may be delegated to the AE senior representative of some or all medical AE assets. Command relationships are defined in the warning/execution/deployment order.

2.5.2. Theater En Route Critical Care Director. During major contingency operations, the Combatant Commander (CCDR) may establish a Theater En Route Critical Care Director. This position will be filled by a qualified AF CCATT member. In coordination with AMC/SGK, the HQ AF/SG CCAT Consultant will select a qualified individual for the position from a list of candidates to be maintained by the consultant. Generally, the Theater En Route Critical Care Director will be assigned to the Air Force Forces (AFFOR)/SG staff. The Theater En Route Critical Care Director serves as an advisor to Combatant Command Surgeon (CCMD/SG) and AFFOR/SG for the development, utilization, and optimization of a theater-wide en route critical care capability. This includes utilization of UTC FFCCT and other special en route critical care capabilities such as TCCET, Lung Teams, as well as other special and coalition medical critical care air transport assets. The Theater En Route Critical Care Director serves as a consultant to the Theater Validating Flight Surgeon (TVFS) regarding critical care transport and does not validate PMRs – validation authority is the responsibility of the TVFS.

2.5.2.1. The Theater En Route Critical Care Director will be provided aeronautical orders (AOs) allowing him/her to travel to locations with deployed CCATT assets as needed and in coordination with AFFOR/SG. The Theater En Route Critical Care Director will meet the same pre-deployment requirements as those deploying on an FFCCT UTC. To evaluate the clinical operations of en route critical care capabilities assigned within the Area of Responsibility (AOR), the Theater En Route Critical Care Director is authorized to participate in intra-theater or inter-theater AE missions, and should have the same priority as CCATTs/AECMs to return to the point of origin at the conclusion of these missions.

2.5.3. AE/En Route Care Unit CCATT Director. When deployed, teams may be assigned to a deployed expeditionary AE unit or another en route care patient movement element. When assigned to any en route care element (AE or other), the unit commander will appoint a unit CCATT Director for management and oversight of all assigned CCATT teams and to serve as CCATT liaison for the unit command section. The CCATT Director will be a physician – that physician may be of lesser rank but greater CCATT experience from the pool of CCATTs assigned. The CCATT Director will be responsible for managing each of the CCATTs assigned to the squadron, establishing the rotational schedule, coordinating with the Director of Operations (DO), reviewing clinical processes, liaison with local ground medical treatment facility to establish processes for

CCATT clinical sustainment, and all other team issues that may arise. The CCATT Director reports directly to the unit commander and is integrated into the unit executive leadership structure at the equivalent level of the DO and the Chief Nurse at AE units.

2.5.4. During mission execution, the CCATT physician is the team chief and the clinical authority for the CCATT patients, and with the other team members, is responsible for documenting and providing care. The CCATT physician may be called upon to consult and/or assist in the care of other patients. Any participation of the CCATT physician with/for the AE patients must be documented by the MCD on the AE patient medical record and a DD Form 2852 should be generated. Significant change in status is communicated to the C2 agency and PMRC governing the mission. When in-flight, the CCATT works with and receives mission operational direction from the MCD. The mission operational management authority and responsibility remains with MCD.

Chapter 3

OPERATIONS

3.1. Scope.

3.1.1. As components of the patient movement system, CCATTs provide advanced specialized medical care to critically ill, injured, or burned patients requiring continuous stabilization or complex care during air transport. CCATTs will be involved in the full spectrum of operations to move critically injured and/or ill patients to the next level of care.

3.2. Force Health Protection.

3.2.1. Global engagement charges Aerospace Expeditionary Forces to rapidly deploy to different parts of the world at a moment's notice. People, systems, and facilities of supporting bases are essential to the launch, recovery, and sustainment of aerospace platforms, usually as part of an AEF. Air Force medical services are crucial to base defense and resumption of operations during a wide spectrum of AEF operations. It is assumed medical personnel may potentially operate in a biological or chemical environment. CCATTs must be deployed with appropriate training and individual protective equipment (IPE) to counter threats. As an AE component, CCATTs will be exposed to the same conditions as AE aircrews and AE ground element personnel.

3.3. CCATT Relationship with Aeromedical Evacuation Crewmembers (AECMs).

3.3.1. CCATTs are not considered a part of the AE aircrew UTC, FFQDE, and are not rated or non-rated aircrew members. CCATTs are OSF. CCATT personnel will be regarded as members of the AE team during deployments and patient transport missions. It is the responsibility of the MCD assigned to a particular AE mission to ensure aircrew and CCATT cohesiveness and integrity between CCATTs and AECMs.

3.4. Support.

3.4.1. The gaining AE unit will be responsible for providing all required support for the CCATTs including billeting, food, water, shelter, transportation, medical oxygen support, communication and coordinate resupply of medical equipment and supplies, and any other items determined essential for the CCATT teams to accomplish their mission. If a patient transport mission terminates at a location different from the host AE unit's or deployed AE unit's location, the AECT or applicable C2 agency will ensure AECMs, CCATT, and support personnel integrity is maintained until all have returned to the point of origin. UTC FFEC1 has been designed to provide essential basic shelter and

equipment storage for ERC personnel deployed to secure, forward airfields in support of tactical operations where their presence exceeds requisite shelter support capability at the host site. CCATTs will receive all base support from the en route AE element. If the CCATTs are separated from the AE crew, the CCATT team chief is responsible to ensure required support by contacting the base command post and controlling C2 agency, i.e., 618 AOC, AMD.

3.5. Official Government Passport.

3.5.1. Personnel assigned to a CCATT UTC are required to have a current and valid Official Government Passport on hand at all times. Passport applications should be submitted immediately upon assignment to a CCATT UTC. Members must have Official Government Passports prior to employment/deployment as CCATT.

3.6. Mission Essential Items.

3.6.1. When flying on any mission, CCATT members will have at minimum, the following items on hand:

- ID card
- Dog tags
- Official Government Passport
- Aeronautical Orders (AOs) (or, Non-interference AOs for training flights)
- North Atlantic Treaty Organization (NATO)/Temporary Duty (TDY)/Deployment orders (as applicable)
- Government Travel Card

3.7. Tasking and Employment.

3.7.1. Standard CCATT Utilization. CCATTs are a rapidly deployable resource available in selected situations to enhance AE capability. The PMRC validates the requirement for CCATT-assigned patient movement. The CCATT is then tasked by the theater AECT or 618 AOC AE cell, through the AE element command for the required mission. Requirements for support will be based on expected casualties, location, available medical capability, and en route care requirements. The number and mix of personnel are based on the requirement identified at execution.

3.7.1.1. CCATTs will receive an aircrew intelligence brief prior to flight. If CCATT joins an AE mission en route, the MCD/Pilot in Command (PIC) will provide the briefing.

3.7.2. AE Mission Tasking. One or more CCATT UTCs may be deployed/employed with AE elements based on operational requirements. CCATTs will deploy and employ as teams with complete equipment sets. The request for CCATTs to support a patient movement requirement comes through a coordinated effort between the originating

physician, PMRC validating flight surgeon, and destination accepting physician. When a sending physician believes CCATT is required for transport, this will be reflected on the PMR. Following review of the PMR, the validating flight surgeon will either concur with the request or collaborate with the sending physician to arrive at a final determination. The validating flight surgeon also has the option to require a CCATT even if not originally requested by the sending physician. In the case of complex CCATT patient movements, the PMRC validating flight surgeon will collaborate with the Theater En Route Critical Care Director, sending physician, accepting physician, and the transporting CCATT physician when planning and coordinating a patient's transfer.

3.7.2.1. Tasking of CCATTs for AE missions will mirror the same process as that for AE crews. In determining the extent of the requirement for CCATT assets, the AECT will consider capabilities and maximum patient loads with regard for acuity of patients and potential care requirements. The AECT will consult with the Theater En Route Critical Care Director for expert critical care clinical guidance as needed.

3.7.2.1.1. High acuity patients are generally those patients requiring mechanical ventilation, multiple vasoactive medications, ongoing resuscitation, or other advanced treatment modalities.

3.7.2.1.2. Low acuity patients are generally those who are hemodynamically stable but require hemodynamic monitoring and some form of more intensive nursing care such as neurovascular checks, employment of various pain management modalities that have the potential to result in respiratory depression, etc.

3.7.2.2. At execution, the TVFS, in consultation with the Theater En Route Critical Care Director (if assigned), will determine the requirement for CCATT on the AE mission and the number of CCATTs needed. The transporting CCATT physician will consult with the theater validating flight surgeon once at the location of mission origin if the number of patients or the acuity of patients exceeds the capability of the team, or if additional teams/personnel are required. The CCATT physician tasked for a mission will retain the final authority in determining a safe CCATT patient load for that particular mission considering patient care requirements, the team's capacity to deliver safe patient care, and the patient's ability to tolerate transport. If the number of CCATT patients assigned to a team exceeds that team's capacity, the CCATT physician will immediately notify the AECT and the PMRC. AECT, in conjunction with the PMRC, will either add additional FFCCT or qualified medical attendants on the mission. As an alternative, the tasked CCATT's patient load may be reduced. Overriding theater operational factors may also impact the final decision on patient load. CCATTs will perform AE missions with complete equipment sets, regardless of the patient load. When the limits of the FFCC4 UTC have been exceeded, the CCATT will supplement with additional equipment/supplies as needed.

3.7.2.3. Upon arrival at an MTF or staging location, the CCATT team will: assess the patient's clinical status for flight; perform required interventions; determine continuing in-flight care requirements; and recommend the need for critical care augmentation in flight. The transporting CCATT physician will make the final determination whether or not a patient will be transported after assessment, considering the patient's ability to tolerate transport and operational requirements. During the mission, the CCATT physician will coordinate with the MCD after which the MCD will notify the PMRC as patient/mission requirements dictate. Consultation will be required prior to mission execution to determine the ideal provider mix to transport neonatal and pediatric critical patients.

3.7.3. Space-Limited Airframes. For patient transports with a CCATT utilizing smaller, space-limited airframes such as C-21, C-12, HU-25, etc., the AE crew may be limited due to weight and space limitations. It may also be necessary to pare and tailor CCATT equipment to essential items. The CCATT physician, in coordination with the tasking authority, will evaluate the mission requirements to ensure patient and mission needs are met with whatever team and equipment complement is utilized.

3.7.4. Non-AE Missions. Combatant Commanders (COCOMs) have the authority to utilize CCATTs on any urgent patient transport of critically ill or injured patients in order to save life, limb or eyesight on any USAF, other Service, or coalition opportune aircraft IAW AFI 11-401. In such cases, care should be exercised on the use of this limited asset. Support for critically injured/ill patients is a priority but must be weighed against over-arching theater requirements, mission risk and threat conditions, and the appropriateness and availability of other assets to safely move the patient(s). CCATT personnel may transport critically ill or injured patients on non-AE missions when operational or patient requirements dictate, in order to save life, limb or eyesight.

3.7.4.1. Utilization of CCATT on US Air Force aircraft without an AE crew requires approval of MAJCOM (COMAFFOR when applicable)/A3 with mission execution authority IAW AFI 11-202, *General Flight Rules, Volume 3*. MAJCOM (COMAFFOR)/A3 should be informed that CCATT are not aircrew and are not qualified to interface with any aircraft systems or portable oxygen systems or configure the interior of an aircraft to accept patients independent of AE. CCATT allowance standards do not include portable oxygen (PTLOX) or a portable frequency converter. CCATT members are not qualified to operate PTLOX or portable frequency converter independent of AECMs. The theater command and control agency governing CCATT should ensure all required equipment are available as necessary. In cases where the use of PTLOX or frequency converter is not required, the CCATT will operate under the auspices of the on-board front-end crew and only operate the equipment using battery power. When PTLOX or a frequency converter is required for the mission a qualified AECM will be assigned to the mission for interface between aircraft systems and medical equipment. CCATT members must be able to communicate the amperage requirement for equipment brought on board, what equipment may operate on aircraft (400Hz) power, and what equipment must use a frequency converter when plugged in. A crewmember qualified in the particular aircraft

must brief the CCATT on ground operations, flight safety, egress, loading/unloading, etc. It is the responsibility of the CCATT leader to ensure members are adequately briefed prior to the mission. It may also be necessary to pare and tailor CCATT personnel and/or equipment. The CCATT physician, in coordination with the tasking authority, evaluates the mission requirements to ensure patient and mission needs are met with the appropriate team and equipment complement utilized.

3.7.4.2. CCATTs may be tasked to fly on non-US Air Force aircraft IAW AFI 11-401, *Aviation Management*. CCATTs are not required to fly with AECMs on non-US Air Force aircraft, however, the tasking authority/agency must be informed that CCATT are not aircrew and are not qualified to interface with any aircraft systems or portable oxygen systems or configure the interior of an aircraft to accept patients independently. CCATTs will follow directions of the assigned aircraft crew on factors pertaining to operating on-board the particular aircraft. Prior to transporting patients on non-AE missions, CCATT members must be properly oriented and equipped for these missions, and briefed on ground operations, flight safety, egress, patient loading/unloading, etc. by a crewmember qualified in the particular aircraft. Due to space and weight limitations on some airframes, it may be necessary to pare and tailor both the personnel and equipment. The CCATT physician, in close coordination with the tasking authority, evaluates the mission requirements to ensure patient and mission needs are met with whatever team and equipment complement is utilized. The theater command and control agency governing CCATT will ensure an alternate oxygen and electrical source that is approved for use on that aircraft are available as required, as CCATT members are not qualified to operate PTLOX or portable frequency converter. The CCATT will utilize the oxygen and electrical source that is used by the aircraft medical crewmember. In cases where there is no medical crewmember support, the CCATT will operate medical equipment on battery only.

3.7.5. Peacetime Taskings. Peacetime taskings, i.e., other than war support contingency operations may include, but are not limited to, President of the United States (POTUS) support, special operations support, within continental United States (CONUS)/outside continental United States (OCONUS) beneficiary transports, DSCA, i.e., hurricane evacuation, humanitarian assistance/disaster response (HA/DR), etc. These taskings will be short notice and may be brief or extended in duration. CCATT members must meet and maintain currency in all training requirements stated herein to perform these missions. Missions within the U.S. Pacific Command (PACOM) AOR and U.S. European Command (EUCOM) AOR will be managed by their respective AF supporting commands and/or assigned Numbered Air Force (NAF) IAW this TTP. An on-call schedule for CCATTs required to support DSCA operations has been established by HQ AMC/SGX and distributed to all MAJCOMs/units with CCATT UTCs assigned.

3.7.5.1. Disaster Relief. During DSCA operations such as pre- and post-hurricane landfall evacuations, or other disaster response operations where local transportation infrastructure or community support structure is compromised,

patients must be transported via local community transportation assets to a patient staging area established near an APOE suitable for handling large mobility aircraft. CCATTs will not be transported to area medical treatment facilities or long-term care facilities to receive patients. Consideration must be given to establishing a ground patient staging/holding capability able to provide care for critically ill and/or injured patients at the APOE until CCATTs arrive to transport patients out of the area. CCATTs and AE crews will be staged at a safe location distant from the evacuation/disaster area. CCATTs and AE crews will be flown in to the APOE to pick up patients. CCATTs will not leave the vicinity of the APOE but will receive their patients from the staging facility at the APOE. APOE critical care staging assets will have pre-positioned critical care equipment and supplies, same as in the CCATT (FFCC4) kit, to support critically ill and/or injured patients awaiting transportation. Patients will be transported via mobility aircraft to pre-determined medical treatment/care facilities located near established APOD. CCATTs may or may not transport patients from the APOD to nearby MTFs. Ideally, transport services capable of providing care for critically ill and/or injured patients should receive CCATT patients at the APOD and transport the patients to nearby MTFs without degradation in the level of care. This will enable CCATTs and AE crews to “quick-turn” back to the APOE to facilitate the swift evacuation of additional patients. Careful attention must be paid to the proper work/rest cycle management of CCATT teams during disaster operations. Team members must be rested and fully able to care for their patients. As AE crews rotate into crew-rest, CCATTs should also be provided proper rest.

3.7.5.2. Beneficiary Patient Transports. Prior to the start of Operation IRAQI FREEDOM, CCATTs routinely conducted beneficiary patient transport missions within CONUS and OCONUS. With the realignment of bases and force restructuring over subsequent years, in many cases it has become more cost effective to utilize the civilian air ambulance (CAA) network that may have transport assets more strategically located to meet critical patient needs. On occasion, CCATTs may still be tasked to support a beneficiary patient transport mission. This may occur more frequently in the European and Pacific theaters, but may include CONUS and other theaters as well. When a CCATT is required for a beneficiary patient transport mission, the originating facility will contact the respective PMRC. The PMRC will contact the closest medical treatment facility with CCATT capability to support the transport.

3.8. CCATT Work/Rest Cycle.

3.8.1. General. CCATT work/rest cycle does not equate to Aircrew Crew Duty Time and should not be used for mission planning purposes. The guidelines herein are to be used as a measuring tool to assess the ability of team members to continually provide optimal patient care for the duration of the mission and to ensure CCATT members are given adequate time for rest/recovery prior to subsequent mission taskings or returning to point of origin.

3.8.2. Contingency, i.e. Wartime/DSCA/Humanitarian Operations. Under typical operating conditions, the standard work cycle for the FFCCT teams is 16 hours. The 16-hour work period begins with show time for mission preparation at the Aeromedical Evacuations Operations Team (AEOT). The work period ends when the team has delivered the patient(s) to the next level of care, the receiving facility has assumed care responsibilities for the patient, and all duties have been completed (to include replenishment of supplies/kits, pallet building when required, etc.).

3.8.3. Non-contingency Individual Beneficiary Transports. When the CCATT originates at the same medical treatment facility as the patient being transported, the 16-hour work period begins four hours prior to scheduled take-off. When the CCATT is transported via aircraft to another facility to pick up a patient, the work period will begin three hours prior to that scheduled take-off.

3.8.4. Under certain circumstances, such as delays en route due to an aircraft maintenance issue, the CCATT chief may extend the work period beyond 16 hours in order to meet patient care requirements, to a maximum of 24 hours without outside coordination with governing C2 agency. The team chief will consider potential benefits (including minimizing remain overnight stops and continuity of patient care) and potential harm (due to delay or fatigue). When extending the work period, the CCATT chief will notify the MCD/PIC who will notify the governing C2 agency (AECT, 618 AOC (TACC) or assigned AOC). The CCATT chief will also consider the ability of the entire team to rest when not engaged in patient care, the appropriateness of the team resting in shifts while engaged in patient care, the team's response to fatigue countermeasures, and individual team member factors affecting operational risk management. The CCATT chief will assess the team's mental and physical abilities to safely complete the mission and provide satisfactory critical care. If the team is assessed as unsafe, the CCATT chief will notify the MCD/PIC who will coordinate mission re-tasking with the AECT or 618 AOC (TACC) as applicable.

3.8.5. There may be times (inclement weather, winds, crew duty day, etc.) when the AE crew must remain overnight (RON) at fields where local medical care is less capable than the care provided by the CCATT. To maintain standard of care, the CCATT may be required to continue caring for the patient, impacting work/rest cycles. The local MTF commander (or equivalent), MCD, and CCATT chief should collectively determine the optimal solution to satisfy competing requirements. In instances where the CCATT work period is projected or has exceeded the recommended 16-hour period, the CCATT chief has the authority to determine if any of the CCATT members are in need of rest/sleep and authorize rest/sleep if deemed necessary.

3.8.6. It will be the responsibility of the en route AE element to assist the CCATT in returning to the duty location of the team (point of origin) as soon as the team has rested. Eight hours of uninterrupted sleep at the destination is recommended, prior to returning to theater (when teams are allowed to sleep at the destination, teams will be more capable of flying again once they return to their duty location).

3.8.7. Any CCATT whose total work period has extended beyond 24 hours, inclusive of mission support and patient care activities will require a minimum 12 hours of uninterrupted rest/sleep prior to returning to their primary duty location. The CCATT chief will be responsible for assessment of the team's health and ability to safely complete the mission and provide satisfactory critical care.

3.8.8. Any CCATT that can be returned to the point of origin duty location within 24 hours from show time of the originating mission may be returned without a rest period. When this occurs, the team shall have a minimum 10 hours of continuous restful activities including an opportunity for at least 8 hours of uninterrupted sleep during the 12 hours immediately prior to a mission (rest period will begin after release from return to point of departure). If the team is assessed as unsafe by the CCATT chief, the AEOT will coordinate mission re-tasking with the AECT or 618 AOC (TACC) as applicable.

3.8.9. In coordination with the Theater En Route Critical Care Director, if available, the AECT/AOC may re-task a CCATT for patient transport prior to returning the team to its home station, to support theater requirements. In this case, the en route AE element will assist the transiting CCATT in replenishment and reconstitution of their expended supplies. When the AECT/AOC re-tasks a CCATT for patient transport immediately following completion of a previous mission, the total duty day, inclusive of mission support and patient care activities should not extend beyond 24 hours. If operational requirements prompt the AECT/AOC to task a CCATT in this manner, the CCATT chief will assess whether the team is mentally and physically able to safely complete the mission and provide satisfactory critical care. If the team is assessed as unsafe, the AEOT will coordinate mission re-tasking with the AECT/AOC as applicable.

3.8.10. CCATT Work/Rest Cycle policy may be waived by the Theater En Route Care Director (or AECT if a Theater En Route Critical Care Director is not appointed) when there is an operational requirement for a team to be returned sooner to the AOR.

3.8.11. To ensure adequate time for rest/sleep cycles for CCATT, a rotational schedule must be established among the deployed teams at a particular location. The CCATT Director at the AE element level will establish the rotational schedule in coordination with the AEOT. In special circumstances, this rotational schedule may be disrupted according to the flow of patients or when the CCATT Director (or designee, if not available) determines that it is medically or operationally necessary to accomplish the mission successfully.

3.9. Flight Operations.

3.9.1. CCATT Patient Assessment. For critically ill or injured patients, assessment of the patient's clinical status for flight should be accomplished by the CCATT at the originating MTF whenever feasible. Patients should be transitioned to CCATT equipment and assessed for stability in an MTF environment when geographically feasible. Any interventions required to enhance stability for transport should be performed prior to transport. Prior to the mission, the PMRC validating flight surgeon

will work with the Theater En Route Critical Care Director, if available, sending physician, accepting physician, and the transporting CCATT physician when planning and coordinating the patient's transfer. The transporting CCATT physician will make the final determination whether or not a patient will be transported after assessment, considering the patient's ability to tolerate transport and operational requirements. Consultation with the Theater En Route Critical Care Director, if available and the PMRC validating flight surgeon will be required prior to mission execution to determine the ideal provider mix to transport neonatal and pediatric critical patients. Determination of continuing pre-flight care requirements must be ongoing as changes in clinical status may require postponement or cancellation of the patient's scheduled transport.

3.9.1.1. Non-CCATT Patients. The PMRC will not validate patients without a normally-required medical attendant because of the presence of a CCATT on the mission. CCATT will only be responsible to provide care for the patient(s) validated as requiring a CCATT for transport. The assignment of additional non-CCATT patients to a CCATT taxes the capability of the CCATT to provide care for assigned patients. Should a mission be diverted en route to pick up additional CCATT patients, the CCATT may not be able to continue to provide care for a non-CCATT patient. Such non-CCATT patients should be assigned to a medical attendant (MA).

3.9.2. AE Mission Responsibilities. The CCATTs will work in conjunction with the AE crews. AE crewmembers will continue with standard in-flight duties and assist CCATTs as required to enhance AE mission capability. The AE crew will ensure all power and oxygen requirements are met and properly configured for CCATT missions. The CCATT physician is responsible for all clinical decisions regarding critically ill patients under their care during patient movement, including notifying the MCD of any changes in patient status requiring collaboration through the AOC with the PMRC and validating flight surgeon. Depending on the mission's critical care requirements, the MCD will incorporate the CCATT capabilities into pre-mission planning and briefings for patient emergencies.

3.9.2.1. The CCATT physician on-board may be consulted at any time during a mission by the MCD to evaluate an AE patient who has exhibited a change in condition. If deemed necessary by the CCATT physician, primary responsibility for the care of the patient will be transferred to the CCATT and further care will be documented on the AF Form 3899L.

3.9.3. At the completion of the AE mission, the patient must be transferred to the receiving medical platform/MTF without degradation in the standard of care.

3.10. Ground Operations.

3.10.1. AE Mission Support. The CCATTs will be integrated into the AE staging and ground mission support operations and may be included in duties related to expeditionary squadron/element deployment, employment (including camp set-up), and re-deployment activities while maximizing operational mission readiness and appropriate work/rest

cycles. Launch and recovery operations and standard aircraft configuration are the responsibility of AEOT and AECM personnel. CCATT personnel may assist trained, experienced AE personnel in aircraft configuration duties and other ground operations when authorized by the CCATT Director, when not on primary call, and are governed by the work/rest guidelines. Before assisting, CCATT personnel must be fully oriented and trained in the performance of ground mission support duties and may perform these duties only under the supervision of, and in conjunction with, experienced AE ground support personnel. Under no circumstances will CCATT personnel be required to perform launch and recovery of aircraft, aircraft configuration, and other ground support activities without proper orientation/training and without experienced AE ground support personnel.

3.10.1.1. AE units should regard the CCATTs as expert critical care medical consultants, available to provide advice whenever questions arise about care of patients during transport. CCATTs may provide clinical in-service training sessions to assigned AE element personnel as operations allow.

3.10.2. Local MTF Assistance. Critical care skills deteriorate quickly and must be practiced continuously in order to maintain the highest expertise and proficiency level. AE element commanders should encourage assigned CCATT members to seek opportunities to assist personnel at a local MTF with the care of critical patients in order to maintain clinical currency and proficiency. CCATT personnel may supplement local MTF staff only when practical and not on primary call/alert. This practice has the added benefit of providing the CCATT with prior knowledge of the status and care requirements for patients that they may be tasked to transport. The CCATT Director coordinates assigned CCATTs to assist in a local MTF after approval from the AE element commander. The CCATT Director will be the primary liaison between AE and other ground patient care facilities and will determine involvement of CCATT in local MTF assistance. CCATT Director will inform the AEOT of members providing local MTF assistance. CCATT personnel must not be scheduled for regular duty hours in a MTF due to the nature of the ever-changing flying environment – assistance in a local MTF must not interrupt work/rest cycle, or mission-ready status.

3.9.3. CCATTs can assist in the support of non-CCATT patient reception and triage at an AE staging location or other AE patient interface point as befitting the team's clinical skills. The CCATT Director should ensure that this support does not interfere with their primary assigned duties, work/rest rule, and their mission-ready status.

3.11. Documentation.

3.11.1 AF Form 3899L, *Patient Movement Record En Route Critical Care*, should accompany each patient to ensure appropriate care is documented during transport and serves as the legal record of patient care. This document is used to direct and record en route care. AF Form 3899L is the required CCATT documentation form. If additional AF Form 3899 attachments (A-K) are required, they should be used in addition to, not in place of, the AF 3899L. Examples include progress notes that require additional space, additional medication sheets, detailed Input-Output recording, restraint use, or patient

resuscitation. If available, copies of patient medical documentation including operative reports should be provided to the CCATT team chief. CCATTs are required to participate in the AE Patient Safety Program, IAW AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care*, Attachment 14, "AE Patient Safety" documentation.

3.12. CCATT Quality Improvement/Performance Improvement (QI/PI) Program.

3.12.1. HQ AMC/SG has designated the CCATT Pilot Unit at the 59th MDW as the central manager for the CCATT QI/PI Program. It is the responsibility of the Pilot Unit to obtain all CCATT mission documentation and maintain a performance improvement platform to ensure safe patient transport. The goal of the program is to identify and correct patient care issues directly impacting patient outcome throughout the continuum of care. Identification of potential problems occurs through two primary channels: 1) CCATT QI/PI manager participates in the weekly clinical theater video teleconference identifying potential areas for improvement, and 2), all pages of the completed AF 3899s are sent to the CCATT Pilot Unit for each CCATT patient transported. After reviewing the documentation, the CCATT QI/PI manager enters data into the CCATT registry. When an item for potential improvement is identified, a PI event is opened in the registry. At the completion of the investigation, the item is closed by the CCATT Pilot Unit Medical Director; and feedback is provided to the involved CCATT team. When a global area for improvement is identified, the information will be forwarded to the Course Director, CCAT Initial Course and/or CCAT Advanced Course for potential inclusion in the curriculum.

3.12.2. If an ARC CCATT is involved or a global issue for improvement is identified, HQ AMC will forward the feedback/information to ANG and AFRC Surgeons' offices.

3.12.3. The CCATT Pilot Unit is the central collection point for all CCATT medical documentation. It is the responsibility of each CCATT to forward medical documentation to the CCATT Pilot Unit on each patient transported during all operations and missions whether peacetime beneficiary movements, contingency, or disaster relief operations. It is required, when the CCATT arrives at the destination medical treatment facility, after giving a patient report to the receiving facility, the team must copy/scan the AF 3899L, and supporting documentation, for each of their patients. The team must then forward the copy of the medical documentation to the Pilot Unit via Fax (DSN 554-5053 / Commercial 210-292-5053) or scan and e-mail the documentation to: ccattpilotunit.59mdw@us.af.mil. Appropriate Health Insurance Portability and Accountability Act of 1996 (HIPAA) /security statements must be included. Faxes are received in a locked office with no through-access. The documentation will be evaluated by the CCATT QI/PI Manager and feedback will be sent to the team. The records will be entered into the theater medical information system, and the QI/PI Manager will upload the documentation into the Joint Theater Trauma Registry (JTTR) for analysis, research, and tracking of trends.

3.13. Security.

3.13.1. Medical personnel and equipment are non-combatant assets. Personnel may be armed as dictated by theater instructions. Security for CCATT personnel and equipment is the responsibility of the host unit. If CCATT personnel require weapons, all team members will be issued and qualified on the assigned weapon, IAW AFI 41-106, *Medical Readiness Program Management*.

Chapter 4

OPERATIONAL SUPPORT FLYING

4.1. Operational Support Flier (OSF).

4.1.1. CCATTs are not considered, nor do they qualify to obtain, rated or non-rated aircrew status. CCATTs are designated as OSF. (Exception: Active flight surgeons holding an API 5 position performing duties as CCATT retain crewmember status.) CCATTs fly in OSF (non-crewmember) status and must comply with AFI 11-401, *Aviation Management*, and AFI 11-402, *Aviation and Parachutist Service, Aeronautical Ratings and Badges*. CCATTs must be medically qualified according to AFI 48-123, *Medical Examination and Standards*, and have completed appropriate physiological training IAW AFI 11-403, *Aerospace Physiological Training Program*, to participate in flying activities. Once these qualifications have been met, a CCATT member may be placed on OSF status. Personnel may not be employed or deployed as CCATT until they meet all requirements for OSF status.

4.1.1.1. Original Training. CCATT personnel will typically accomplish Original Training (initial aerospace physiological training) IAW AFI 11-403 for OSF status while attending the CCAT Initial Course. All CCATTs must have a current OSF physical with AF Form 1042, *Medical Recommendation for Flying or Special Operational Duty*, in order to participate in and receive initial physiological (altitude chamber) training during the course. Recurrent physiologic training must be accomplished IAW AFI 11-403.

4.1.1.2. Host Aviation Resource Management (HARM) Office and Flight Record. Upon successfully completing the CCAT Initial Course and meeting the qualifications for OSF status, CCATT members will report to their home station HARM or Squadron Aviation Resource Management (SARM) office with a copy of their certificate for the CCAT Initial Course, a copy of their current OSF physical with AF Form 1042 and their AF Form 1274, *Physiological Training* (previously, AF Form 702, *Physiological Training Record* – AF Form 702 has been eliminated). The HARM office will establish a flight record folder for the member. Upon completing the CCAT Advanced Course, members will bring a current copy of the course certificate to the HARM office to be added to the flight record folder. Members must bring a copy of the course certificate after each time the CCAT Advanced Course is completed.

4.2. Flight Operations Protective Clothing and Equipment.

4.2.1. CCATT members must be properly equipped to perform duties in the flying environment to include issue of aircrew personal protective clothing items. CCATT members must have the same flight personal protective clothing, equipment, and IPE as the organic AE crew. A list of initial-issue minimum-required protective clothing/equipment items for CCATT flight operations is shown in Attachment 6. A list of minimum-required protective clothing/equipment items for CCATT flight operations

in a deployed location is shown in Attachment 7. Each CCATT member must be provided the required protective clothing and equipment for flight operations to perform patient transport missions according to threat and environmental conditions. CCATTs do not fall under the Operations Group for training and equipping and do not receive support from Aircrew Flight Equipment personnel. It is the responsibility of the home station unit commander to properly train and equip each member identified to fill CCATT position requirements.

4.2.2. Individual Body Armor (IBA) vs. Aircrew Body Armor (ABA). CCATTs must deploy with National Institute of Justice (NIJ) Level IV Ballistic Individual Body Armor (IBA). When aircrews and aircraft are operating in potentially high-threat regions, Aircrew Flight Equipment operations will issue ABA to each crewmember. CCATTs, however, are not rated or non-rated aircrew; they are OSF. Thus, Aircrew Flight Equipment does not provide ABA to CCATTs. Unlike the front-end and AE aircrew members, CCATTs must leave the aircraft and flight line area to retrieve patients, potentially directly exposing themselves to hostile elements, thus requiring a higher level of personal protection. If ballistic IBA is not provided by the COCOM prior to or upon entry into the theater, home units are responsible for supplying their deploying CCATTs with IBA beforehand. NIJ Level-IV ballistic IBA should not be confused with flak vest/fragmentation vest. These items do not provide the required level of protection. Additional information on body armor requirements for CCATT may be found in Attachment 7.

4.3. Aeronautical Orders (AOs).

4.3.1. As operational support fliers, CCATTs must be on appropriate AOs when on-board U.S. aircraft for training or real-world missions (exception: verbal order of the commander IAW AFI 11-401). AOs authorize personnel to perform frequent and regular flights on-board U.S. aircraft and allow the CCATT's to legally be listed on the Flight Authorization and perform duties on-board the aircraft.

4.3.2. In order to qualify for regular AOs, CCATT members must:

- Have completed the CCAT Initial Course; one-time attendance (copy of training certificate must be in member's flight record folder).
- Have a current OSF physical with AF Form 1042, *Medical Recommendation for Flying or Special Operational Duty*; annual requirement.
- Have a current AF Form 1274, *Physiological Training*; after original training, flying personnel complete refresher training once every five years.
- Have completed and maintain currency in the CCAT Advanced Course (see paragraph 5.4.1.2.); required every two years (copy of current training certificate must be in member's flight record folder).

4.3.3. AOs must be requested in writing with a letter signed by the CCATT's unit commander. The AOs should be requested to cover the duration of the deployment. Requests must be presented to the HARM office well in advance of the date AOs are required in order to allow for proper processing. When requested in advance, the HARM office will ensure the AOs are prepared in time to accompany the member to the deployed location. It is the responsibility of the home station Readiness Office to ensure CCATTs deploy with AOs. **Note:** ARC CCATT members must be on mobilization orders, extended man-day (MPA) orders, or extended active duty in support of flying missions of an on-going contingency operation or disaster response/relief missions in order to qualify for AOs and to record primary flight time and receive incentive pay. ARC members flying missions while in UTA status, Annual Tour, or any status/condition other than previously stated are not eligible for regular AOs, may not record flight time, or receive incentive pay.

4.3.4. Non-interference AOs for Training/Exercises. IAW AFI 11-401, *Aviation Management*, Active Component and ARC CCATTs participating in training flights where they will set up and train on their medical equipment kits must be on non-interference AOs for the duration of the training activity in order to participate in the training flight(s). This applies to training flight activities conducted during the CCAT Advanced Course, Joint Readiness Training Center (JRTC), Theater Aeromedical Evacuation System (TAES) exercises, local training flights, or similar training flight activities. Non-interference AOs will allow the CCATTs to be listed on the Flight Authorization and permits them to set up their medical equipment and perform training during the flight. If a CCATT member reports to a training flight activity without non-interference AOs, they will not be able to participate in the training activities during flight. CCATTs may fly on familiarization (FAM) flights without AOs if approved IAW AFI 11-401, but will not be listed on the Flight Authorization, nor may they set up equipment and conduct training during the flight. CCATTs must meet and maintain the qualifications for OSF status in order to be on non-interference AOs – completed CCAT Initial Course, and have current AF Fm 1042 and AF Fm 702/1274 (completion/currency in the CCAT Advanced Course is not required for non-interference AOs). The process for requesting non-interference AOs mirrors the process for requesting regular AOs for normal CCATT missions; AOs must be requested in writing with a letter signed by the CCATT's unit commander. The letter must clearly state the request is for non-interference AOs. The AOs should be requested to cover the duration of the course, exercise, or other particular training activity. When flying with non-interference AOs, OSF personnel do not log time and are not eligible for incentive pay. They do not need to complete and file an AFTO Form 781, *ARMS Aircrew/Mission Flight Data Document*, with their local HARM office. **Note:** Air Reserve Component members may obtain non-interference AOs while in any duty status in order to participate in training or exercise flights.

4.3.5. AF Form 1887, *Aeronautical Order (PA) Aviation Service*. OSF AOs are issued monthly. Unless an earlier termination date is known, OSF AOs expire on the last day of each month. New AOs must be published monthly for those members who need to be on AOs for extended periods. When CCATT members require AOs for periods greater than one month, the HARM office will prepare the AOs on AF Form 1887 and give the

deploying CCATT members sufficient AOs required for the duration of their deployment. **(Exception:** When a member's deployment will stretch from one fiscal year to the next, the HARM office will only supply AOs effective through the last day of the fiscal year. The CCATT-OSF Program is funded on a fiscal year basis. As the central manager for the CCATT-OSF Program, HQ AMC/SGK requests program allocations each fiscal year from HQ USAF/A3O-AT. Normally, 15-30 days prior to the beginning of a fiscal year, HQ USAF/A3O-AT will provide a program allocation to HQ AMC/SGK. In turn, HQ AMC/SGK will provide new fiscal year program allocations to each HARM office supporting CCATT teams. Excess allocations from the prior fiscal year may not be carried into the following fiscal year; HARM offices will turn in excess/unused CCATT-OSF program allocations to HQ AMC/SGK at the end of each fiscal year.)

4.3.6. AFTO Form 781 *ARMS Aircrew/Mission Flight Data Document* and Logging Flight Time. As OSF, CCATT members are authorized to log flight time on AFTO Form 781. AFTO Form 781 is the source document for recording and reporting operational flight information for each individual authorized to take part in a mission. This form is the primary record of both personnel and aerospace vehicle flying hours. It is also the official record to validate pay eligibility for qualified members required to fly. CCATT members may be eligible for hazardous duty incentive pay (HDIP) providing conditions are met. In order to qualify for HDIP for any particular month, CCATT members must log a minimum of four hours of primary flight time within that month, or the appropriate fractional time required to qualify for partial HDIP if member is on orders for less than 30 days (DoD Financial Management Regulation, Volume 7A, Chapter 22). Only primary time logged counts toward credit for HDIP; CCATTs only log primary time when actually performing patient care duties on-board the aircraft. CCATT members may not bank flying time. En route missions to pick up patients requiring medical care may be logged as other time when patients are not on board the aircraft. (For example: A CCATT is tasked to fly to pick up a patient downrange. On the en route mission to pick up the patient, the CCATT logs other time. Primary time will then be logged when the patient is on board the aircraft and the CCATT provides medical assistance in-flight.) Complete AFTO Form 781 IAW AFI 11-401. Member(s) will list duties performed on the back of AFTO Form 781 in the remarks section. The completed AFTO Form 781 must be submitted to the CCATT's home station HARM office in a timely manner, preferably at the end of each mission, but not later than the fifth day of the month following the month in which a mission was flown. AFTO Form 781s not turned in on time, may result in a member not receiving flight time credit or HDIP for the month during which the corresponding mission was flown. Under no circumstances are AFTO Form 781s to be held until the end of an extended deployment before being turned in to the HARM office.

4.3.7. Aircraft Commander, Senior OSF, and/or MCD Responsibilities. Aircraft commanders, senior OSF, and/or MCD will ensure OSF personnel fly only on missions that require performance of valid in-flight duties and will ensure primary flying time is logged only during portions of the mission when valid in-flight duties are performed. The aircraft commander, MCD, or senior OSF member is authorized to certify OSF duties performed by the CCATT members on the AFTO Form 781 by signing under the remark. CCATT members will include their home station HARM/SARM base, DSN

phone number, and fax number in the remarks section on the back of the (original and extract) AFTO Form 781. (Example statement: *CCATT members X, MD; Y RN; and Z RT performed primary critical care duties on patients 1,2,3... en route from [location] to [location], and I certify this is a true and verifiable statement. [Signed]*). **Note:** AOs alone do not authorize a member to fly and log time for entitlement to incentive pay. The member must be qualified for aerial flight, required for the mission, and actually perform in-flight duties. Do not log time spent in observation, familiarization, or point-to-point travel on the AFTO Form 781.

4.4. Aviation Service Code (ASC)/Flying Activity Code (FAC).

4.4.1. The assigned aviation service code (ASC) for CCATT members performing duties as operational support fliers is ASC 9C. The flight authorization duty code for CCATTs on OSF is FZ per AFI 11-401, *Aviation Management*.

4.4.2. Active Flight Surgeon on CCATT (Ref: AFI 11-401). Active Flight Surgeons in an API 5 position may be employed as CCATT members provided they also hold one of the qualifying AFSCs required for CCATT duty as outlined in the MISCAP statement and Manpower Force (MANFOR) packaging document. Active flight surgeons will log FS crew position and primary-time duty credit, record ASC 8A, and will qualify for aviation career incentive pay (ACIP).

4.4.3. Inactive Flight Surgeon on CCATT (Ref: AFI 11-401). Inactive flight surgeons – those in an API 0 position – may also be employed as CCATT members provided they hold one of the qualifying AFSCs as outlined in the CCATT MISCAP. Because they are rated officers, their ASC must remain “8J” (based on no API 5/no ACIP authorized), their AO must reflect a “FAC 8” IAW AFI 11-401 (rated officer performing non-crew duty), and they must log flight authorization duty code “FZ” time on CCATT missions. Following this guidance, inactive flight surgeons employed as CCATTs are authorized HDIP, if otherwise qualified.

4.5. Flight Authorization.

4.5.1. The AE unit providing the AE crew for a live AE mission or a CCATT training mission is responsible for adding the CCATT members on the flight to the manifest of the AE Flight Authorization (FA) after validating CCATT members have current aeronautical orders. For a CCATT joining the mission en route, the MCD will validate member has current aeronautical orders, ensure the members’ names are handwritten onto the FA and that flight time is logged IAW AFI 11-401.

Chapter 5

TRAINING

5.1. Introduction.

5.1.1. Initial, advanced, and recurrent training are required in order to maintain the operational and clinical proficiency of personnel assigned to a CCATT UTC. CCATT members (to include the Theater En Route Critical Care Director) will not be employed or deployed in a CCATT capacity unless they are current in all training requirements IAW this TTP and AFI 41-106.

5.2. Unit CCATT Coordinator.

5.2.1. A CCATT coordinator should be established at each medical unit that has a CCATT UTC assigned. A unit CCATT coordinator may be a senior member of the unit's CCATT UTCs or may be a member of the unit medical readiness office, or may be shared between the two entities. Whichever course is chosen by the unit commander, the CCATT coordinator should be someone with extensive knowledge of CCATT's unique requirements and capabilities. Examples of duties/responsibilities that may be assigned to the unit CCATT coordinator are as follows: (1) central point of contact within the unit for all matters pertaining to CCATT interface with the unit, MAJCOM, and higher headquarters for CCATT issues, (2) establishing and maintaining training folders for each CCATT member assigned and ensuring that all requirements are appropriately listed/tracked in the Medical Readiness Decision Support System (MRDSS), (3) ensuring all initial and sustainment training requirements are scheduled to be met/current, (4) initiating all required forms and documentation for all new CCATT members, (5) ensuring CCATTs are properly equipped for patient movement missions, (6) identifying and scheduling personnel to meet initial training and sustainment training requirements in coordination with the training office and the medical readiness office, (7) coordinating with the medical readiness office to ensure members are ready to deploy, (8) track CCATT member Duties Not to Include Flying (DNIF) status and ensure members are not scheduled for flight duties while in DNIF status, and (9) other responsibilities that may be assigned and necessary for unit-level CCATT administration. When a CCATT coordinator is appointed, notify HQ AMC/SGK and HQ AMC/SGX of the member's name and contact information to ensure appropriate distribution of information. (Key information distributed by HQ AMC/SGK and SGX offices should include owning MAJCOM SGX offices for situational awareness.) **Note:** This does not apply to AE units when CCATTs are temporarily assigned/attached. During deployments, when CCATTs are assigned to an AE element, a CCATT Director is assigned for local management of CCATTs.

5.3. Entry into CCATT Training.

5.3.1. Personnel are selected at the unit level for consideration for nomination/appointment to a CCATT UTC. Validation will be performed by the Clinical

Validation Committee administered by AFEMSI, under the authority of the CCAT MEFPAK, HQ AMC/SG

5.4. Training Pipeline (see Attachment 8, Table A13.1).

5.4.1. UTC Formal Training.

5.4.1.1. CCAT Initial Course. All Active Component CCATT personnel will attend the CCAT Initial Course within 6 months of validation for appointment to the UTC, with priority given to those scheduled in the AEF Tempo Band Construct to meet contingency/steady-state deployment requirements. ARC CCATT personnel will complete the CCAT Initial Course within 24 months of validation for appointment to the UTC. All CCATT members must successfully complete this formal training prior to employment and/or deployment as CCATT.

5.4.1.2. CCAT Advanced Course. All CCATT UTC personnel must complete the CVC process prior to attending the CCAT Advanced Course. All (Active Component and ARC) CCATT personnel must successfully complete the CCAT Advanced Course training prior to employment and/or deployment as CCATT. All CCATT personnel are afforded the same precedence for training; a higher priority should be given to those scheduled in the AEF Construct to meet deployment requirements.

5.4.1.2.1. All CCATT (Active Component, AFRC, and ANG) UTC members will attend the CCAT Advanced Course IAW AFI 41-106.

5.4.1.2.2. Every effort must be made to schedule CCATT personnel to attend this UTC training *in advance* of their potential AEF Tempo Band assignment to ensure they are successful in course completion. **DO NOT WAIT** to schedule this course. Currency must be maintained throughout any deployment. If a member's training will expire during deployment, the member must complete the course prior to deployment. Attendees who do not successfully complete the CCAT Advanced Course will require remediation prior to deployment as a CCATT member. The remediation training plan will be issued to the individual and his/her commander by the course director, through AFEMSI.

5.4.1.2.2.1. ANG CCATT members must go through ANG/SGX to schedule the CCAT Advanced Course. CCAT Advanced Course packages should be sent to ANG/SGX at ang.sgx@ang.af.mil.

5.4.1.2.3. The course curriculum culminates in a field exercise involving static training and a flying training mission. CCATT members attending the CCAT Advanced Course must be current in OSF requirements and have non-interference aeronautical orders on hand to participate in flying training activities during the course.

5.4.2. CCATT Flight Training. The primary objective of the CCATT flight training requirement is to develop and maintain the skills necessary for the effective employment of CCATTs within the flight environment during all manner of contingencies, operations, and missions. The secondary objective is to ensure the successful integration of CCATTs into AE operations, primarily working alongside AECMs to transport patients. Recommend CCATT members participate in at least 4 hours of flying training activity every 24 months; the 4-hour period should include a CCATT Training Mission in concert with an AE training mission. Initial and subsequent flight training requirements will normally be met through attendance at the CCAT Advanced Course. CCATTs are encouraged to seek additional flight training opportunities beyond the recommended requirement through participation in activities such as exercises or local unit training in collaboration with available AE assets. CCATT members will complete the CCAT Initial Course and maintain currency in OSF requirements prior to participating in flight training missions outside of the CCAT Advanced Course. CCATTs must be on non-interference aeronautical orders to participate in any flight training activities, however no time is logged and HDIP is not authorized.

5.4.2.1. CCATT Training Mission (CTM). CCATT flight training missions should be structured to achieve maximum training effectiveness. CTM sessions will include at least one enplaning or deplaning event with occupied or weighted litter(s); transport, loading, and exercising of the full CCATT kit (FFCC4) to include set up of medical equipment; and appropriate patient treatment/transport scenario(s). Sessions should also include one aircraft emergency scenario under the direction of the MCD.

5.4.3. Contingency Training. CCATT members will undergo initial contingency operations training at the Aeromedical Evacuation and Patient Staging Course (AEPSC). Primary introduction to CCATT integration into deployed AE operations as well as hands-on experience with the Base Operations Support package will occur at AEPSC. All CCATT personnel must complete AEPSC IAW AFI 41-106. Active component CCATT personnel will complete AEPSC within 18 months of completion of the CCAT Initial Course. ARC CCATT personnel will complete AEPS within 24 months of completion of the CCAT Initial Course. All CCATTs must have at least completed the CCAT Initial Course prior to attending AEPS.

5.4.3.1. AEPSC training may be waived based on experience gained/roles played as a member of a CCATT UTC during assignment to a deployed TAES, JRTC rotation, or participation in an exercise that encompassed a fully deployed TAES. Member must have been assigned to a deployed TAES, JRTC rotation, or TAES exercise for at least 5 consecutive days and participated in at least 2 live or simulated (JRTC/other exercise) CCATT missions to be considered for initial AEPSC waiver. Waiver requests for AEPSC training will be processed through the unit medical readiness office, signed by the unit commander, and forwarded to HQ AMC/SGX for review/approval. AEPSC training for CCATT will only be waived by HQ AMC/SGX. See Attachment 9 for a sample AEPSC waiver request.

5.4.3.2. For ANG, all waiver packages must be sent through ANG/SGX at ang.sgx@ang.af.mil and will be forwarded to HQ AMC/SGX by ANG/SGX.

5.4.4. Operational Support Flier Training. All CCATT personnel must complete the requirements for OSF status IAW AFI 11-402. CCATT personnel must maintain currency in OSF requirements as long as they are assigned to a CCATT UTC. Personnel may not be employed or deployed as CCATT members if they have not completed or are not current in OSF requirements. CCATTs must be on AOs in order to participate in flight activities on-board U.S. and coalition aircraft.

5.4.5. Operational Exercises. Some sustainment training and RSVs may be completed at operational exercises. In order to receive credit, the exercise must have a written training plan outlining day-to-day objectives for the CCATTs. Training plan must follow CCATT UTC METLs. Exercise/evaluations must pair the personnel CCATT UTC, FFCCT, and the equipment UTC, FFCC4. The CCATTs must perform relevant tasks associated with the CCATT mission, e.g., mission planning, patient preparation, setting up and exercising their medical equipment, transport and treatment of simulated casualty(ies) or mannequin(s), etc. CCATT members participating in exercises must have non-interference aeronautical orders on hand to participate in flying activities during the exercise.

5.4.5.1. CCATT Observer Controller/Standards Evaluator. A qualified CCATT Observer Controller (OC)/Standards Evaluator (SE) should be present for exercises (qualified CCATT OC/SE is defined as any CCATT UTC member who has completed the CCAT Initial and Advanced Courses, and is current in all required training; JRTC/deployment/mission experience is preferred but not required). Standards and responsibilities of CCATT OC/SE are outlined in the CCATT Observer Controller/Standards Evaluator Pamphlet available from AMC/SGK. Requesting unit will pay travel and expenses for individual(s) to participate in exercise as OC/SE. Availability of personnel to support OC/SE requests shall be at the discretion of the supporting unit. There should be at least one OC/SE per two CCATT teams, availability permitting. **NOTE:** The lack of qualified CCATT OC/SE personnel does not preclude CCATTs from participation in an exercise; they may, however, be unable to receive credit for some CCATT UTC sustainment training and RSV requirements. The exercise must still develop a written training plan with relevant objectives for the CCATT, following the CCATT METLs. Every effort should be made to secure qualified CCATT OC/SE personnel for the exercise(s).

5.4.6. Readiness Training. Personnel must meet readiness requirements IAW AFI 41-106 and this TTP.

5.4.7. High Risk of Isolation (HRI) Training. HRI training may be mandated for fliers involved in air operations over specific areas within or flying into a combatant command AOR during contingency operations. When so designated, the training requirement is identified by a combatant command in the AOR OPORD for the contingency. HRI training may be accomplished via briefer-led training; or, Secure Internet Protocol Router

(SIPR) web-based training (WBT) when available. It is to be conducted by a certified Survival, Evasion, Resistance and Escape (SERE) specialist. Each CCATT member tasked for deployment to a combat zone where a requirement for HRI is identified must attend HRI training prior to deployment. HRI training is good for three years. To schedule an HRI briefing, contact your local SERE specialist. If a local SERE specialist is not assigned/available, schedule training IAW CCMD reporting instruction or contact MAJCOM SERE Functional Manager (FM) for additional information/direction. After the training is complete, a copy of the training certificate, AF Form 1522, or other documentation record should be retained in the individual's CCATT training record. Training is also recorded on the Isolated Personnel Report (ISOPREP), block 24. Prior to training, all personnel must have their security clearance (Secret) verified by their unit CCATT coordinator or readiness office.

5.4.7.1. Isolated Personnel Report (ISOPREP). The ISOPREP is Department of Defense Form (DD 1833) containing information designed to identify and authenticate an evader by a recovery force. The ISOPREP is prepared by home-station intelligence personnel for deploying members prior to departure to an AOR where ISOPREP and HRI training is required. The ISOPREP is mandatory for all HRI personnel. It contains personal data known only to the isolated individual and is used by recovery forces to positively authenticate the survivor. An initial form is completed and then reviewed at least every 6 months. Once completed, the ISOPREP is classified Confidential and is maintained by the appropriate unit intelligence, SERE, or operations personnel. A guide for completing ISOPREPs can be found on the AF Portal CCATT website.

5.4.8. N95 Mask Fit Testing/Training. CCATT personnel are potentially exposed to highly communicable diseases during patient care and transport. IAW Occupational Safety and Health Act of 1970, the Air Force Occupational Safety and Health Program (AFOSH), and AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care*, state that personnel must be medically cleared, fit tested, and trained for wear of an N95 respirator prior to first use. N95 masks are Occupational Safety and Health Program (OSHA) approved for Personal Protective Equipment (PPE). Personnel must receive subsequent fit-testing and training annually. Reference AFOSH Standard 48-137, *Respiratory Protection Program*, for specific requirements and contact the supporting occupational health staff for support.

Chapter 6 LOGISTICS

6.1. Allowance Standards.

6.1.1. CCATT equipment packages are to be used in conjunction with the standard AE in-flight kit and PMI to provide focused critical care capability.

6.1.2. Standard Operations. Each CCATT adult kit (FFCC4) has the capability to support up to three high-acuity, ventilated patients or up to six lower-acuity, non-ventilated patients per intra- or inter-theater mission. A basic adult mission would require the adult kit with initial capability. Each kit is only good for one mission support and will require replenishment at mission end.

6.1.2.1. FFCCB is the adult resupply equipment package. FFCCB supports up to 15 missions.

6.1.2.2. FFCC2 is the pediatric augmentation package. FFCC2 should be deployed to support up to 3 FFCC2 teams at locations where pediatric casualties are likely.

6.1.2.3. CCATTs deploy into theater and are paired with a War Reserve Material (WRM) CCATT equipment/supply kit. One FFCC4 will be positioned at a location for each CCATT deployed there. Each team at that location will be assigned a kit, and it will be that team's primary responsibility to restock bag sets and ensure that equipment is recharged and maintained properly between missions. PMI bar codes are attached to the CCATT equipment once in theater to facilitate tracking of those assets. CCATTs should fly all AE missions with their complete allowance standard. While performing patient care duties, CCATTs will utilize equipment from their CCATT kits to the fullest extent. When a CCATT has exhausted equipment items from their assigned CCATT kit, the team will utilize equipment from the PMI system if a PMI pool of equipment has been tasked and deployed to support on ongoing and sustained contingency operation.

Note: This is only applicable to the AFCENT Area of Operations (AOR) currently and any future contingency operation that may be established and ongoing. There is no PMI pool of equipment established for peacetime operations. Sending MTFs are supposed to identify patient movement equipment requirements in the Patient Movement Request for transport.

6.1.2.4. When picking up multiple patients at a facility in theater that is a PMI node, the sending facility will provide additional PMI equipment in cases where the CCATT allowance standard is exhausted. The sending facility will also provide PMI items not on the CCATT allowance standard (wound vacuums, sequential compression devices, pain control pumps, etc.) with enough supplies to support the patient during flight.

6.1.2.5. When transporting multiple patients from a facility that is not a PMI node and the CCATT anticipates its allowance standard will be exhausted or that PMI equipment not on the CCATT allowance standard will be required to perform a safe transport, the CCATT must bring the additional PMI from their originating location (PMI node). Sending MTFs identify patient movement equipment requirements in the Patient Movement Request for transport.

6.1.2.6. For situations in which ground time is limited due to the tactical situation, the CCATT may trade equipment items from its allowance standard for like PMI items from the sending facility. This practice will expedite patient assessment and packaging prior to transport, but it will not result in a net gain or loss of PMI for either the CCATT or the sending facility. The return exchange of this equipment must be coordinated by the sending facility and the CCATT team, as it may be on different Defense Medical Logistics Standard Support (DMLSS) accountable records, to ensure equipment accountability and integrity.

6.1.3. Pediatric Support During Operations. During operations where FFCCT CCATTs are deployed in support of critical care patient movements, there may be occasions when it is necessary to transport pediatric patients. The Adult CCATT Kit, UTC FFCC4, does not provide equipment to support pediatric patients. A pediatric equipment augmentation kit, UTC FFCC2, has been developed which provides additional equipment/supplies to FFCC4 equipment to support FFCCT when a team is required to transport pediatric patients. This kit provides single mission support for a maximum of 2 pediatric patients weighing < 15 kg, and, a maximum of 2 pediatric patients weighing between 15 – 40 kg. Close coordination between the PMRC, the tasking authority, and the CCATT team considering such factors as patient acuity, transport care requirements, age, weight, and size of child is necessary in determining which team may be most appropriate for a pediatric transport mission.

6.1.4. Equipment requirements will be supported to the greatest extent possible by the equipment in the CCATT teams FFCC4 equipment package kit and/or PMI pool if one is established for the operation. Packing lists and pharmaceutical lists for individual kits are provided on the Air Force Medical Logistics website URL: <https://medlog.us.af.mil/>. The allowance standards for the various equipment UTCs are as follows:

FFCC4 – Adult Basic Kit: 887N

FFCCB – Adult Basic Kit Re-supply: 887H

FFCC2 – Pediatric Augmentation to Adult Basic Kit: 887O

FFEC1 – Expeditionary Support Package: 887J

6.2. Pre-flight of Equipment.

6.2.1. CCATT equipment will be checked prior to flight to ensure operability IAW AFI 10-2909, *Aeromedical Evacuation Equipment Standards*. NOTE: CCATT equipment with non-current calibration and servicing dates will not be used. When deployed, teams

are responsible to frequently assess PMI equipment operational capability and ensure adequate battery life. CCATTs will ensure appropriate charging capabilities are available for medical equipment prior to declaring full operational capability. A waiver will be obtained for all equipment not on the CCATT allowance standard or non-PMI equipment IAW AFI 11-2AE Volume 3 and AFI 10-2909 prior to bringing the equipment on a mission.

6.3. Narcotics Accountability.

6.3.1. CCATT personnel will ensure accountability of narcotics IAW AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care*.

6.4. Aircraft Medical Equipment Operations.

6.4.1. Some medical equipment is incompatible with the airborne environment. Medical equipment approved for use during aircraft operations is identified in AFI 41-309, *Aeromedical Evacuation Equipment Standards*. AMC/SG ensures standardization for medical equipment used system wide.

6.4.2. All medical equipment will be tested, deemed airworthy and approved for use during aircraft operations prior to use in the aircraft environment. A specific test protocol establishing test and evaluation methods is developed for each piece of equipment. Tests include altitude/rapid decompression, vibration, electromagnetic interference and in-flight performance.

6.4.3. Medical equipment and supplies are vital to the CCATT mission. There are many hazards associated with dynamic in-flight environmental conditions that are not encountered in fixed medical treatment facilities. Equipment used onboard aircraft must continue to operate properly under flight conditions. It is essential that CCATT members know the capability and performance limitations of equipment items in the CCATT kits.

6.5. Medical Equipment Waiver Protocol.

6.5.1. At times, patient medical requirements may necessitate the use of non-standard medical equipment that has not been approved for flight. HQ AMC/A3VM is the waiver authority for non-certified/non-standard medical equipment required for patient moves. Waiver requests will be routed as follows: hospital/MTF will notify the appropriate PMRC; PMRC will contact appropriate C2 agency, C2 agency will contact TACC AE Cell, AE Cell will contact AMC/A3VM. AMC/A3VM will consult with 311 HSW/YAML (AE Equipment Lab) during their hours of operation. Further consultation on aircraft impact of non-certified/non-standard equipment will occur with the PMRC Validating Flight Surgeon on duty.

6.5.2. Waiver will be obtained prior to use of non-certified/non-standard equipment onboard the aircraft and will apply only to that specific mission.

6.6. Medical Equipment Malfunction/Failure.

6.6.1. CCAT teams will notify the MCD immediately during flight operations on AE missions when medical equipment malfunctions or fails during operation on a mission. On return to home station/deployed location, the team will notify local or unit-supported medical maintenance organization as soon as possible of unusual or repeated equipment failure and safety incidents.

6.6.2. If equipment malfunction/failure occurs during an AE mission, the CCAT Team Chief, in collaboration with the MCD, will ensure the following documentation/actions are accomplished: 1) complete AF4449, *En Route Care Equipment Malfunction Report Tag*; 2) complete DD Form 2852, *Aeromedical Evacuation Event/Near Miss Report*.

6.6.2.1. Completion of AF 4449.

6.6.2.1.1. When medical equipment is found to be non-operational or operating outside of acceptable parameters, and troubleshooting attempts have failed to rectify the situation, disconnect the device and fill out AF 4449. Any CCAT team member or AECM may complete the form. Give a detailed description of the equipment problem and circumstances leading to the discovery of the problem. Attach the AF 4449 to the piece of equipment for turn-in. (Example description: "During pre-flight of 326M suction unit, tried to adjust suction to 100mmHg but only able to obtain 75mmHg w/knob turned to max; normal should be 0 to 550mmHg."). It is important that all settings, dials, etc. be left as they were during the incident. Do not turn the knobs or change settings.

6.6.2.1.2. Upon arrival to home station/deployed location, **immediately** send tagged equipment and all accessories (cords, supplies, etc.) attached to the equipment to home station/deployed location medical maintenance organization. Medical maintenance will impound the equipment and conduct an investigation of the malfunction.

6.6.2.2. Completion of DD Form 2852, *Aeromedical Evacuation Event/Near Miss Report*.

6.6.2.2.1. If an equipment malfunction occurs, the CCATT team chief and the MCD will collaborate to complete DD Form 2852 and document the issue immediately after the occurrence. Upon return to home station/deployed location, turn the DD Form 2852 in to the Patient Safety Monitor (PSM) who will then enter the event into the AE Patient Safety Database tool.

6.6.2.2.2. Provide as complete a description of the malfunction as possible and the operating conditions when the malfunction occurred; identify make, model, serial number, AF Form 4368 certification information, and what other equipment/power was involved. Provide circumstances leading to the event and include any pertinent information such as: O₂

source, patient activity, turbulence, cabin altitude, trouble-shooting attempted, etc., as may be applicable. Also provide names of individuals involved and contact information.

6.6.2.3. When equipment malfunction affects the aircraft, the MCD will notify the PIC and provide details of the incident to facilitate mishap reporting (to be forwarded to wing safety).

6.7. Base Operating Support.

6.7.1. Integration of deployed CCATTs is critical to successful AE operations. CCATTs are not stand-alone units. The gaining AE unit will be responsible for providing all required support to the CCATTs, including billeting, food, water, shelter, power, transportation, medical oxygen support, computer support, and communications. During missions away from home base, CCATTs will receive base ops support from the en route AE element.

6.7.2. Expeditionary Support Package General. UTC FFEC1 is designed to provide essential, basic shelter and equipment storage for en route care personnel deployed to secure, forward airfields in support of tactical operations where their presence exceeds requisite shelter support capability of the host site. The FFEC1 may be employed at locations with AF or other component service assets.

6.7.3. Initial Response. The support package contains a modular general purpose tent system (MGPTS) to provide shelter and equipment storage space for a maximum of 30 personnel. It includes infrastructure items to support power and refrigeration. The package is designed for transport on 463L pallet transport. Vehicles of opportunity may also be used.

6.7.4. Support. Suitable real estate (approx. 1440 square feet) is required to erect the shelter. To sustain operations for the duration of the employment period, this UTC is dependent upon the host location for base operating support: subsistence (food and water), fuel, communications, transportation, civil engineering, and site security. Support requirements are to be arranged for and provided by the host component service.

6.7.5. Training. Every CCATT should have hands-on training of erecting and tearing down MGPTS tentage. Training for CCATTs on assemblage and conducting operations in a contingency environment will be provided at AEPSC. When able, training should also be provided at TAES exercises or at JRTC.

6.7.6. Mobilization. Requirements for employment of CCATTs and equipment packages will be identified and requested by the theater SG. In order to support initial operating capabilities during the opening phases of an operation, CCATTs, and the expeditionary support package should be marshaled together at specific CONUS or overseas locations. Personnel, equipment, and the support package must be deployed together on the same carrier if initial operating capability timelines are to be achieved at the operating location.

6.8. Resupply and Patient Movement Items (PMI).

6.8.1. Teams will have to coordinate with MTF/AE medical logistics personnel for re-supply of medical items that are not part of the allowance standard for CCATT kits. PMI maintenance issues should be coordinated with the Medical Equipment Repair element associated with the closest MTF. CCATTs will carry PMI with them. PMI will be appropriately tracked utilizing the PMI Tracking System (PMITS) when and where available. Accountability will be maintained on a Custodian Receipt Locator List (CRL) at the host MTF DMLSS under RCCC XX5881. All members are required to scan PMI assets each time a piece of PMI changes status (i.e. PMITS codes: QA for maintenance, OUT, and RDY). CCATTs and/or AECMs are responsible for scanning all PMI in their allowance standard prior to and after each mission. Sending MTFs identify patient movement equipment requirements in the Patient Movement Request for transport and will be responsible for providing a one-day minimum of medical supplies.

6.8.2. Patient Movement Item In-transit Visibility Tracking. Supported units will actively scan equipment assets using the government-provided PMITS. These assets should be clearly labeled with PMI bar codes and scanned no less than monthly for in-garrison activities and at least every two to three days in a deployed area. All assets should be scanned each time they move in or OUT of the unit and/or change from RDY to QA status to provide in-transit visibility. Assets without labels (not bar coded) or needing additional labels must be identified/reported to: hqamcpmi@us.af.mil or the closest PMI Center. Labels will be validated and, if approved, prepared and sent to the requesting unit.

6.9. Operational CCATT Kit Program.

6.9.1. HQ AMC/SG MEFPAK Management Branch (HQ AMC/SGXM) Support and Sustainment Guidelines for AD & ARC Operational CCATT Kits:

6.9.2. General. AMC/SG will support initial outfitting of a basic minimum operational capability of one CCATT kit to support contingency operations in CONUS and familiarization training for all CCATT Unit Type Code tasked organizations and to provide supply replenishment and sustainment of those kits at no expense to the supported unit, with the following exceptions: narcotics and refrigerated items. This operational support program will be continued by HQ AMC/SG as long as funding is available. Equipment maintenance support and repair or replacement is a unit-funded responsibility.

6.9.2.1. Operational kits must be maintained as ready kits to support live or real world mission contingency support requirements. Units will report the readiness status of these assets quarterly to AMC/SGXM. Contact HQ AMC/SGXM for guidance and report format. The daily maintenance, repair, and asset accountability is the responsibility of the assigned organization. Tracking and use of these additional operational kits will follow the same guidance as provided for FFCC4 WRM kits. Each supported organization must provide adequate storage, oversight, protection, management attention, and periodic inventory

support to ensure proper maintenance of the kit. The operational kits are not WRM assets. It is understood, after periodic training activities, items in the kits may be expended or damaged during training, rendering the kit “Not Mission Ready” for a brief period. In such cases, expended or damaged items should be ordered, repaired and/or replaced, IAW the guidance herein, as soon as possible after the training event. This is to ensure operational kits are returned to “Mission Ready” status expeditiously.

6.9.2.2. Operational kits are intended for frequent, active use to support local team training and exercise support, as well as operational mission use in CONUS. Medical WRM FFCC4 UTC will be ULN tasked to support CONUS CCATT contingency requirements. OCONUS deployments will use WRM UTC FFCC4 packages for mission support.

6.9.3. Operational Kit Re-Supply/Sustainment. The CCATT kit consists of a series of bags/containers packed-out in accordance with Allowance Standard (AS) 887N. Allowance standards can be found on the AFMOA/SGALX Readiness UTC URL: <https://medlog.us.af.mil/>. Contact HQ AMC/SGXM for supply replenishment for operational kits. Supply replenishment for CCATT (887N) operational kits will be furnished in the lowest unit-of-measure quantities. (*Exception: AMC/SGXM does not furnish narcotics or refrigerated items. It is the unit's responsibility to establish supply support from their host unit for these items.*) A request for supplies that are not on the AS, is the responsibility of the CCATT organization and will not be accepted or supported by HQ AMC/SGXM. Supply replenishment orders should be placed as needed/supplies are consumed, but not more frequently than once every week. Orders may be submitted via furnished shopping guide electronically via e-mail to the HQ AMC/SGXM Operational Kit Support Program, e-mail address: SG.SGXM.Opkits@us.af.mil. Telephone orders may be submitted (commercial 618-229-6952 or DSN 312-779-6952), but will be limited to 10 items or less due to the total number of items in the kit. Shipments to the requesting units will be within 10 duty days after receipt of order and will usually be via the most economical method. Premium transportation (such as FedEx overnight) will require a commercial carrier account number, i.e. FEDEX or USPS, from the requesting activity. During contingencies, all AE resupply will be through the designated Theater Lead Agent for Medical Materiel (TLAMM). Contact HQ AMC/SGXM for additional information on unit procedures and responsibilities.

6.9.4. Medical Equipment. Medical equipment furnished for this program belongs to the AF PMI Program and will be maintained on host medical treatment facility Medical Equipment Management Office (MEMO) accountable records on account XX5881 for global visibility. Biomedical equipment maintenance services support will continue to be from the supporting activity and/or regional Medical Equipment Repair Center (MERC). ARC units with an operational kit assigned must establish an appropriate Memorandum of Agreement/Understanding (MOU/MOAs) with the host medical treatment facility. Expenses for normal repair and/or replacement due to loss/damage are the responsibility of the unit. Equipment accessories not maintained on the AS, or above the AS authorized

quantity will be the unit's responsibility to replace. AMC/SG will provide the initial outfitting quantities of the equipment, program for replacements when a change in make/model is designated, and manage system wide modifications to equipment based on the allowance standard and AS quantity.

6.9.5. Quality Assurance Program. Scott PMI Center will help ensure all supporting units receive quality assurance action messages. This will include recall notices and quality assurance messages from AFMOA. This does not relieve the unit from responsibility of managing their own Quality Assurance (QA) program.

6.9.6. Return Goods Program. ARC AE and CCATT units will process outdated/recalled drugs through their host medical treatment facility IAW AFI 41-209, *Medical Logistics Support*, and local policies/regulations.

6.9.7. Annual Inventory and Test. Inventory and test assigned Operational CCATT Kit equipment annually. Operational testing will involve team members and is defined as full set-up, turning equipment on, performing function checks, validated all necessary pieces and accessories are available and in fully operational condition, and re-packing the assemblage for future training or potential operational use.

THOMAS W. TRAVIS
Lieutenant General, USAF, MC, CFS
Surgeon General

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

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AFPD 11-2, *Aircrew Operations*, 19 January 2012
AFI 11-2AEV3, *Aeromedical Evacuation (AE) Operations Procedures*, 18 May 2010
AFI 11-301V1, *Aircrew Flight Equipment (AFE) Program*, 25 February 2009
AFI 11-401, *Aviation Management*, 10 December 2010
AFI 11-402, *Aviation and Parachutist Service, Aeronautical Ratings and Aviation Badges*, 13 December 2010
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AFI 41-106, *Medical Readiness Program Management*, 1 July 2011
AFI 41-209, *Medical Logistics Support*, 13 August 2013
AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care*, 20 August 2003
AFI 44-102, *Medical Care Management*, 20 January 2012
AFI 44-119, *Medical Quality Operation*, 16 August 2011
AFI 46-101, *Nursing Services and Operations*, 28 October 2011
AFI 48-123, *Medical Examination and Standards*, 5 November 2013
AFI 51-401, *Training and Reporting to Ensure Compliance with the Law of Armed Conflict*, 11 August 2011
AFPAM 10-100, *Airman's Manual*, 1 March 2009
AFTTP 3-42.5, *Aeromedical Evacuation (AE)*
AF Portal CCAT website URL: <https://www.my.af.mil/gcss-af/USAF/ep/globalTab.do?channelPageId=s6925EC13493A0FB5E044080020E329A9> (non-.mil domain computers – requires registration to Air Force Portal)
Air Mobility Command SG MEFPK SharePoint website, maintained by AMC/SGX; URL: <https://cs3.eis.af.mil/sites/27468/default.aspx>

Abbreviations and Acronyms

ABA—Aircrew Body Armor
ACIP—Aviation Career Incentive Pay
ACLS—Advanced Cardiac Life Support
ADCON—Administrative Control
AE—Aeromedical Evacuation
AECM—Aeromedical Evacuation Crew Member
AECT—Aeromedical Evacuation Control Team
AEF—Aerospace Expeditionary Force
AEPS—Aeromedical Evacuation Patient Staging
AEOT—Aeromedical Evacuation Operations Team
AETF—Air and Space Expeditionary Task Force
AFEMSI—Air Force Expeditionary Medical Skills Institute
AFFOR—Air Force Forces
AFMAN—Air Force Manual
AFOSH—Air Force Occupational Safety and Health Program
AFRC—Air Force Reserve Command
AFRIMS—Air Force Records Information Management System
AFSC—Air Force Specialty Code
AFTTP—Air Force Tactics, Techniques, and Procedures
AMC—Air Mobility Command
AMD—Air Mobility Division
ANG—Air National Guard
AEPS—AE Patient Staging
APOD—Aerial Port of Debarkation
APOE—Aerial Port of Embarkation
AO—Aeronautical Order
AOC—Air Operations Center
AOR—Area of Responsibility
ARC—Air Reserve Component
AS—Allowance Standard
ASC—Aviation Service Code
ATCN—Advanced Trauma Care for Nurses
ATLS—Advanced Trauma Life Support
BLS—Basic Life Support
C2—Command and Control
CAA—Civilian Air Ambulance
CASEVAC—Casualty Evacuation
CC—Commander
CCAT—Critical Care Air Transport
CCATT—Critical Care Air Transport Team
CCMD/SG—Combatant Command Surgeon
CCDR—Combatant Commander
CCRN—Critical Care Registered Nurse / Certification in Critical Care Nursing
COCOM—Combatant Commander
COMAFFOR—Commander Air Force Forces

CONUS—Continental/Contiguous United States
CRT—Certified Respiratory Therapist
CTM—CCATT Training Mission
CVC—Clinical Validation Committee
DIRMOBFOR-AIR—Director of Mobility Forces-Air
DNIF—Duties Not to Include Flying
DO—Director of Operations
DOD—Department of Defense
DSCA—Defense Support of Civil Authorities
EMEDS—Expeditionary Medical Support
ERC—En Route Care
ERCC—En Route Critical Care
ERPSS—En Route Patient Staging System
EUCOM—European Command
FA—Flight Authorization
FAM—Familiarization Flights
GCC—Geographic Combatant Commander
GPMIC—Global Patient Movement Integration Center
HA/DR—Humanitarian Assistance/Disaster Response
HARM—Host Aviation Resource Management
HDIP—Hazardous Duty Incentive Pay
HIPPA—Health Information Portability and Protection Act of 1996
HRI—High Risk of Isolation
HSS—Health Service Support
IAW—In Accordance With
IBA—Individual Body Armor
ICU—Intensive Care Unit
IPE—Individual Protective Equipment
ISOPREP—Isolated Personnel Report
JFACC—Joint Forces Air Component Commander
JFC—Joint Force Commander
JFS—Joint Forces Surgeon
JMATT—Joint Medical Attendant Transport Team
JRTC—Joint Readiness Training Center
JTTR—Joint Theater Trauma Registry
MA—Medical Attendant(s)
MAJCOM—Major Command
MANFOR—Manpower Force Packaging System
MCC—Mission Clinical Coordinator
MCD—Medical Crew Director
MEDEVAC—Medical Evacuation
MEFPAK—Manpower and Equipment Force Packaging
MEMO—Medical Equipment Management Office
MERC—Medical Equipment Repair Center
METL—Mission Essential Task List
MGPTS—Modular General Purpose Tent System

MISCAP—Mission Capability
MPA—Man-Day Orders
MRA—MEFPAK Responsible Agent
MRDSS—Medical Readiness Decision Support System
MTF—Medical Treatment Facility
NAF—Numbered Air Force
NATO—North Atlantic Treaty Organization
NICU—Neonatal Intensive Care Unit
NIJ—National Institute of Justice
OCONUS—Outside the Continental/Contiguous United States
OC/SE—Observer Controller/Standards Evaluator
OG—Operations Group
OPCON—Operational Control
OPORD—Operation Order
ORI—Operational Readiness Inspection
OSF—Operational Support Flier
OSHA—Occupational Safety and Health Program
PA—Privacy Act
PACOM—Pacific Area of Command
PALS—Pediatric Advanced Life Support
PECC—Patient Evacuation Control Center
PI—Process Information
PIC—Pilot In Charge
PMI—Patient Movement Items
PMR—Patient Movement Request
PMRC—Patient Movement Requirements Center
POTUS—President of the United States
PPE—Personal Protective Equipment
PSM—Patient Safety Manager
PTLOX—Portable Liquid Oxygen
QA—Quality Assurance
QI/PI—Quality Improvement/Performance Improvement
RDS—Records Disposition Schedule
RSV—Readiness Skills Verification
RON—Remain Over Night
SARM—Squadron Aviation Resource Management
SERE—Survival, Evasion, Resistance, Escape
SG—Surgeon General
TACON—Tactical Control
TAES—Theater Aeromedical Evacuation System
TCCET—Tactical Critical Care Evacuation Team
TDY—Temporary Duty
TLAMM—Theater Lead Agent for Medical Materiel
TNCC—Trauma Nursing Core Course
TTP—Tactics, Techniques and Procedures
TVFS—Theater Validating Flight Surgeon

URL—Universal Resource Locator

USAF—United States Air Force

USAFSAM—United States Air Force School of Aerospace Medicine

USTRANSCOM—United States Transportation Command

UTA—Unit Training Assembly

UTC—Unit Type Code

VFS—Validating Flight Surgeon

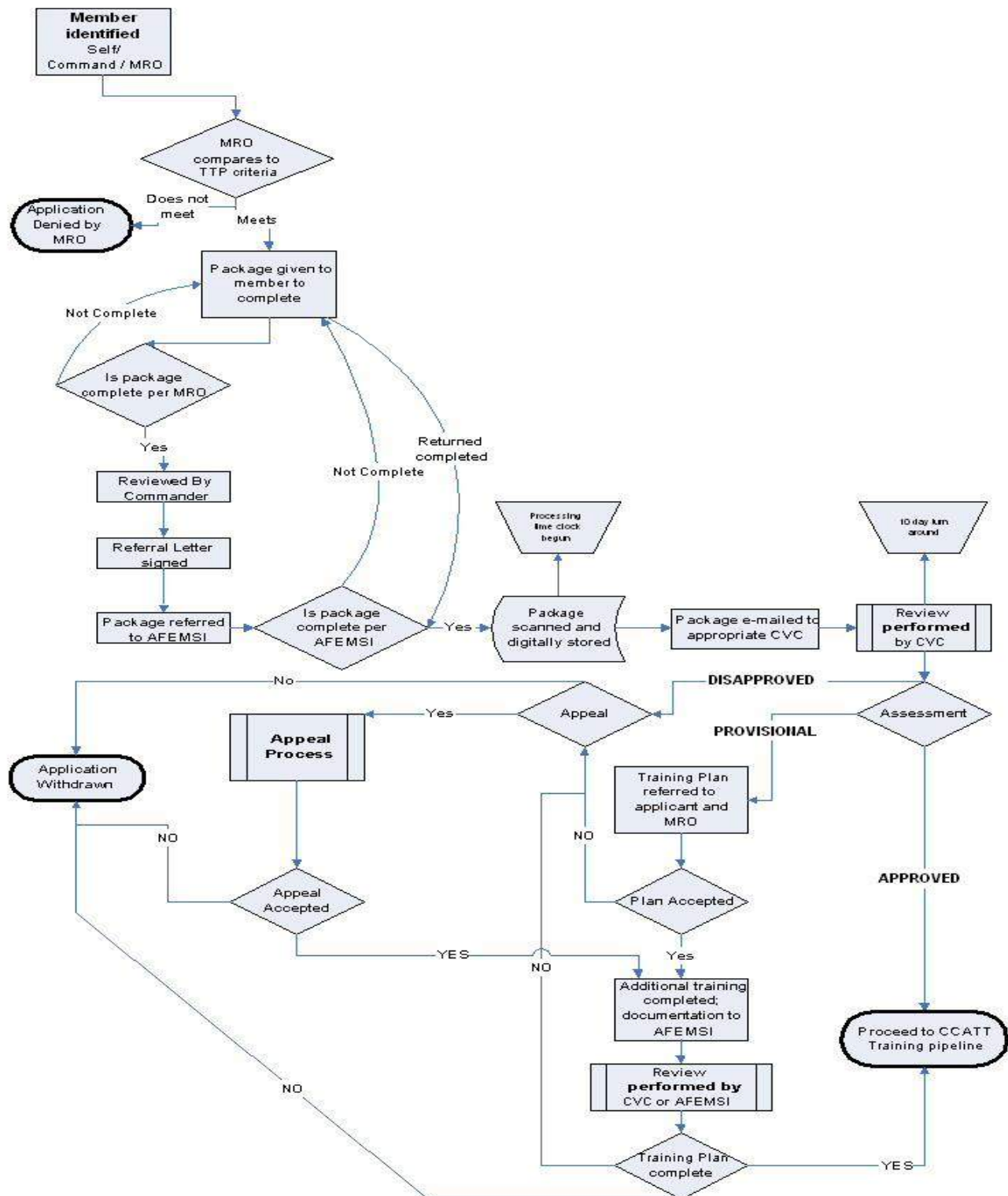
WRM—War Reserve Materiel

WMP—War Mobilization Plan

Attachment 2

VALIDATION PROCESS FLOWCHART

Figure A2.1. Validation Process Flowchart.



Attachment 3**SAMPLE COVER LETTER FOR APPLICATION PACKAGES FOR CCATT
CANDIDATES**

(Date)

MEMORANDUM FOR USAFSAM/ETS
CCATT CLINICAL VALIDATION COMMITTEE

FROM: (UNIT OF ASSIGNMENT/CC or designated representative)

SUBJECT: Nomination for CCATT UTC Assignment – (Member Rank, Name)

1. (Rank, Name, AFSC) is presently assigned to the (unit of assignment) and is nominated for appointment to a CCATT Unit Type Code (UTC). The member meets all standards and requirements for this appointment as set forth in AFTTP 3-42.51, AFI 41-106, and AFI 11-402.
2. Documentation is attached to this request to verify member's qualification/experience. Request review of the application package, and concurrence on member's appointment to a CCATT UTC.
3. My POC for this request is (Rank, Name, Email Address, DSN or Commercial Phone number).

(Signature)
TYPED NAME, Grade, USAF, CORPS
Commander or designated representative

Attachment(s):
(List supporting documentation)

Attachment 4

SAMPLE LETTER OF REBUTTAL

(Date)

MEMORANDUM FOR HQ AMC/SG
(Address)

FROM: (UNIT OF ASSIGNMENT/CC)
(Address)

SUBJECT: Letter of Rebuttal: Member Disapproved for CCATT Selection – (Member Rank, Name)

1. (Rank, Name, AFSC) is presently assigned to the (unit of assignment) and was nominated for appointment to a CCATT Unit Type Code (UTC). Member was deemed acceptable for appointment to CCATT and a selection review package was forwarded to the Air Force Expeditionary Medical Skills Institute (AFEMSI) for formal consideration by the CCATT Clinical Validation Committee.
2. On (date), I received notice from the CCATT Clinical Validation Committee that the member was disapproved for appointment to a CCATT UTC. I am writing to respectfully protest the disapproval.
3. (Provide sufficient justification to reverse/amend the disapproval. Attach additional documentation.)
4. Request your review and consideration to approve member for appointment to CCATT.

(Signature)
TYPED NAME, Grade, USAF, CORPS
Commander

Attachment(s):
(List supporting documentation)

cc:
USAFSAM/ETS

Attachment 5

**CCATT CANDIDATE APPLICATION PACKAGE – CLINICAL VALIDATION COMMITTEE
CHECKLIST COVERSHEET**

Table A5.1. CCATT Candidate Application Package – Clinical Validation Committee Checklist Coversheet.

Note: Complete applicable section. Please ensure EVERY item is scanned in order. INITIAL each completed box and SEND as one complete package to AFEMSI.	
PHYSICIAN CANDIDATE PACKAGE	
Initial Items Completed	Member Rank/Name:
	Cover Letter: Commander Recommendation
	Current Resume
	Hospital Privilege List (AF Form 1562 or equivalent)
	Medical License(s)
	Basic Life Support: Current through 6 months from application
	Advanced Cardiac Life Support: Current through 6 months from application
	ATLS or Equivalent Clinical Experience
	PALS (desired)
	Completed (044Y3) RSV Checklist
	(*) Documentation of hours of [independent] patient care in critical care setting
NURSE CANDIDATE PACKAGE	
Initial Items Completed	Member Rank/Name:
	Cover Letter: Commander Recommendation
	Current Resume
	Current Job Description
	2 Letters of Reference
	Nursing License(s)
	Basic Life Support: Current through 6 months from application
	Advanced Cardiac Life Support: Current through 6 months from application
	Additional Certifications (as desired)
	Completed RSV Checklist
	(*) Documentation of hours of [independent] patient care in critical care setting
CARDIOPULMONARY TECHNICIAN CANDIDATE PACKAGE	
Initial Items Completed	Member Rank/Name:
	Cover Letter: Commander Recommendation
	Current Resume
	Documentation of 5 Level
	Phase II Certificate
	CRT Certification/Registry or License
	Basic Life Support: Current through 6 months from application
	Advanced Cardiac Life Support: Current through 6 months from application
	Completed RSV Checklist
	(*) Documentation of hours of [independent] patient care in critical care setting

(*) Independent Hours: Does not include fellowship, residency, upgrade training, student status, CSTARS, etc.

Date AFEMSI Received Complete Package:

Attachment 6

**CCATT MINIMUM INDIVIDUAL PROTECTIVE CLOTHING & EQUIPMENT FOR
FLIGHT OPERATIONS (INITIAL).**

**Table A6.1. CCATT Minimum Individual Protective Clothing & Equipment
for Flight Operations (Initial).**

ITEM DESCRIPTION	U/I	QTY
Coveralls, Flying, Nomex (flight suit)	EA	2
Boots, Flying	PR	1
Gloves, Flight, Nomex	PR	1
Gloves, insert, 8415-00-269	PR	1
Gloves, shell, 8415-00-261	PR	1
Jacket, Flight, CWU-36/P Summer	EA	1
Jacket, Flight, CWU-45/P Winter	EA	1
Drawers, Flyer's, heat resistant	PR	2
Undershirt, Flyer's, heat resistant	EA	2
Watch Cap, black/dark blue/sage green	EA	1
Reflective Belt, Safety	EA	1
Flashlight, crook-neck, o.d./blk/tan, 2 D-cell	EA	1
Bag, Flyer's (helmet)	EA	1
Kit Bag, Flyer's (aka: "A/B/C" bag)	EA	1

Attachment 7

¹CCATT MINIMUM INDIVIDUAL PROTECTIVE CLOTHING & EQUIPMENT FOR FLIGHT OPERATIONS (DEPLOYED)**Table A7.1. ¹CCATT Minimum Individual Protective Clothing & Equipment For Flight Operations (Deployed).**

ITEM DESCRIPTION	U/I	QTY
^{2,3} Coveralls, Flying, Nomex, “flight suit” (see notes)	EA	3
^{2,3} Boots, Flying, Desert (see notes)	PR	1
^{2,3} Gloves, Flight, Nomex, (see notes)	PR	1
³ Gloves, insert, 8415-00-269	PR	1
³ Gloves, shell, 8415-00-261	PR	1
^{2,3} Jacket, Flight, CWU-36/P Summer -or- CWU-45/P Winter (see notes)	EA	1
³ Drawers, Flyer’s, heat resistant	PR	3
³ Undershirt, Flyer’s, heat resistant	EA	3
³ Watch Cap, knit, black/dark blue/sage green	EA	1
Neckerchief, cotton, brown/tan/sage green	EA	1
³ Reflective Belt, Safety	EA	1
Flashlight, blk finish, (e.g., Inova™ X5MT LED or equiv.)	EA	1
³ Bag, Flyer’s (helmet)	EA	1
³ Kit Bag, Flyer’s (aka: “A/B/C” bag)	EA	1
² Pants, Gortex, (see note)	PR	1
² Jacket, Gortex (see note)	EA	1
Multi-tool (e.g., Leatherman™, Gerber™, SOG™, Schrade™, or equiv.)	EA	1
Goggles, sun/sand/dust (e.g., Wiley X™ SG-1 or equivalent)	EA	2
Holster, for M-9 handgun (shoulder or hip)	EA	1
Backpack (e.g., “bug-out bag,” rucksack-type, or equiv.)	EA	1
⁴ Ballistic Individual Body Armor (IBA), Type-IV, IAW NIJ Standard 0101.06 1) vest: minimum type III-A protection 2) type III-A full side ballistic protection 3) front & back 10” X 12” plates, type IV protection [w/appropriate outer shell]; groin protector preferred option	EA	1
ADDITIONAL REQUIRED ITEMS		
Official Government Passport (no-fee)		
NATO orders		
Aeronautical Orders, OSF physical with AF 1042, AF 702		
Physician Only: Transfer Brief		
All other deployment/mobility and theater-required clothing and equipment		

¹Not intended to be an all-inclusive list of required deployment/mobility clothing/equipment. This list addresses minimum required items for deployed flight operations. Verify theater reporting instructions, line remarks, etc. for other required items.

²Desert tan flight clothing is strongly preferred for deployed team members conducting missions within/into the Middle-East and/or Central Asia AORs. However, if desert tan flight suits are not available, green flight suits may be substituted. Verify theater reporting instructions for color requirements. If green flight suits and clothing are substituted, do not issue items in addition to member’s initial clothing issue. Flight suits and jackets must be of the same color; do not mix colors. One additional flight suit to the initial issue is required for deployed operations.

³Do not issue if item was included in member's/team's initial clothing/equipment issue. (**NOTE:** One additional flight suit to the initial issue is required for deployed operations.) Consider color requirements. Do not wear nylon undergarments.

⁴Type IV ballistic individual body armor (IBA) is required for CCATT operations. Aircrew Flight Equipment does not issue aircrew body armor (ABA) to CCATT, as they do for front-end and back-end (AE) aircrew members. Do not substitute ABA/flak vest/fragmentation vest as the protection level is not sufficient for CCATT operations. CCATT personnel must supply their own IBA for deployed operations, if not supplied in-theater.

Attachment 8

CCATT REQUIREMENTS MATRIX

Table A8.1. CCATT Requirements.

CORE REQUIREMENTS				
Requirement	Frequency	Duration	Definition	Remarks
Candidate Clinical Validation	One-time	N/A	Candidates for CCATT must possess the requisite skills and experience in critical care patient management in order to fill a position on a CCATT UTC. The validation process assists MTF commanders in finding and assigning only those individuals with the appropriate clinical expertise for CCATT duty.	All members selected for CCATT duty will undergo a position-specific skill validation process administered by AFEMSI. Personnel must be approved for CCATT duty through the validation process prior to assignment to a CCATT UTC and entry into the CCATT training pipeline. (AFI 41-106)
CCAT Initial Course	One-time	12 days	The CCAT Initial Course is designed to orient Active Component and ARC personnel assigned to CCATT UTCs to the unique capabilities of the CCATT mission and meet the wartime task of caring for critically ill and injured patients in the aeromedical evacuation environment.	All FFCCT personnel must attend the initial formal training course within 6 months of appointment to the UTC as part of UTC training, and will be SORTS reportable. (AFI 41-106)
CCAT Advanced Course	Every 24 months	14 days	The CCAT Advanced Course is designed specifically for personnel assigned to the CCATT UTC. This UTC training focuses on management and transport of critically injured or ill patients; there will also be didactics on aeromedical evacuation culminating in a field exercise involving a flight out of Wright-Patterson AFB.	All FFCCT members must complete the CCAT Advanced Course prior to employment or deployment. CCATTs identified for deployment during the AEF Tempo Band Construct in which they completed the

			This course also enables the student to complete the AFSC specific RSV's and the CCATT sustainment training items. The course is designed to meet 100% of the RSV's for the individuals assigned to the CCATT UTC.	CCAT Initial Course must complete the CCAT Advanced Course prior to deployment regardless of when they completed the CCAT Initial Course. The CCAT Advanced Course is part of UTC training, and is SORTS reportable. (AFI 41-106)
Basic Life Support (BLS)	Every 24 months	N/A	Mandatory for all personnel assigned to CCATT UTC.	All personnel assigned to a CCATT UTC will maintain current BLS. BLS will be good for entire deployment.
Advanced Cardiac Life Support (ACLS)	Every 24 months	N/A	Mandatory for all personnel assigned to CCATT UTC.	All personnel assigned to a CCATT UTC will maintain current ACLS. ACLS will be good for entire deployment.
Flight Training	Every 24 months	4 hours (minimum)	The objective of the flight training requirement is to develop and maintain skills necessary for the effective employment of CCATTs within the flight environment. The secondary objective is to ensure successful integration of CCATTs into AE operations.	Completion of CCAT Initial Course, currency in CCAT Advanced Course, and currency in OSF requirements is required prior to participating in flight training (outside of the CCAT Advanced Course). Must be on non-interference AOs to participate in flight training.
Aeromedical Evacuation Patient Staging Course (AEPSC) – Web-based Training Course	One-time	2 hours	AEPSC Web-based Training is a pre-requisite to AEPSC, concentrating on the Aeromedical Evacuation process. The course is designed to provide familiarity with the structure and mission of USAF AE.	Complete prior to attending AEPSC; bring certificate of completion to AEPSC. (AFI 41-106)
Aeromedical Evacuation Patient Staging Course	One-time	5 days	AEPSC is an orientation/familiarization course concentrating on the Aeromedical Evacuation	All CCATTs must at least complete the CCAT Initial

(AEPSC)			process. The course is designed to provide cognitive and performance-based field training to officers and enlisted personnel assigned to UTCs supporting a TAES.	Course prior to attending AEPSC. Active Component CCATTs will complete AEPSC within 18 months of completing the CCAT Initial Course; ARC CCATTs will complete AEPSC within 24 months of completing the CCAT Initial Course. (AFI 41-106)
OPERATIONAL SUPPORT FLIER REQUIREMENTS				
Requirement	Frequency	Duration	Definition	Remarks
OSF Physical with AF Form 1042, <i>Medical Recommendation for Flying or Special Operational Duty Log</i>	IAW AFI	N/A	Conveys medical qualification for flying or special operational duty.	Physiologic training standards (AFI 48-123), qualifies individuals for non-rated duties in ASC 9C (operational support flier). Frequency is annual but may be extended in certain situations.
Current AF Form 702, <i>Individual Physiological Training Record</i>	Every 5 years	2-day initial; 1-day refresher	Documents altitude chamber qualification and training.	Required for operational support fliers assigned ASC 9C. (AFI 11-403, <i>Aerospace Physiological Training Program</i>)
OTHER REQUIREMENTS				
Requirement	Frequency	Duration	Definition	Remarks
Official Government Passport (AKA: no-fee government passport)	5 yrs.	N/A	Mandatory for all personnel assigned to CCATT UTC.	CCATTs must have an Official Passport on hand at all times. Passport applications must be submitted immediately upon assignment to a CCATT UTC. Members must have Official Passports prior to

				employment/deployment as CCATT.
High Risk of Isolation	3 yrs.	4 hours	Mandated for fliers involved in air operations over specific areas within or flying into a combatant command AOR during contingency operations, when so designated. Training requirement is identified in respective AOR OPORD.	HRI training is conducted by a certified Survival, Evasion, Resistance, Escape (SERE) instructor. Training is documented on AF Form 1522, <i>AFORMS Additional Training Accomplishment Input</i> , and in block 24 of the Isolated Personnel Report (ISOPREP).
Isolated Personnel Report (ISOPREP)	Initial; then, reviewed at least every 6 months	N/A	Department of Defense form (DD 1833) containing information designed to facilitate the identification and authentication of an evader by a recovery force. The ISOPREP is maintained on all HRI personnel. It contains personal data known only to the isolated individual and is used by recovery forces to positively authenticate the survivor. Once completed, the ISOPREP is classified Confidential and is maintained by the appropriate unit Intelligence, SERE, or operations personnel.	ISOPREP is prepared by home-station Intelligence (A2) personnel prior to departure to an AOR where ISOPREP and HRI training is required.
N95 Mask Fit Testing/Training	Annual	Approx. 30 mins.	CCATT personnel are potentially exposed to highly communicable diseases during patient care and transport. IAW Occupational Safety and Health Act (OSHA), Air Force Occupational Safety and Health Program (AFOSH), and AFI 41-307, <i>Aeromedical Evacuation Patient Considerations and Standards of Care</i> , requirements, personnel must be medically cleared, fit-tested, and trained for wear of an N95 respirator prior to first use.	Contact Occupational Health staff for support. (AFOSH48-137, <i>Respiratory Protection Program</i>)

Attachment 9

REQUEST FOR WAIVER OF AEPSC

(Date)

MEMORANDUM FOR HQ AMC/SGX
(Address)

FROM: (UNIT OF ASSIGNMENT/CC)
(Address)

SUBJECT: Request for Waiver of Aeromedical Evacuation Patient Staging Course (AEPSC) Attendance
(Member Rank, Name)

1. (Rank, Name, AFSC) is presently assigned to the (unit of assignment) and is appointed to a CCATT Unit Type Code (UTC). Request waiver of requirement for member to attend AEPSC for the reasons listed below:

a. Provide justification per requirements in TTP 3-42.51, para 5.4.3.1.; (i.e. Member was deployed as part of a CCATT UTC in support of Operation XXX/participated as CCATT during Joint Readiness Training Center Rotation #___/participated as CCATT during Exercise ___), from “date” to “date.”

b. Member was deployed to Operation XXX/JRTC/Exercise ____ for at least 5 or more consecutive days and performed 2 or more live/simulated critical-care-patient aeromedical evacuation missions as CCATT.

2. Documentation is attached to this request to verify deployment/JRTC/exercise experience. (After-action Report(s), CCATT Mission Reports, assignment orders, deployment/TDY orders, AF Form(s) 781, etc.)

(Signature)
TYPED NAME, Grade, USAF, CORPS
Commander

Attachment(s):
(List supporting documentation)