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Aerospace Medicine

AEROSPACE MEDICINE ENTERPRISE

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This instruction implements AFPD 48-1, *Aerospace Medicine Enterprise*. It provides guidance and establishes procedures for conducting the multidisciplinary aspects of the Aerospace Medicine Enterprise (AME). It describes the key Aerospace Medicine programs in support of the operational aerospace mission and links them to the desired operational effects: Promote and Sustain a Healthy and Fit Force, Prevent Illness and Injury, Restore Health, and Sustain Human Performance. This publication serves as a program management outline for the AME and the seven subordinate programs. It provides a strategic overview of the objectives, desired effects, metrics and reporting requirements for the programs which constitute the AME. Tactical management of the subordinate programs is referenced in the appropriate publications.

This instruction addresses the requirement for development of Team Aerospace. This instruction interfaces with Air Force 10-, 11-, 36-, 40-, 41-, 48-, 60-, 61-, 62-, 63, and 90 series publications. This publication applies to the regular Air Force and the Air Reserve Components. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, for a description of the authorities associated with the Tier numbers. Requests for waivers must be submitted through the chain of command to the appropriate Tier waiver approval authority, or, alternately, to the Publication OPR for non-tiered compliance items. Any organizational level may supplement this instruction. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using AF Forms 847, *Recommendation for Change of Publication*; route AF Form 847 from the field through the appropriate chain of command. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with

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Chapter 1

PROGRAM OVERVIEW

1.1. Overview. This instruction provides guidance, responsibilities, and procedures for execution of the AME. The AME provides direct support to Air Force operations by promoting and sustaining force health, preventing injury and illness, restoring health, and sustaining human performance. These key mission areas are accomplished at the unit level through effective management of seven major Aerospace Medicine programs. These are:

- 1.1.1. Flight and Operational Medicine Program.
- 1.1.2. Occupational and Environmental Health Program.
- 1.1.3. Force Health Protection and Medical Readiness Program.
- 1.1.4. Community Health Program.
- 1.1.5. Human Performance Sustainment Program.
- 1.1.6. Emergency Response/Disaster Management Program.
- 1.1.7. Health Promotion.

1.2. AME Unit-Level Management.

1.2.1. Management of the Aerospace Medicine programs to achieve objectives and desired effects will follow established principles of program management:

- 1.2.1.1. Establish clear objectives and goals.
- 1.2.1.2. Define tasks and responsibilities necessary to achieve objectives.
- 1.2.1.3. Specify clear and reasonable timelines.
- 1.2.1.4. Ensure accountability.
- 1.2.1.5. Measure effectiveness of reaching the objectives and desired effects.
- 1.2.1.6. Redirect local plans, guidance, and practices as needed to better achieve desired effects.

1.3. AME Scope.

1.3.1. The AME is comprised of personnel (Team Aerospace (TA)) and activities that include, but are not limited to: Aeromedical Evacuation (AE), Aerospace & Operational Physiology (AOP), En Route Patient Staging, Bioenvironmental Engineering (BE), Flight and Operational Medicine (FOM), Occupational Medicine (OM), Optometry, Public Health (PH), Personnel Reliability Program (PRP), and Health Promotion as well as education, research and development activities related to these programs. TA personnel work collaboratively for the success of the seven Aerospace Medicine programs. Medical treatment facilities' (MTF) AMEs are represented to the Air Force Medical Service (AFMS) corporate structure for the purposes of planning and programming by the Aerospace Operations (AO) panel.

1.3.2. The AME is implemented at locations wherever there is an AF mission. Locations include Regular Air Force (RegAF), Air National Guard (ANG), and Air Force Reserve (AFR) installations, Geographically Separated Units (GSU), sites with a Limited Scope Medical Treatment Facility (LSMTF), sites with a medical aid station (MAS), sites with a Medical Squadron, sites with no assigned medical personnel, and deployed locations.

1.3.3. Sites with a MTF will implement the appropriate scope of the AME with assigned personnel as the base operational mission demands. Defining the scope of the AME and missions covered will be the responsibility of the base Chief of Aerospace Medicine (SGP), Squadron and Medical Group (MDG) commanders in consultation with the base line command and Major Command (MAJCOM)/SGP.

1.3.4. GSUs, sites with a Medical Squadron, LSMTF, MAS, or no assigned medical personnel will implement the AME with the assistance of a supporting MTF designated by the unit's owning MAJCOM/SG. The overall responsibility for the execution of the AME at supported sites will reside with the supporting MTF Commander (MTF/CC). If the nearest MTF is from another MAJCOM, the supported site will arrange through Memorandum of Understanding (MOU) or Support Agreement (SA) with that MTF after consultation with the supporting and supported MAJCOM/SGPs for the appropriate support.

1.3.5. Deployed sites will implement all Aerospace Medicine programs tailored to support the operational mission. As these sites mature, phasing in of more robust AME is indicated as directed by the Combatant Command (COCOM) or Air Force Forces (AFFOR)/Surgeon General (SG) or SGP. The timeline for phasing in will be developed by the local SGP after coordination with the appropriate COCOM, AFFOR or MAJCOM/SG or SGP.

1.3.6. ANG or AFRC medical units will implement the AME either utilizing organic capabilities or they will ensure the quality of the AME through an actively enforced host-tenant support agreement (HTSA). The overall responsibility for ensuring the execution of the AME will reside with the ANG or AFRC medical unit, even though AME services may be provided through HTSA or contract.

1.3.6.1. AD units will be responsible for services and program support agreed to in a HTSA.

1.3.7. AF units in a supported relationship on a joint base will implement the appropriate scope of the AME through organic capabilities or they will ensure the quality of the AME through agreement with the host base.

1.4. Specific Organizational Responsibilities.

1.4.1. The Office of the Assistant Secretary of the Air Force for Manpower and Reserve Affairs (SAF/MR) serves as an agent of the Secretary and provides guidance, direction, and oversight for all matters pertaining to the formulation, review, and execution of plans, policies, programs, and budgets addressing medical readiness and health promotion of active and reserve component members. (T-1)

1.4.2. The Office of the Assistant Secretary of the Air Force for Installations, Environment, and Logistics (SAF/IE) provides direction and oversight of matters pertaining to the formulation, review and execution of policies, plans, programs, and budgets relative to environment, safety and occupational health (ESOH) resources and missions. (T-1)

1.4.3. The Office of the Assistant Secretary of the Air Force for Acquisition (SAF/AQ) establishes acquisition policy for Human Systems Integration (HSI). (T-1) Acquisition policy shall require the identification, assessment, mitigation, and formal acceptance of HSI, human performance, and health-related risks in the development, acquisition, sustainment, and support for weapon systems, munitions, and other materiel systems. (T-1)

1.4.4. The Director of Operations (AF/A3O):

1.4.4.1. Prescribes the operational qualification requirements for flight surgeons (FS). (T-1)

1.4.4.2. Provides guidance on physiological training requirements for aircrew and special duty personnel. (T-1)

1.4.4.3. Oversees physical standards guidance established by AF/SG3 for aircrew and special duty personnel. (T-1)

1.4.4.4. Serves as approval authority for use of pharmacological fatigue countermeasures and coordinates implementation guidance with AF/SG3. (T-1)

1.4.5. The AF/SG provides strategic guidance, resources, policies and procedures to execute the AME. (T-1)

1.4.6. The AF/SG3 shall:

1.4.6.1. Provide guidance necessary to successfully execute the AME. (T-1)

1.4.6.2. Oversee strategic planning and programming activities. (T-1)

1.4.6.3. Maintain liaison with Department of Defense (DoD) agencies for aircrew health, disease prevention, occupational and environmental health, and crew performance issues. (T-1)

1.4.6.4. Advise AF/A3O on physical standards, physiological training requirements for aircrew and special duty personnel, and operational countermeasure guidance for physiologic stressors. (T-1)

1.4.7. The AF/SG3P shall:

1.4.7.1. Develop guidance to optimize the health, safety, and performance of the USAF, including physical standards, force protection, environmental safety, and occupational and operational medicine programs, as defined in HAF MD 1-48. (T-1)

1.4.7.2. Chair the AO panel in development of programming recommendations to support strategic guidance of AF/SG. (T-1)

1.4.7.2.1. Support field identification and root-cause analysis of human performance problems, and advocate for their mitigation or resolution through non-materiel means (e.g., doctrine, organization, training, leadership, education, personnel, etc.), materiel means (e.g., technology, facilities), or some combination thereof. (T-1)

1.4.7.2.2. Develop an AME-oriented research/discovery/forecasted requirement strategy, plan, and prioritized programming recommendations. (T-1)

1.4.7.2.3. Guide research programming and investment strategy within the AFMS to support the prioritized list of AME research gaps, needs, and requirements. (T-1)

1.4.7.3. Chair the Flight and Operational Medicine Corporate Board. (T-1)

1.4.7.3.1. Membership composed of: Air Force Medical Support Agency (AFMSA)/SG3P, Air Force Medical Operations Agency (AFMOA)/SGP, SG Consultant for Aerospace Medicine, Branch Chiefs/Corp Chiefs, and MAJCOM and Direct Reporting Units (DRU) (United States Air Force Academy (USAF) and Air Force District of Washington (AFDW)) SGP.

1.4.7.3.2. The Corporate Board shall provide strategic guidance and programming recommendations to the AO panel for the AME. (T-1)

1.4.7.3.3. The Board convenes annually or as needed. (T-1)

1.4.7.4. Develop plans and programs, provide liaison and consultative services, and execute the AME in support of and at the direction of AF/SG3. (T-1)

1.4.7.5. Ensure integration and coordination of AME initiatives and guidance with line Headquarters AF (HAF) entities when appropriate. (T-1)

1.4.7.6. Provide consultants in all TA disciplines on behalf of AF/SG to MAJCOM, HAF, and other agencies. (T-1)

1.4.7.7. Interface with AFMSA/SGP, AFMOA/SGP and all MAJCOM/SGPs to facilitate successful execution of all aspects of the AME. (T-1)

1.4.7.8. Maintain liaison with AF Directorates, other Services and Federal agencies. (T-1)

1.4.7.9. Appoint an AFMSA-assigned FS (AFSC: 48A4) as the Air Force casualty management officer point of contact (POC) for Chemical, Biological, Radiological, and Nuclear (CBRN) guidance development and implementation. (T-1)

1.4.7.10. Appoint an AFMSA-assigned FS, Air Force Specialty Code (AFSC): 48A4, as the Air Force Public Health Emergency Officer (PHEO) action officer for guidance development and implementation (may be delegated to a senior PH officer at AF/SGP discretion). (T-1)

1.4.7.11. Develop objective indicators to measure the success of the AME. (T-1)

1.4.7.12. Coordinate prioritization of AME requirements with AF/SG5. (T-1)

1.4.7.13. Coordinate follow-on funding and Program Objective Memorandum (POM) actions with SG5 for material and process solutions that will require transition from Modernization panel to AO panel funding. (T-1)

1.4.8. The AF/SG3P Branch Chiefs/Corp Chiefs shall:

1.4.8.1. Chair Functional Corporate Boards with membership composed of MAJCOM and DRU (USAF) and AFDW) functional branch chiefs and the Career Field Manager for the respective AFSC. (T-1)

1.4.8.2. Provide strategic guidance and programming recommendations to the AO Panel. (T-1)

1.4.8.3. Convene functional corporate boards semi-annually or as needed. (T-1)

1.4.9. The AFMSA/SG5 shall work with MAJCOMs, AFMOA, AF/SG3, and MTFs to identify, analyze, and select the modernization initiatives that have the greatest potential of satisfying AF and AFMS capability gaps and requirements. (T-1) AFMSA/SG5 will:

1.4.9.1. Coordinate prioritization of AME requirements from AF/SG3P and AF/SG3P branch chiefs into the Medical Research, Development, and Acquisition (RD&A) portfolio. (T-1)

1.4.9.2. Coordinate transition planning with AF/SG3P, to include sustainment funding and POM actions for material and process solutions. (T-1)

1.4.10. The MAJCOM/SG shall:

1.4.10.1. Organize, facilitate training, and advocate for necessary resources and personnel to support AME execution within their command. (T-1)

1.4.10.2. Appoint a MAJCOM/SGP, and ensure appropriate MAJCOM staffing to successfully execute the AME. (T-1)

1.4.10.3. Assign/coordinate a supporting MTF for each Medical Squadron, LSMTF, GSU, Munitions Support Squadron site (MUNSS), or other site without medical capability within their Area of Responsibility (AOR) to assist with the execution of the Aerospace Medicine programs at those sites. (T-1) Where designated, the supporting MTF carries ultimate responsibility for the execution of the Aerospace Medicine programs at the supported site.

1.4.10.4. Ensure SG personnel provide appropriate support to the acquisition program offices in support of [paragraph 1.4.3](#) of this instruction. (T-1)

1.4.11. MAJCOM/SGPs shall:

1.4.11.1. Develop guidance to assist subordinate installation medical units to properly execute all aspects of the AME. (T-1)

1.4.11.2. Identify personnel and resource requirements and establish resource and manpower priorities for successful execution of the AME throughout the command. (T-1)

1.4.11.3. Use AF/SG3P derived objective indicators to gauge success of the AME at subordinate facilities. (T-1)

1.4.11.4. Collect human weapon systems problems, validate event-driven human performance problem reports from all field units in the MAJCOM, and forward these products to AF/SG3P for review and analysis. (T-1)

1.4.12. The 711th Human Performance Wing shall:

1.4.12.1. Provide education and training for all disciplines of the AME. (T-1)

1.4.12.2. Conduct research and development in support of AF operational Defense Health Program (DHP) requirements and objectives. (T-1)

1.4.12.3. Provide consultative and analytical services to support AME through the Aeromedical Consultation Service, the Epidemiology Consultation Service, and the Occupational and Environmental Health Team. (T-1)

1.4.12.4. Provide HSI training and consultative support to both Line of the Air Force (LAF) and AFMS organizations and agencies. (T-1)

1.4.12.5. Provide reach-back support to base level AME personnel for the Human Performance Sustainment and the Occupational and Environmental Health programs. (T-1)

1.4.13. The MDG/CC (RMU/GMU/CC for ARC) shall:

1.4.13.1. Ensure resources and personnel (requested through the Wing/CC for ARC). (T-1) Provide guidance for successful execution of the AME at their installation. (T-1)

1.4.13.2. Ensure AME personnel are properly led, trained and resourced to successfully execute the AME at deployed locations. (T-1)

1.4.13.3. Appoint the most qualified FS as the SGP. (T-1) If he/she is not the Aerospace Medicine Squadron Commander, the SGP will be a stand-alone 3-digit functional manager aligned directly subordinate to and rated by the MDG/CC. (T-1) The SGP must be a FS with sufficient experience and formal training, optimally a graduate of the AF Residency in Aerospace Medicine (RAM) program, and be knowledgeable in all aspects of clinical and operational Aerospace Medicine. (T-1) If there is a RAM assigned as Sq/CC or below, he/she should normally be designated as the SGP. When no RAM is assigned, the SGP will be the most qualified FS in terms of training, experience, and aptitude. If not a RAM, then attendance at the SGP course is required within 12 months of assignment as SGP (N/A for ARC). (T-1)

1.4.13.4. Execute the AME at their location and at other supported sites as directed by the MAJCOM/SG. (T-1)

1.4.13.5. Request additional medical personnel to meet the requirements to support assigned GSU or MUNS sites based on current manpower models and workload. (T-1)

1.4.14. The Squadron/CC or ARC/SGP under whose command the AME resides shall provide:

1.4.14.1. Leadership:

1.4.14.1.1. Serve as a member of the MTF's Executive Council/Committee. (T-1)

1.4.14.1.2. Ensure execution of Aerospace Medicine activities using an integrated team approach through the Aerospace Medicine Council (AMC) and the SGP. (T-1)

1.4.14.2. Planning/Programming:

1.4.14.2.1. Ensure the formulation of plans, policies and procedures for delivering health care services and/or health care support for operational missions. (T-1)

1.4.14.2.2. Ensure availability of medical support to meet operational requirements. (T-1)

1.4.14.2.3. Ensure coordination of AME activities within the MTF, Reserve Medical Unit (RMU) or Guard Medical Unit (GMU) and other medical activities. (T-1)

1.4.14.2.4. Review, coordinate, and negotiate HTSAs, MOUs, inter-service support agreements, letters of agreement, etc. (T-1)

- 1.4.14.2.5. Ensure contingency support requirements for squadron assets are codified and are properly executed. (T-1)
- 1.4.14.3. Funding/Financial Oversight:
 - 1.4.14.3.1. Direct squadron financial budget and execution activities. (T-1)
 - 1.4.14.3.2. Ensure fiscal accuracy and responsible stewardship within the squadron. (T-1)
 - 1.4.14.3.2.1. Project and advise MTF and higher headquarters leadership of financial requirements for mission accomplishment. (T-1)
- 1.4.14.4. Manpower Personnel Programs:
 - 1.4.14.4.1. Ensure squadron personnel meet training requirements. (T-1)
 - 1.4.14.4.2. Identify new personnel requirements to meet mission needs and ensure proper communication to higher authority. (T-1)
 - 1.4.14.4.3. Evaluate and rate subordinate personnel. (T-1)
 - 1.4.14.4.3.1. See AFI 48-149, *Flight and Operational Medicine Program*, for Squadron Medical Element (SME) personnel rating policies.
- 1.4.15. The MTF/SGP or ARC/SGP shall:
 - 1.4.15.1. Be responsible for developing and maintaining a strong relationship with the LAF to facilitate the effectiveness of the AME. (T-1)
 - 1.4.15.2. Maintain at least an active Top Secret security clearance. (T-1) If this level of clearance is not already possessed, as soon as the SGP is selected, he/she shall be processed for the appropriate clearance (N/A for ARC). (T-1)
 - 1.4.15.2.1. Serve as the medical consultant to the operational AF, its mission and personnel. (T-1) If a mission or operation is classified, then the SGP shall receive appropriate security clearance and be read in to the degree required to provide operational, occupational, environmental, aeromedical, and general medical support to the personnel and operation. (T-1) SGP shall:
 - 1.4.15.2.2. Consult with personnel that work in classified operations/systems and/or have medical, occupational, or environmental health concerns and evaluate their operational, occupational, and environmental health concerns to facilitate/liaison with the MTF or ARC RMU/GMU for appropriate intervention. (T-1)
 - 1.4.15.3. Be completely familiar with all flying and operational activities at their assigned location to effectively provide flight and operational medicine support to the commander and mission. (T-1) SGP shall:
 - 1.4.15.3.1. Seek opportunities to become familiar with all DoD operational missions since mishaps and deployments may involve missions other than those present at home station. (T-2)
 - 1.4.15.4. Provide programmatic oversight of the AME. (T-1) SGP shall:
 - 1.4.15.4.1. Oversee all aspects of the AME and coordinate all Aerospace Medicine activities. (T-1) These programs directly support the line mission by ensuring a

healthy and fit force, preventing injury and illness, restoring health, and sustaining human performance. (T-1)

1.4.15.4.2. Chair the AMC, the Occupational and Environmental Health Working Group (OEHWG) (the SGP may delegate this to an experienced Occupational Medicine Physician if available), the Deployment Availability Working Group (DAWG), the Wing Public Health Emergency Working Group (PHEWG) (if designated as Public Health Emergency Officer (PHEO)), and the Flight and Operational Medicine Working Group (FOMWG) (may delegate to Flight Medicine Flight Commander or most senior FS). (T-1)

1.4.15.4.3. Serve as both the senior profile officer and the Lead Competent Medical Authority (CMA) for the PRP. (T-1)

1.4.15.5. Serve as the wing Aerospace and Operational Medicine Consultant:

1.4.15.5.1. Serve as the MTF and installation authority, consultant, and subject matter expert in the medical specialty of Aerospace Medicine and in all Aerospace Medicine programs to include: aerospace, operational, occupational, deployment, disaster, and preventive medicine, human factors, human performance enhancement and sustainment, disease surveillance and prevention, occupational, operational, and environmental health risk assessment and risk communication, PRP, and the application of medical standards. (T-1)

1.4.15.5.2. Serve as a member of the MTF Executive Committee as the 3-letter functional manager. (T-1)

1.4.15.5.3. Serve as the installation PHEO IAW AFI 10-2603, *Emergency Health Powers on Air Force Installations*. (T-1) A qualified Public Health Officer can be designated as the alternate (N/A for ANG).

1.4.15.6. Provide AME support to designated GSU and MUNSS sites when designated by a support agreement. (T-1)

1.4.15.7. Provide Aerospace Medicine career guidance for all physicians with primary or secondary 48XX designations as appropriate. (T-2) The SGP will coordinate with the MTF/CC or ARC (RMU or GMU)/CC and appropriate Squadron Commander (Sq/CC) to involve FSs not currently assigned to the Flight Medicine Clinic in the base AME to assist in maintenance of proficiency in Aerospace Medicine. (T-2)

1.4.15.8. Maintain clinical currency in the practice of Aerospace Medicine. (T-1)

1.4.15.9. Provide consultation to Wing Inspector General (IG)/Plans and Medical Readiness in the development of plans and exercises for emergency response/disaster management. (T-1) SGP shall:

1.4.15.9.1. Provide professional medical perspective to exercises and plans to ensure medical realism in plans and exercises. (T-1)

1.4.15.9.2. Facilitate liaison/integration of wing, local, regional, and federal medical response capabilities. (T-1)

1.4.16. In LSMTFs, Medical Squadron or MAS Officer in Charge (OIC) shall:

1.4.16.1. Execute the AME in conjunction with personnel from the supporting MTF or ARC medical unit. (T-2)

1.4.16.2. Ensure that assigned medical personnel fulfill their programmatic obligations in support of the AME. (T-2)

1.4.16.3. Coordinate with local LAF/CCs and supervisors to ensure obligations, requirements, and responsibilities as part of the AME are met in a timely and professional manner. (T-2)

1.4.16.4. Ensure specific responsibilities for the supported and supporting medical units are contained in the functional AFIs for each program. (T-2)

1.5. AME Organization and Management at Unit Level.

1.5.1. The AME shall be organizationally aligned IAW AFI 38-101, *Air Force Organization*, and the current MDG guidance within the utilized installation construct, (e.g. Aerospace Medicine Squadron, Aeromedical-Dental Squadron, Medical Operations Squadron or Medical Squadron). (T-1)

1.5.2. Units may combine or divide programs based on their unique circumstances to achieve maximum efficiency and effectiveness in accomplishing the AME objectives.

1.6. Aerospace Medicine Program Leadership Forums.

1.6.1. Aerospace Medicine Council.

1.6.1.1. The AMC is a collaborative decision making body chaired by the SGP responsible for the functional oversight of the AME and is directly accountable to the MDG/CC. The AMC is the reviewing/approval authority for the OEHWG, the FOMWG, and the DAWG minutes.

1.6.1.2. The AMC should convene on a monthly basis, but not less than quarterly. (T-1) The minutes will be reviewed/approved by the MDG executive committee. (T-2) The AMC exists as a separate meeting from squadron staff meetings dealing with leadership and management issues. For a sample agenda see [attachment 2](#).

1.6.1.3. The AMC membership, at a minimum, will include the SGP, OICs and NCOICs of AOP, BE, FOM, Optometry, PH, Medical Standards Management Element (MSME), Health Promotion, and all assigned FS (SMEs included). (T-3) Dental is also a member where part of the Aeromedical Dental Squadron (AMDS). (T-3)

1.6.1.3.1. The SGP may invite the Operations Group/CC and Wing Safety to send a representative to the AMC.

1.6.1.4. As key functions, the AMC will:

1.6.1.4.1. For each Aerospace Medicine program:

1.6.1.4.1.1. Review the program objectives and desired mission effects. (e.g., What are we trying to accomplish?) (T-1)

1.6.1.4.1.2. Review program activities and indicators to measure success. (e.g., How are we doing in accomplishing the objectives and desired mission effects?) (T-1)

1.6.1.4.1.3. Assess whether to continue present activities or to make adjustments to program plans. (e.g., Do we need to change anything?) (T-1)

1.6.1.4.2. Review, evaluate, solve, and up-channel current issues within the AME or issues that have been referred from other committees. (T-1)

1.6.1.4.2.1. When issues discussed at the AMC cannot be resolved without change(s) in AF level doctrine, tactics, guidance or instructions, they will be elevated to the MAJCOM/SGP. (T-1)

1.6.1.4.3. Ensure TA members enter data into DOEHRS-IH for program indicator surveillance. (T-1)

1.6.2. The OEHWG is a collaborative decision making body chaired by the SGP or Occupational Medicine Physician and is responsible for providing guidance and establishing medical surveillance requirements for the installation Occupational and Environmental Health Program. It is directly accountable to the MDG/CC through the AMC. Key functions of the OEHWG are detailed in AFI 48-145, *Occupational and Environmental Health Program* and in AFI 48-149, *Flight and Operational Medicine Program*.

1.6.3. The DAWG is a cross-functional tracking and decision making body chaired by the SGP with the purpose of administratively managing the medical cases of all personnel identified as having a deployment-limiting medical condition. It is directly accountable to the MDG/CC through the AMC. Key functions of the DAWG are detailed in AFI 10-203, *Duty Limiting Conditions*.

1.6.4. The FOMWG is a forum chaired by the SGP or delegate for administratively managing and tracking all flying and special duty personnel medical actions. It is directly accountable to the MDG/CC through the AMC. Key functions of the FOMWG are detailed in AFI 48-149, *Flight and Operational Medicine Program*.

1.6.5. The PHEWG is a wing level, cross-functional working group chaired by the PHEO and is charged with overseeing the planning and management of public health emergency preparedness and response activities for the installation. The PHEWG is a sub-group of a wing emergency management program body chaired by the Mission Support Group commander, usually the Emergency Management Working Group. Key functions of the PHEWG are detailed in AFI 10-2603, *Emergency Health Powers on Air Force Installations* (N/A for ANG).

1.6.6. TA members will attend other meetings that directly support Aerospace Medicine Programs to include:

1.6.6.1. Medical Group Executive Committee or ARC equivalent. (T-1)

1.6.6.1.1. The Sq/CC with direct oversight of Aerospace Medicine functions will attend as the responsible agent for all squadron activities and programs. (T-1)

1.6.6.1.2. The SGP will attend as the 3-letter functional. (T-1)

1.6.6.2. Installation Environment, Safety, and Occupational Health (ESOH) Council. (T-1)

1.6.6.2.1. The OEHWG Chair will attend or ensure representation to provide professional expertise regarding occupational and environmental health issues. (T-2)

- This includes an annual OEH Program Management Review brief to ESOHC leadership. (T-2)
- 1.6.6.2.2. A BE representative will attend to present metrics detailing occupational and environmental health surveillance, and as subject matter expert on recognition, evaluation, and control of occupational and environmental hazards to include related risk management/risk communication. (T-2)
- 1.6.6.2.3. A PH representative will attend to present metrics detailing occupational health medical exam compliance rates and address issues relevant to this program. (T-2)
- 1.6.6.3. Threat Working Group. The Medical Intelligence Officer and BE should attend regularly. (T-2) The PHEO or alternate will attend as needed. See AFI 10-245, *Antiterrorism (AT)* and 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations* for specific information.
- 1.6.6.4. Force Protection Working Group. BE and/or PH should attend regularly. (T-2) The PHEO or alternate will attend as needed. See AFI 10-245, *Antiterrorism* and 10-2501, *Air Force Emergency Management Program Planning and Operations* for specific responsibilities.
- 1.6.6.5. Medical Readiness Committee (Executive Management Committee for ARC).
- 1.6.6.5.1. The Sq/CC (MDG/CC or designee for ARC) will attend as the responsible agent for squadron readiness activities and requirements. (T-2)
- 1.6.6.5.2. The SGP (or designee if unavailable) will attend as the appointed consultant for professional oversight issues related to the AME. (T-2)
- 1.6.6.5.3. The Medical Intelligence Officer or designated representative will attend to provide and receive medical intelligence information. (T-2)
- 1.6.6.5.4. The BE Officer or NCO will attend to provide and receive CBRN information. (T-2)
- 1.6.6.6. Wing/Squadron Flight Safety Meetings. FSs and AOP will attend and each will periodically brief topics of aeromedical relevance for the flying community. (T-2) Involvement in ground safety issues is also encouraged in order to help mitigate locally unique safety concerns.
- 1.6.6.7. Population Health Working Group (N/A for ARC).
- 1.6.6.7.1. SGP and/or PH will attend as the epidemiology consultant to help formulate questions regarding population health issues and provide meaningful analysis of resulting data. (T-2)
- 1.6.6.7.2. SGP and/or Health Promotion will attend as human performance sustainment and enhancement consultants to aid in identification and targeting of at risk individuals and subpopulations. (T-2)
- 1.6.6.8. Installation Restoration Program Advisory Board. The SGP and BE personnel should attend as needed to address community concerns associated with installation restoration and clean-up programs. BE may represent ANG where no SGP is assigned.

1.6.6.9. Operations Group Executive Staff Meeting. The SGP should request permission to attend in order to interface with the wing flying leadership regarding medical support to the flying and operational mission.

1.6.6.10. Wing Deployment Process Working Group (DPWG). A PH representative attends as needed.

1.6.6.11. Installation Emergency Management Working Group. Meeting chaired by the Mission Support Group Commander and attended by the PH, BE, and PHEO. (T-2) See AFI 10-245 and 10-2501 for specific information.

Chapter 2

FLIGHT AND OPERATIONAL MEDICINE PROGRAM

2.1. Objectives.

2.1.1. The purpose of the Flight and Operational Medicine Program is to optimize the health and sustain the performance of aviation (manned and unmanned), missile, nuclear, weapon system operators, space and special operations personnel in support of the operational mission of the Air Force.

2.2. Key Team Aerospace Players: AOP, FOM, Optometry, PH and Health Promotion.

2.3. Desired Effects.

2.3.1. Medically ready aircrew, missile and special operations personnel.

2.3.2. Trusted rapport with LAF leadership, and with flying, missile and special operations personnel enabling the effective assessment of health and safety threats and involvement in operational planning.

2.3.3. Aircrew, missile, and special duty personnel confident that their families' healthcare requirements are met.

2.3.4. FOM personnel appropriately and constructively engaged in all aspects of the unit operational and flying mission.

2.4. Indicators.

2.4.1. Aircrew Duties not to Include Flying (DNIF), Duties not to Include Alert (DNIA), and Duties not to Include Controlling (DNIC) rates tracked and reported to operational squadron and group commanders (e.g. DNIF rate is # aircrew DNIF/#aircrew assigned calculated monthly). (T-1)

2.4.2. Prioritized installation specific FS Mission Essential Tasks and Line Support (METALS) developed or validated annually. (T-1)

2.4.2.1. Annual plan for completion of installation specific FS METALS approved by SGP with copy provided to MAJCOM/SGP. (T-1)

2.4.2.2. Compliance with SGP approved plan for METALs completion >90%. (T-1)

2.4.3. FS Mission Qualification Training (MQT) status. All FS assigned to FOM (MTF and SME) shall obtain and maintain MQT status IAWAFI 48-149, *Flight and Operational Medicine Program* timelines and criteria. (T-1)

2.4.4. Aerospace Medical Service technicians (4N0X1F) assigned to FOM attend centrally provided advanced FOM training within six months of assignment to the FOM clinic for RegAF and per ARC guidance for ARC members. (T-1)

2.4.5. Initial Flying and Special Duty Exam Appointment Access rate tracked monthly. Appropriate actions documented to maintain access. (T-2) Any additional metrics as directed by MAJCOM (N/A for ANG).

2.5. Leadership Forums.

- 2.5.1. FOMWG.
- 2.5.2. Wing/Squadron Flight Safety Meeting.
- 2.5.3. AMC.
- 2.5.4. OG Executive Staff Meeting.

2.6. Reporting.

- 2.6.1. Flight and Operational Medicine program review will occur at the AMC at a periodicity determined by the SGP. (T-2)
- 2.6.2. Flight and Operational Medicine indicators will be reported at least quarterly to the MDG Executive Committee or ARC equivalent. (T-2)
- 2.6.3. The SGP may present some or all of the Flight and Operational Medicine indicators at the OG staff meeting (after coordination with the OG).

2.7. Flight And Operational Medicine Program Management.

- 2.7.1. The following AFIs define the roles and responsibilities of TA members in the Flight and Operational Medicine Program: AFI 48-149, *Flight and Operational Medicine Program*, AFI 48-123, *Medical Examinations and Standards*, AFI 10-203, *Duty Limiting Conditions*, AFI 11-202V1, *Aircrew Training*, AFI 11-202V2, *Aircrew Standardization/Evaluation Program*, AFI 11-202V3, *General Flight Rules*, AFI 11-401, *Aviation Management*, AFI 11-402, *Aviation and Parachutist Service*, *Aeronautical Ratings and Badges*, AFI 11-403, *Aerospace Physiological Training Program*, AFI 11-405, *The Pilot-Physician Program*, AFI 11-412, *Aircrew Management*, AFI 11-421, *Aviation Resource Management*, AFI 13-204V3, *Airfield Operations Procedures and Programs*, DOD5210.42-R_AFMAN 10-3902, *Nuclear Weapon Personnel Reliability Program (PRP)*, and AFI 91-204, *Safety Investigations and Reports*.

Chapter 3

OCCUPATIONAL AND ENVIRONMENTAL HEALTH (OEH) PROGRAM

3.1. Objectives.

3.1.1. The purpose of the AF OEH program is to protect military and civilian employee health while enhancing combat and operational capabilities.

3.2. Key Team Aerospace Players: BE, FOM, and PH. For AFRC: Stand-alone installation full-time BE/PH will collaborate with the RMU and where AFRC is a tenant with an RegAF host, the RMU will collaborate with the AD MTF.

3.3. Desired Effects.

3.3.1. All OEH hazards and associated risks identified and assessed.

3.3.2. All known risks eliminated or mitigated through engineering and administrative controls or personal protective equipment.

3.3.3. All OEH hazards and risks communicated effectively to populations at risk.

3.3.4. All personnel potentially exposed to OEH hazards evaluated for health effects as determined by the Installation Occupational & Environmental Medicine Consultant (IOEMC), and in accordance with Occupational Safety and Health Administration (OSHA) and AF Occupational Safety and Health (AFOSH) standards.

3.4. Indicators.

3.4.1. Occupational and Environmental Health Medical Examination (OEHME) completion rate tracked and reported to wing leadership ($\geq 90\%$ current). (T-1)

3.4.2. OEH Site Assessment (OEHSA) completed and QA-approved annually by BE. (T-1)

3.4.3. Performed Category-1 and Category-2 routine health risk assessments within established timeframes ($\geq 90\%$ current). (T-1)

3.4.4. Percentage of Defense Occupational Environmental and Health Readiness System (DOEHRS) High Priority special assessments closed within 60 days from identification trending upward. (T-2)

3.4.5. Category 1 annual workplace shop visit rate greater than 90%. (T-1)

3.4.6. Category 1-3 OEH Risk Assessment Codes (RACs) are assigned when appropriate. (T-2)

3.4.7. Workplace assessment completion rate for Fetal Protection Program within 5 days of referral with workplace specific guidance provided within 15 days, greater than 90%. (T-1) For ARC units, compliance will be measured by next unit training assembly vice the 5 and 15 day requirement.

3.4.8. MAJCOMs and installations may also develop their own installation-specific performance measures to assess objectives for location-unique programs.

3.5. Leadership Forums.

3.5.1. OEHWG.

3.5.2. AMC.

3.5.3. Installation Environment, Safety and Occupational Health (ESOH) Council.

3.6. Reporting.

3.6.1. OEH program review will occur at the AMC at a periodicity determined by the SGP. (T-2)

3.6.2. OEH program indicators will be reported at least quarterly to the MDG Executive Committee or ARC equivalent. (T-2)

3.6.3. OEH program indicators will be briefed at the OEHWG and, when OEHWG chair deems appropriate, reported to installation ESOH Council meeting. (T-2)

3.7. OEH program management.

3.7.1. AFI 48-145, *Occupational and Environmental Health Program*, defines the roles and responsibilities of TA members in the OEH program. AFMAN 48-146, *Occupational & Environmental Health Program Management*, provides more comprehensive guidance on overall OEH program management.

Chapter 4

FORCE HEALTH PROTECTION AND MEDICAL READINESS PROGRAM

4.1. Objectives.

4.1.1. The purpose of the Force Health Protection and Medical Readiness Program is to ensure a healthy and fit force, and to maximize operational readiness and performance.

4.2. Key Team Aerospace Players: AOP, BE, FOM, Optometry, PH, and Health Promotion.

4.3. Desired Effects.

4.3.1. Periodic Health Assessments are completed at the required interval and Individual Medical Readiness (IMR) currency is maintained for all assigned AF service members.

4.3.2. Profiles are completed in prescribed timeline and effectively communicate work and mobility restrictions to commanders to facilitate operational readiness.

4.3.3. Deployment limiting conditions (DLCs) are accurate and reported in a timely manner.

4.3.4. Medical Evaluation Boards (MEBs) are completed in a timely and appropriate manner.

4.3.5. Deployment processing is comprehensive and efficient, meeting DoD and AF standards.

4.3.6. Health Promotion identifies units with relatively poor health for targeted outreach.

4.4. Indicators.

4.4.1. Fully ready IMR rate tracked and reported to wing leadership. (T-1)

4.4.2. Pre and post deployment assessments compliance tracked and reported to wing leadership for:

4.4.2.1. Deployment Related Health Assessment (DRHA) #1 - DD Form 2795, *Pre Deployment Health Assessment*. (T-1)

4.4.2.2. DRHA #2 - DD Form 2796, *Post Deployment Health Assessment*. (T-1)

4.4.2.3. DRHA #3 - DD Form 2900, *Post Deployment Health Re-Assessment*. (T-1)

4.4.2.4. DRHA #4 - DD Form 2978, *Deployment Mental Health Assessment*. (T-1)

4.4.2.5. DRHA #5 - DD Form 2978, *Deployment Mental Health Assessment*. (T-1)

4.4.3. DAWG required metrics IAW AFI 10-203.

4.5. Leadership Forums.

4.5.1. DAWG.

4.5.2. AMC.

4.5.3. Medical Readiness Committee.

4.5.4. DPWG.

4.5.5. Wing Force Protection Working Group.

4.6. Reporting.

4.6.1. Force Health Protection and Medical Readiness program review will occur at the AMC at a periodicity determined by the SGP. (T-2)

4.6.2. Force Health Protection and Medical Readiness program indicators will be reported monthly to the MDG Executive Committee or ARC equivalent. (T-2)

4.6.3. Force Health Protection and Medical Readiness Program indicators (e.g. IMR, DRHA) will be briefed or presented to squadron, group, and wing leadership on a monthly basis. (T-2)

4.7. Force Health Protection and Medical Readiness Program Management.

4.7.1. The following AFIs define the roles and responsibilities of TA members in the Force Health Readiness Program: AFI 48-122, *Deployment Health*, AFI 10-203, *Duty Limiting Conditions*, AFI 48-123, *Medical Examinations and Standards*, AFI 44-170, *Preventive Health Assessment*, AFI 10-250, *Individual Medical Readiness*, AFI 10-246, *Food and Water Protection Program*, AFI 48-110, *Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases*, AFI 10-403, *Deployment Planning and Execution*, DoDD 6490.02E, *Comprehensive Health Surveillance*, DoDD 6200.04, *Force Health Protection*, DoDI 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees*, and DoDI 6490.03, *Deployment Health*.

Chapter 5

COMMUNITY HEALTH PROGRAM

5.1. Objectives.

5.1.1. The purpose of the Community Health (CH) Program is to protect the military, dependents and beneficiary civilian populations from infectious and communicable diseases, non-communicable chronic diseases, food-borne illnesses, and environmental hazards that may adversely impact the health of the community and degrade operational performance.

5.2. Key Team Aerospace Players: BE, FOM, PH and HP. For AFRC: Stand-alone installation RMU provides CH programs as appropriate for the assigned population and where AFRC is a tenant with an RegAF host, the RMU will collaborate with the AD MTF.

5.3. Desired Effects.

5.3.1. Base population educated on and protected from infectious and communicable diseases, environmental hazards, and food-, water-, and vector-borne illnesses.

5.3.2. Prevent and/or control the spread of communicable diseases in the community, schools and childcare programs, food facilities, and within the Medical Treatment Facility.

5.3.3. Individuals with communicable diseases are appropriately treated and managed.

5.3.4. Appropriate surveillance programs in place to identify, describe, and report disease and conditions of public health significance.

5.3.5. Plans and assets in place to identify, describe, respond to, and control outbreaks and events of public health concern.

5.3.6. Safe drinking water.

5.3.7. Evidence-based policies, programs and communications are implemented to promote a healthy and high-performing population.

5.4. Indicators.

5.4.1. Identification, tracking, and appropriate management of all latent Tuberculosis infection (LTBI) cases and reportable medical events completed as defined by the current Tri-Service Reportable Medical Events Guide. (T-1)

5.4.2. Medical employee health program compliance of 95% or greater. (T-1)

5.4.3. Food and facility inspections completed at frequency determined by the AMC. (T-1)

5.4.4. Surveillance programs to identify, describe, and report disease and conditions of public health significance conducted and reviewed at frequency determined by AMC. (T-1)

5.4.5. Drinking water surveillance activities completed at frequency determined by the AMC. (T-1)

5.4.6. MTF employees exposed to blood-borne pathogens tracked to ensure appropriate clinical management, identification of trends, and implementation of mitigation strategies when necessary. (T-1)

5.4.7. Other indicators based on local threats.

5.4.8. Health surveillance of tobacco use, obesity, physical activity and nutrition. (T-2)

5.5. Leadership Forums.

5.5.1. AMC.

5.5.2. Infection Control Committee.

5.5.3. PHEWG (N/A for ANG).

5.5.4. Population Health Working Group (PHWG).

5.6. Reporting.

5.6.1. Community Health Program review will occur at the AMC at a periodicity determined by the SGP. (T-2)

5.6.2. Community Health Program indicators will be briefed as needed to the MDG Executive Committee or ARC equivalent. (T-2)

5.7. Community Health Program management.

5.7.1. The following AFIs define the roles and responsibilities of TA members in the Community Health Program: AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance*, AFI 10-2603, *Emergency Health Powers on Air Force Installations*, AFI 10-2604, *Disease Containment Planning Guidance*, AFI 48-116, *Food Safety Program*, AFI 48-144, *Drinking Water Surveillance Program*, AFMAN 10-246, *Food and Water Protection Program*, AFMAN 48-138, *Sanitary Control and Surveillance of Field Water Supplies*, AFI 48-117, *Public Facility Sanitation*, AFI 48-110, *Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases*, AFI 34-248, *Child Development Centers*, AFI 34-249, *Youth Programs*, AFI 34-276, *Family Child Care Programs*, and AFI 40-101, *Health Promotion*.

Chapter 6

HUMAN PERFORMANCE SUSTAINMENT PROGRAM

6.1. Definitions of Human Performance Terms.

6.1.1. Personnel are the most important and valuable resource for the AF. The Airman is a “human weapon system” requiring “total life-cycle support and maintenance.” This line of reasoning leads to three interrelated human performance areas.

6.1.1.1. Human Performance Sustainment covers accession through separation/retirement with the goal of maintaining target performance levels throughout an Airman’s career while minimizing adverse health effects. Preventive medicine is a major contributor to performance sustainment because physical and mental health are necessary precursors to performance. Accordingly, performance sustainment encompasses health service support functions.

6.1.1.2. Human Performance Optimization seeks to achieve the most efficient use of limited human resources by comprehensively integrating Airmen with organizational and technical systems. It goes well beyond human-machine interface design and involves deliberate planning to efficiently leverage Airmen through the process of HSI. This area aligns both line and medical resources and objectives.

6.1.1.3. Human Performance Enhancement enables Airmen to operate beyond currently achievable and sustainable performance thresholds. It is chiefly accomplished through science and technology initiatives that range across the spectrum from intra-human (e.g., biotechnology and pharmacology) to extra-human (e.g., hardware and software).

6.2. Objectives.

6.2.1. The purpose of the Human Performance Sustainment Program is to sustain the performance of Airmen, whether in the face of enemy conflict, environmental threats and stressors, or advancing age. AME personnel provide feedback and lessons learned on human performance shortfalls and/or emerging threats to those organizations and agencies responsible for Human Performance Optimization and Enhancement.

6.2.2. Physical, mental and emotional health as well as physical fitness are necessary precursors to human performance. As such, any activity that supports or encourages improvement in health or fitness contributes to sustaining baseline human performance. Therefore, the other six AME programs described in this Instruction each contribute to human performance sustainment and their indicators can be classified as human performance sustainment indicators. This program, while looking at all AME programs and indicators, will also focus base-wide on the threats that are specific to subordinate units and/or locations. The AMC will consult with operational line leadership and develop a prioritized list of local human performance sustainment threats. The AMC/line leadership team will develop interventions and indicators to measure implementation effectiveness. Examples of human performance sustainment threats are: fatigue, degraded visual acuity, inappropriate shift work cycles, weather extremes (cold and heat), spatial disorientation, hazardous noise, G-induced loss of consciousness (GLOC), inadequate manpower for task, air sickness, vibration, inadequate diet, use of nutritional supplements and hydration, hypoxia, etc. (T-2)

6.3. Key Team Aerospace Players: AOP, BE, FOM, Optometry, PH, and Health Promotion.**6.4. Desired Effects.**

- 6.4.1. Successful accomplishment of the AF mission with minimal risk to personnel.
- 6.4.2. Airmen available for and capable of deployment and/or employment to successfully accomplish assigned missions with minimized assumed risk.
- 6.4.3. Operational commanders' decision-making and risk management processes are informed by consideration of mission-specific human performance capabilities, limitations, and requirements and associated full spectrum threats.
- 6.4.4. Threats to human performance are proactively mitigated (i.e., primary prevention), negative human performance trends are quickly identified and corrected (i.e., secondary prevention), and processes to minimize the impact of the adverse effects of human performance failures are in place (i.e., tertiary prevention).
- 6.4.5. Organizations and agencies responsible for Human Performance Optimization are aware of human performance shortfalls or emerging full spectrum threats.
- 6.4.6. Organizations and agencies responsible for Human Performance Enhancement are aware of the need for potential new human performance capabilities (i.e., capabilities that cannot be achieved with or derived from current programs and/or systems).

6.5. Indicators.

- 6.5.1. An AMC validated prioritized list of local human performance sustainment threats developed. (T-1)
- 6.5.2. A plan in place for mitigating or minimizing the adverse effects of each major threat as determined by the SGP. (T-1)
- 6.5.3. Indicators to measure mitigation strategy effectiveness developed and utilized for each identified major threat as stated in paragraph 6.5.1. and paragraph 6.5.2. of this instruction. (T-1)

6.6. Leadership Forums.

- 6.6.1. FOMWG.
- 6.6.2. OEHWG.
- 6.6.3. Wing and Squadron Flight and Ground Safety Meetings.
- 6.6.4. AMC.

6.7. Reporting.

- 6.7.1. Human Performance Sustainment Program review will occur at the AMC at a periodicity determined by the SGP.
- 6.7.2. Human Performance Sustainment Program indicators will be briefed as needed to the MDG Executive Committee or ARC equivalent.
- 6.7.3. The SGP may present some or all of the Human Performance Sustainment Program indicators at the OG staff meeting (after coordination with the OG).

6.8. Human Performance Program Management.

6.8.1. The following AFIs define the roles and responsibilities of TA members in the Human Performance Program: AFI 11-202V1, *Aircrew Training*, AFMAN 11-210, *Instrument Refresher Course (IRC) Program*, AFI 11-290, *Cockpit/Crew Resource Management Training Program*, respective AFI 11-2 mission design series (MDS) volumes 1-3 (e.g. , AFI 11-2C-17V3 for the C-17) describing various responsibilities (e.g. anti-G straining maneuver (AGSM) review, night vision goggle training, fatigue management), AFI 11-301V1, *Aircrew Flight Equipment Program*, AFI 11-403, *Aerospace Physiological Training Program*, AFI 11-404, *Centrifuge Training For High-G Aircrew*, AFI 11-409, *High Altitude Airdrop Mission Support Program*, AFI 11-410, *Personnel Parachute Operations*, AFI 21-101, *Aircraft and Equipment Maintenance Management*, AFI 40-101, *Health Promotion*, AFI 48-149, *Flight and Operational Medicine Program*, AFI 63-101, *Acquisition and Sustainment Life Cycle Management*, AFI 91-204, *Safety Investigations and Reports*, AFMAN 91-223, *Aviation Safety Investigations and Reports*, and AFMAN 48-151, *Thermal Injury*.

Chapter 7

EMERGENCY RESPONSE/DISASTER MANAGEMENT PROGRAM

7.1. Objectives.

7.1.1. The purpose of the Emergency Response and Disaster Management program is the timely and professional emergency response to aviation, operational, mass casualty, and CBRN events to minimize adverse health consequences and preserve operational capabilities.

7.2. Key Team Aerospace Players: BE, FOM, PH and PHEO. For AFRC: Stand-alone installation full-time BE/PH will collaborate with the RMU PHEO (SGP) and where AFRC is a tenant with an AD host, the RMU will collaborate with the AD MTF.

7.3. Desired Effects.

7.3.1. Aerospace Medicine Enterprise personnel fully trained and proficient in emergency response skills, roles, and responsibilities based on the principles of the Air Force Incident Management System (AFIMS) IAW AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations* and AFI 41-106, *Medical Readiness Program Management*.

7.3.2. Local emergency response plans, exercises and execution seamlessly integrated with Medical Readiness Office and wing emergency response agencies.

7.3.3. Development of local emergency response priorities in coordination with Medical Readiness Office based on local threat analysis.

7.3.4. Local Disease Containment Plan exercised, validated, and fully integrated with wing response agencies.

7.4. Indicators.

7.4.1. Each TA AFSC trained IAW respective directives and identified vulnerabilities/threats and planned responses. (T-1)

7.4.2. Completion of all required exercises for TA personnel as specified in AFI 10-403, *Deployment Planning and Execution*, AFI 10-2501, *Air Force Emergency Management Program Planning and Operations*, AFI 10-2603, *Emergency Health Powers on Air Force Installations*, and AFI 10-2604, *Disease Containment Planning Guidance*, and as directed by SGP to meet local training requirements. (T-1)

7.4.3. TA personnel fully trained IAW AFI 10-2501. (T-1)

7.5. Leadership Forums.

7.5.1. FOMWG.

7.5.2. AMC.

7.5.3. Medical Readiness Committee.

7.5.4. PHEWG (N/A for ANG).

7.5.5. Wing Emergency Management Working Group.

7.5.6. Threat Working Group.

7.6. Reporting.

7.6.1. TA Emergency Response and Disaster Management program review will occur at the AMC at a periodicity determined by the SGP. (T-2)

7.7. Emergency Response & Disaster Management Program management.

7.7.1. The following AFIs define the roles and responsibilities of TA members in the Emergency Response & Disaster Management Program: AFI 48-149, *Flight and Operational Medicine Operations*, AFI 91-204, *Safety Investigations and Reports*, AFI 10-2603, *Emergency Health Powers on Air Force Installations*, AFI 41-106, *Medical Readiness Program Management*, AFI 10-2501, *Air Force Emergency Management Program Planning and Operations*, AFI 10-403, *Deployment Planning and Execution*.

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

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

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AFI 40-104, *Health Promotion Nutrition*, October 4, 2011.

AFI 41-106, *Medical Readiness Program Management*, April 22, 2014.

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

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

AFI 48-116, *Food Safety Program*, March 22, 2004.

AFI 48-117, *Public Facility Sanitation*, June 26, 2014.

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

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

AFI 48-144, *Drinking Water Surveillance Program*, September 28, 2010.

AFI 48-145, *Occupational and Environmental Health Program*, July 22, 2014.

AFI 48-149, *Flight and Operational Medicine Program*, August 29, 2012.

AFI 63-101/20-101_AFGM01, *Integrated Life Cycle Management*, March 7, 2013.

AFI 90-801, *Environment, Safety, and Occupational Health Councils*, March 25, 2005.

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AFMAN 10-246, *Food and Water Protection Program*, May 27, 2014.

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AFMAN 91-223, *Aviation Safety Investigations and Reports*, May 16, 2013.

HAF MD 1-48, *The Air Force Surgeon General*, November 17, 2011.

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*.

DD Form 2795, *Pre-Deployment Health Assessment*.

DD Form 2796, *Post-Deployment Health Assessment*.

DD Form 2900, *Post Deployment Health Reassessment (PDRHA)*.

DD Form 2978, *Deployment Mental Health Assessment*.

Abbreviations and Acronyms

AE—Air Evacuation

AFIMS—Air Force Incident Management System

AFMS—Air Force Medical Service

AFRC—Air Force Reserve Command

AGSM—Anti-G Straining Maneuver

AMC—Aerospace Medicine Council

AME—Aerospace Medicine Enterprise

ANG—Air National Guard

AO—Aerospace Operations Panel

AOP—Aerospace and Operational Physiology

ARC—Air Reserve Component

BE—Bioenvironmental Engineering

CBRN—Chemical, Biological, Radiological, and Nuclear

CMA—Competent Medical Authority for the Personnel Reliability Program

DAWG—Deployment Availability Working Group

DHP—Defense Health Program

DLC—Deployment Limiting Condition

DNIF—Duties Not To Include Flying

DoD—Department of Defense

DOEHRS—Defense Occupational Environmental and Health Readiness System

DPWG—Deployment Process Working Group

DRHA—Deployment Related Health Assessment

DRU—Direct Reporting Unit

ESOH—Environment, Safety, and Occupational Health

ESOHC—Environmental, Safety, and Occupational Health Council

FHP—Force Health Protection

FOM—Flight and Operational Medicine

FOMWG—Flight and Operational Medicine Working Group

FS—Flight Surgeon

GDF—Guide for the Development of Forces

GLOC—G-induced Loss of Consciousness

GMU—Guard Medical Unit

GSU—Geographically Separated Unit

HP—Human Performance

HPW—Human Performance Wing

HSI—Human Systems Integration

HTSA—Host-Tenant Support Agreement

IMR—Individual Medical Readiness

IOEMC—Installation Occupational and Environmental Medicine Consultant

LAF—Line of the Air Force

LSMTF—Limited Scope Medical Treatment Facility

LTBI—Latent Tuberculosis Infection

MAS—Medical Aid Station

MDG—Medical Group

MDGI—Medical Group Instructions

MDS—Mission Design Series

MEB—Medical Evaluation Board

METALS—Mission Essential Tasks and Line Support

MOU—Memorandum of Understanding

MQT—Mission Qualification Training

MTF—Medical Treatment Facility

MUNSS—Munitions Support Squadron Site

NAF—Numbered Air Force

OEH—Occupational and Environmental Health

OEHME—Occupational and Environmental Health Medical Examination

OEHSA—Occupational and Environmental Health Site Assessment

OEHT—Occupational and Environmental Health Team

OEHWG—Occupational and Environmental Health Working Group

OM—Occupational Medicine

PH—Public Health

PHEO—Public Health Emergency Officer

PHEWG—Public Health Emergency Working Group

POC—Point of Contact

PRP—Personnel Reliability Program

RAM—Graduate of the Residency in Aerospace Medicine

RD&A—Research, Development, and Acquisition

RegAF—Regular Air Force

RMU—Reserve Medical Unit

SA—Support Agreement

SG—Surgeon General

SGP—Chief of Aerospace Medicine

SME—Squadron Medical Element

SPO—Senior Profile Officer

TA—Team Aerospace

Attachment 2**EXAMPLE TEMPLATE: AMC MEETING AGENDA****A2.1. Date, time, and location of meeting.****A2.2. Attendance.****A2.3. Review of previous minutes.**

A2.3.1. Previous AMC minutes

A2.3.2. DAWG minutes

A2.3.3. OEHWG minutes

A2.3.4. FOMWG abbreviated minutes (no HIPAA information) *NOTE: the SGP will determine the frequency that program metrics are briefed and reviewed to ensure the AME is achieving the stated objectives. The purpose of the AMC is to: (1) Review the program objectives and desired mission effects. (What are we trying to accomplish?) (2) Review the program activities, indicators and measures of success. (How are we doing in accomplishing the objectives and desired mission effects?) (3) Assess whether to continue present activities or to make adjustments to program plans. (Do we need to change anything?)*

A2.4. Flight and Operational Medicine Program.

A2.4.1. Aircrew Mission Ready Rate or Aircrew DNIF rate

A2.4.2. FS installation METAL plan developed, approved and complied >90%.

A2.4.3. FS Mission Qualification Training status rate.

A2.4.4. 4N0X1F completion of advanced Flight Medicine training.

A2.4.5. Other emphasis areas may be added as determined locally, such as:

A2.4.5.1. Flyer dental readiness

A2.4.5.2. Clinic access (customer satisfaction)

A2.4.5.3. PRP program compliance

A2.4.5.4. Soft Contact Lens Program

A2.4.5.5. Ground testing

A2.4.5.6. Air evacuation

A2.5. Occupational and Environmental Health Program.

A2.5.1. OEHME completion rate

A2.5.2. OEH Site assessments

A2.5.3. High and medium risk health risk assessments

A2.5.4. Flight Surgeon category 1 annual workplace shop visit rate

A2.5.5. Open DOEHRS High Priority special assessments; status of RACs

A2.5.6. Workplace assessment completion rate for Fetal Protection Program

A2.5.7. Other emphasis areas may be added as determined locally, such as:

- A2.5.7.1. Industrial mask fit testing
- A2.5.7.2. Confined space permits
- A2.5.7.3. QNFT mask fit testing
- A2.5.7.4. Occupational illness and injury rates
- A2.5.7.5. Industrial ventilation program
- A2.5.7.6. Thermoluminescent Dosimetry Program
- A2.5.7.7. Radioactive materials permits
- A2.5.7.8. HAZMAT authorization report
- A2.5.7.9. Initial threshold shift rate
- A2.5.7.10. Permanent threshold shift rate

A2.6. Force Health Readiness Program.

- A2.6.1. IMR rate tracked and reported
- A2.6.2. Pre and post deployment processing tracked and reported
- A2.6.3. DAWG required metrics
- A2.6.4. Other emphasis areas may be added as determined locally, such as profiling report.

A2.7. Community Health Program.

- A2.7.1. Management of LTBI
- A2.7.2. Medical employee health program compliance
- A2.7.3. Food and facility inspection rate
- A2.7.4. Surveillance
- A2.7.5. Other emphasis areas may be added as determined locally:
 - A2.7.5.1. Water vulnerability assessment
 - A2.7.5.2. Food safety assessment
 - A2.7.5.3. Immunization rate in DoDDs teachers and daycare providers
 - A2.7.5.4. Communicable disease report
 - A2.7.5.5. Child lead screening
 - A2.7.5.6. Mosquito surveillance
 - A2.7.5.7. Environmental sampling (potable water, swimming pools, etc)
 - A2.7.5.8. Animal bite protocol compliance
- A2.7.6. Community outreach to promote health installation (tobacco use, nutrition, physical activity and other health behaviors).

A2.8. Human Performance Program.

A2.8.1. An AMC validated prioritized list of local human performance sustainment threats developed.

A2.8.2. A plan in place for mitigating or minimizing the adverse effects of each local threat.

A2.8.3. Indicators to measure mitigation strategy effectiveness developed and utilized for each identified local threat as stated in paragraph 6.6.1 of this instruction.

A2.9. Emergency Response and Disaster Management Program.

A2.9.1. AFSC trained rate

A2.9.2. TA required exercise completion rate/status. (Focus on AME specific exercises as directed by SGP to meet local training requirements.)

A2.9.3. TA personnel fully trained IAW AFI 10-2501.

A2.10. Review of any new HHQ AFIs, policies, or taskings.

A2.11. Status of MDGI and OIs for currency/review/revision.

A2.12. Old Business.

A2.13. New Business.

A2.14. Subjects/items referred to/from other committees.

A2.15. Adjournment.

A2.16. Date/time/location of next meeting.