BY ORDER OF THE COMMANDER SPECIAL OPERATIONS COMMAND

AIR FORCE SPECIAL OPERATIONS COMMAND INSTRUCTION 48-1010

8 MARCH 2016

Incorporating Change 1, 5 JUNE 2019

Aerospace Medicine

AEROMEDICAL SPECIAL OPERATIONS

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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RELEASABILITY: There are no releasability restrictions on this publication.

OPR: AFSOC/SGP

Certified by: HQ AFSOC/SGP (Col Maximilian S. Lee)

Supersedes: AFSOCI48-101, 30 November 2012

Pages: 54

This instruction implements Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42.6., *United States Air Force (USAF) Medical Support for Special Operations Forces (SOF)*, and Air Force Policy Directive (AFPD) 48-1, *Aerospace Medicine Enterprise*. This instruction applies to all active duty Air Force Special Operations Command (AFSOC) operational medical personnel, pararescueman (PJ), and Combat Rescue Officer (CRO) personnel. This instruction applies to AFSOC gained Air Force Reserve Command (AFRC) and Air National Guard (ANG) units, and units will comply with this instruction in applicable areas. AFSOC operational medical personnel are defined as medical personnel assigned to AFSOC medical unit type codes (UTCs), as well as other specific medical personnel assigned to AFSOC units (i.e. special tactics medical personnel). Additionally, this instruction applies to Air National Guard (ANG) and to Air Force Reserve (AFRC) medical personnel assigned to AFSOC medical unit type codes (UTCs). Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with (IAW) Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of IAW Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS). Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the Air Force (AF) Form 847, *Recommendation for Change of Publication*; route AF Forms 847 from the field through the appropriate functional's chain of command. This publication may be supplemented at any level with OPR approval. Requests for waivers must be submitted to the OPR listed above for consideration and approval. The authorities to waive wing/unit level requirement in this

publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. Requests for waivers must be submitted through the chain of command to the appropriate Tier waiver approval authority IAW AFI 33-360, *Publications and Forms Management*, Table 1.1. Requests for waivers of non-tiered items must be processed through command channels to the publication OPR for consideration.

SUMMARY OF CHANGES

This interim change revises AFSOCI 48-1010 by removing paragraph 5.18.3, editing the language in paragraph 5.18.2, and including the term Advanced Medical Training which will be followed as outlined in USSOCOM Directive 350-29, Special Operations Forces (SOF) Baseline Interoperable Medical Training Standards.

Chapter 1

FUNCTIONAL AREA RESPONSIBILITIES

1.1. Introduction and Overview. This Instruction highlights responsibilities at wing level and below and establishes procedures for all Air Force Special Operations Command (AFSOC) operational medical personnel described in AFTTP 3-42.6, *USAF Medical Support for Special Operations Forces (SOF)*, Chapter 3. AFSOC Operational Medical Personnel, or "Operational Medics," are defined as medical Air Force Specialty Codes (AFSC) assigned to Operational Support Medical (OSM) and Special Tactics (ST) units, and any personnel assigned to an AFSOC unit type codes (UTC) outside of the 1st Special Operations Medical Group (1 SOMDG), 27th Special Operations Medical Group (27 SOMDG), 193rd Medical Group (193 MDG), 137th Medical Group (137 MDG), and 919th Medical Group (919 MDS). Additionally, AFSOC operational medical personnel will execute Global Health Engagement (GHE) operations. PJ/CRO personnel are not considered operational medical personnel. **Note:** "OSZ" is the Unit Deployment Manager (UDM) code for OSMs. For the sake of brevity, "OSM" includes "OSZ," and will be used throughout this publication.

1.2. Waiver Authority. Requests for waivers must be submitted through the chain of command to the appropriate Tier waiver approval authority.

1.3. Organizational Responsibilities.

1.3.1. AFSOC Surgeon General (AFSOC/SG). The AFSOC surgeon general is responsible for establishing, coordinating, and sustaining a health care system for AFSOC personnel and for organizing, training, and equipping AFSOC medical forces for contingency medical support. As the air component surgeon to United States Special Operations Command (USSOCOM), the AFSOC/SG plans execution of all Air Force medical support for Air Force Special Operations Command medics , and serves as the principal Air Force medical service advisor to USSOCOM. AFSOC/SG is the waiver authority for all Command level requirements listed in this document.

1.3.2. Special Operations Wing Surgeon (SOW/SG). Serves as the Functional Area Manager (FAM) for medical within special tactics (ST), and provides advice and guidance to the SOW commander. Responsible for ensuring Special Tactics Group (STG) and Special Tactics Squadron (STS) medical leaders comply with established medical policies. SOW/SG provides functional area review of medical unit reports and requests to higher headquarters, career mentoring to junior medical personnel, and oversight of evaluations, awards, and decorations for assigned medical personnel. Also acts as liaison and consultant to AFSOC/SG for ST specific medical issues.

1.3.3. Special Tactics Group Surgeon (STG/SG). The STG/SG coordinates medical training and oversees appropriate medical equipment for medics and pararescuemen assigned to STG. The STG Surgeon plans medical support for special tactics missions, and selection of special tactics candidates. STG/SG fosters a good relationship with host Chief, Aerospace Medicine (SGP) and Flight and Operational Medicine Clinic (FOMC) to ensure STG medics maintain their clinical skills and currencies by supporting home station and deployed MTFs as a provider.

1.3.4. Medical Group Commander (MDG/CC). MDG/CC is responsible for oversight of all medical care on the installation. MDG/CC is the waiver authority for clinical currencies as established in this publication. This authority cannot be delegated. **(T-2)**

1.3.5. Military Treatment Facility (MTF) Chief of Aerospace Medicine (MTF/SGP). Oversees all activities related to flight and operational medicine on their facility. Functions as liaison between the MTF and all AFSOC embedded medics to include ambulatory care units (ACU) and Operational Support Medical (OSM) flights. MTF/SGP fosters a good relationship with line medical assets and ensures OSM and ACU personnel are integrated with the host MTF.

1.3.6. Operational Support Medical Operations Flight Commander (OSM/CC). OSM/CC coordinates with line leadership the best and most appropriate employment of line medical assets. OSM/CC fosters a good relationship with host SGP; and Flight and Operational Medicine Clinic. Ensures OSM personnel maintain their clinical skills and currencies by integrating clinic time at the host MTF.

1.3.7. OSM Medical Planner. OSM Medical Service Corps officers serve as the unit medical planner and administrator ensuring management and oversight of war reserve materiel projects, budget forecast and execution, training programs, readiness reporting, and currency of unit manning documents. Additionally, medical planners are integral to planning medical support in deliberate/contingency plans and exercise participation.

Chapter 2

ADMINISTRATION OF MEDICAL ACTIVITIES

2.1. Command and Control (C2). AFSOC, to include operational medical personnel, are under the combatant command authority of the US Special Operations Command and under Administrative Control (ADCON) of the Commander, AFSOC. A geographic combatant commander (GCC) normally exercises operational control (OPCON) of SOF through the commander, theater special operations command (CDRTSOC) or a subordinate joint force commander (JFC). The CDRTSOC may also be designated as the joint force special operations component commander by the GCC. To preserve unity of command and enable the most effective use of limited Special Operations aviation assets, AFSOC operational medical personnel are normally placed under the OPCON of a Joint Special Operations Air Component Commander (JSOACC). During smaller scale operations when a JSOAC is not established, operational medical personnel will remain under the operational control of the TSOC. Mission commanders will normally exercise tactical control of AFSOC operational medical personnel. The Flying or Operational Sq/CC retains administrative control (ADCON), operational oversight (OPCON), and punitive authority (UCMJ or State equivalent) over operational medical personnel. Rating chain will be through the flying or operational squadron. (T-3)

2.2. Privileging Documentation. All healthcare providers (HCPs) will maintain a current copy of their medical credentials in their deployment folder. Likewise, independent duty medical technicians (IDMTs) will maintain a copy of their current initial and sustainment training documentation via the electronic Air Force Training Record (AFTR). All IDMTs will hand carry these documents while deployed. If deployed to a location with medical facilities, HCPs and IDMTs will provide the medical facility commander with a copy of these documents. While deployed with SOF, AFSOC operational medics assigned to line units remain within the special operations chain of command. However, AFSOC medical personnel will comply with co-located medical facility credentialing/privileging processes. The senior AFSOC physician at the deployed location will review Inter-facility Credentials Transfer Briefs (ICTBs) and IDMTs certification documents. **(T-0)**

2.3. Quality Assurance (QA). The senior AFSOC physician assigned to each deployed unit is responsible for that unit's quality assurance program. The senior deployed AFSOC physician is responsible for medical quality assurance during deployments. Quality assurance will include peer review as described by the credentialing facility, both at home station and deployed. IDMT quality assurance will be completed IAW AFI 44-103, *The Air Force Independent Duty Medical Technician Program*. **(T-2)**

2.3.1. After return from deployment, a copy of all chart review documentation (See Attachment 3, Deployed QA Oversight Documentation Sample), will be forwarded to the host MTF for continued credentialing/privileging actions. **(T-2)**

2.4. Reporting. When AFSOC medical units receive an alert order, are deployed, or are employed, a Situation Report (SITREP) will be completed IAW AFI 10-206, *Operational Reporting*. Send to **AFSOC.SGX@afsoc.af.smil.mil**.

2.4.1. In-garrison medical units and those medical units/elements deployed in support of SOF taskings will submit a weekly unit status report through their operational chain of

command to AFSOC/SGX via SIPR to **AFSOC.SGX@afsoc.hurlburt.af.smil.mil**. This report is essential for required weekly AFSOC/SG activity reports to AF/SG and is due NLT 0700 Central Standard Time (CST) each Monday. **(T-2)**

2.4.1.1. AFSOC/SG or AFSOC/SGX will be contacted by secure system to request waiver from SITREP reporting if operational security (OPSEC) or other security considerations may preclude transmission of SITREP reports for a specific mission.

2.4.2. IAW AFI 90-1601 *Air Force Lessons Learned Program,* units participating in operations not supported by a continuing AEF cycle (i.e., contingencies and exercises) will submit an after action report (AAR) to HQ NLT 30 days (for ARC units 60 days) after the end of the event unless otherwise directed. Forward through the appropriate chain of command to AFSOC/SGX via SIPRNET to **AFSOC.SGX@afsoc.af.smil.mil**. Attachment 6 is the approved template. AARs will be reported to AFSOC/SGX for each and every Casualty Evacuation (CASEVAC) mission. **(T-2)**

2.4.3. Executive Activity and Clinical Currency Quarterly Report. All operational AFSOC medical units will complete quarterly (Jan - Mar, Apr - June, July - Sep, and Oct - Dec) executive summaries describing unit deployments (unclassified (UNCLASS)), activities, and complete the clinical activities report card in Attachment 4. Requirements for the clinical currency report card are outlined in the Training Tables (see Chap 5). Reports are due NLT 15 days following the last day of the quarter to AFSOC/SGP, via NIPR, to AFSOC.SGX@ hurlburt.af.mil. AFSOC/SGX will forward to the other AFSOC/SG divisions. **(T-2)**

2.4.4. Medical Logistics. All Geographically Separated Units (GSU) will forward War Reserve Materiel (WRM) Inventory Summary Letters upon completion of annual WRM inventories, per AFI 41-209, *Medical Logistics Support* to AFSOC/SGAL and AFSOC/SGXL. **(T-2)**

Chapter 3

FORCE HEALTH AND AIRCREW MANAGEMENT

3.1. Objectives. To ensure protection and promotion of Airmen's health in garrison and when deployed. Integral to this is familiarity of aircrew physical standards, deployment health requirements, health surveillance, and medical information management.

3.2. Aircrew Physical Standards. When making aeromedical dispositions, AFSOC flight surgeons must refer to AFI 48-123, *Medical Examinations and Standards*, the Medical Standards Directory, AF and AFSOC policy letters, and the USAF Aerospace Medicine Waiver Guide published by the Aeromedical Consultation Service on the AFMS Knowledge Exchange.

3.2.1. Disqualification Authority. Refer to AFI 48-123 for certification/disqualification authority. Local disqualification is not authorized.

3.2.2. Aeromedical Consultation Service (ACS). All ACS evaluation requests must be submitted through Aeromedical Information Waiver Tracking System (AIMWTS) to AFSOC/SGPA for review and subsequent forwarding to the ACS. **(T-2)**

3.3. Diving Medical Standards. Physical exams and standards for military diving are governed by applicable sister-service standards. These standards are located in Army Regulation (AR) 40-501, Section 8-12, and SS521-AG-PRO-010, 0910-LP-106-0957, *U.S. Navy Diving Manual*.

3.3.1. Diving duty physical exams may be performed by USAF flight surgeons or Navy dive medical officers. **(T-2)**

3.3.2. Dive physical examinations will be performed a minimum of every 5 years, IAW SS521-AG-PRO-010, 0910-LP-106-0957, *U.S. Navy Diving Manual*. **(T-2)**

3.3.3. AFSOC/SGPA is the waiver authority for initial medical qualification of AFSOC personnel for diving duty. AFRC/SG and ANG/SG retain waiver authority for their personnel.

3.3.4. PJs, CROs, Combat Controllers (CCTs), and Special Tactics Officers (STOs) are combat swimmers (military divers). AFI 10-3501, *Air Force Diving Program*, governs special tactics diving. **(T-2)**

3.4. Aeromedical and Special Duty Disposition. All DD Form 2992, *Medical Recommendations For Flying or Special Operational Duty,* holders are Duties Not to Include Flying (DNIF)/Duties Not Including Controlling (DNIC), if seen by a non-flight surgeon provider, including IDMTs. Physician Assistant (PA) may, in some deployed settings, perform the return to fly function, see below.

3.4.1. Only a credentialed USAF or US Department of Defense (DOD) flight surgeon may determine that aircrew are fit to return to flying status, or that special operational duty personnel are fit to return to special operational duty (controller duty, parachute duty). A flight surgeon or a Diving Medical Officers (DMO) may return a diver to duty. Only US flight surgeons will be used as consultants for aeromedical dispositions. **(T-0)**

3.4.1.1. As identified in AFI 48-149, *Flight and Operational Medicine Program*, AF/SG delegates to the MTF Commander the authority to grant aeromedical disposition privileges to AFSOC PAs working independently in support of USSOCOM, when

deployed and without reasonable access to a FS preceptor. This privilege is granted only to those PAs who have audited the required Aerospace Medicine Primary (AMP) courses, and who have the appropriate annotation on the flight medicine section of their privilege list with approval of the host MTF Chief, Medical Staff (SGH). **(T-2)**

3.4.1.2. IDMTs must contact a US military flight surgeon for appropriate aeromedical disposition. This contact must be documented in the aviator's or special tactics team member's medical record and subsequently countersigned by the consulted flight surgeon or a home station flight surgeon upon return from deployment. **(T-2)**

3.4.1.3. AF Form 1041, *Medical Recommendation for Flying or Special Operational Duty Log Review*. All AFSOC flight surgeons available for duty must attend and participate in the weekly Flight and Operational Medicine Working Group (FOMWG) at the host MTF. The intent is that line-assigned flight surgeons actively monitor and manage the aeromedical status of all DD Form 2992 holders in their assigned units. **(T-2)**

3.5. Pre-Deployment Health Requirements. Current DOD and AF pre-deployment health requirements can be accessed at: **https://kx2.afms.mil/kj/kx3/DeploymentHealth**. OSM providers are required to have accomplished specific training prior to conducting a Deployment Related Health Assessment (DRHA). The training can be found at the Kx deployment health website (navigate to the provider section or click **https://kx2.afms.mil/kj/kx3/DeploymentHealth/Pages/ProviderEducationTraining.aspx**).

3.5.1. AFSOC unit commanders are responsible for identifying all deploying personnel to the Installation Personnel Readiness (IPR) prior to deployment. IPR will provide the names of deploying personnel to the host MTF. **(T-2)**

3.6. Deployment Health. Unit commanders are responsible for ensuring compliance with all deployment health requirements. Appropriate deployment health coding will be used with all deployment-related health issues. Coding can be found at: **https://kx2.afms.mil/kj/kx3/DeploymentHealth/Pages/DeploymentHealthCoding.aspx**. **(T-2)**

3.6.1. Operational medical units at bases supported by non-AFSOC MTFs are responsible for coordination of deployment health activities with the supporting MTF.

3.6.2. Deployment Health Requirements. DOD requirements for deployment health surveillance are published in DODI 6490.03, *Deployment Health*, DODI 6490.12, *Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation*, and AFI 48-122, *Deployment Health*, can be accessed at: **https://kx2.afms.mil/kj/kx3/DeploymentHealth** (navigate to policy and guidance or click **https://kx2.afms.mil/kj/kx3/DeploymentHealth/Pages/PolicyAndGuidance.aspx**). Air Force Manual (AFM) 48-154, *Occupational and Environmental Health Site Assessment*, contains current Occupational and Environmental Health site assessment guidance. In addition to DODIs and AFIs, current guidance and policy memos can also be found at the Kx website. Combatant Commands (COCOMs) may publish additional requirements.

3.6.3. AF MTF Public Health will track and ensure compliance with deployment health surveillance requirements for deploying AFSOC personnel. AFSOC unit medical personnel will track and ensure compliance with deployment health surveillance requirements for AFSOC personnel with assistance from host MTFs. **(T-2)**

3.7. Health Surveillance Requirements at Deployed Locations. The senior deployed medical officer/healthcare provider will establish processes to ensure DOD, AF, GCC, and COCOM health surveillance requirements are fulfilled.

3.7.1. In-process personnel at deployed location to accomplish the following tasks:

3.7.1.1. For deployments greater than 30 days, collect DD Form 2766, *Adult Preventive and Chronic Care Flow*, sheet. **(T-2)**

3.7.1.2. If pre-deployment Health Assessments (DRHA #1) are required for the deployment, check for completion of DD Form 2795, *Pre-Deployment Health Assessment Questionnaire*. If not completed at home station, accomplish DD Form 2795 at the deployed location. **(T-2)**

3.8. Requirements for Redeploying Personnel from Theater to Home Station. Current DOD and AF redeployment health surveillance requirements can be accessed at: **https://kx2.afms.mil/kj/kx3/DeploymentHealth**. Ensure personnel complete DD Form 2796, *Post-Deployment Health Assessment (DRHA #2)*. The post-deployment health assessment must be completed via a face-to-face encounter with a provider (physician, nurse practitioner, or physician assistant) and must be accomplished electronically. **(T-0)**

3.8.1. Bioenvironmental engineers (BEE) conduct Occupational and Environmental Site Assessments at deployed locations IAW AFMAN 48-154, *Occupational and Environmental Health Site Assessment.* Information collected will be used to generate the Occupational and Environmental Health Exposure Data (OEHED) and/or a Periodic Occupational and Environmental Measurement Summary (POEMS). BEE will coordinate with Public Health to ensure exposure data is incorporated into personnel medical records as required. **(T-2)**

3.9. Requirements for Post-Deployment Processing at Home Station. DOD and AF post-deployment surveillance requirements can be accessed at: **https://kx2.afms.mil/kj/kx3/DeploymentHealth**. The DD Form 2796 (DRHA #2) will be accomplished within 30 days of return to station if not already accomplished in theater. DRHA #3, 4, and 5 will also be accomplished within the appropriate window. If the member deploys again before all 5 are accomplished, the member will restart with DRHA # 1. The timeline will be automatically readjusted to the new deployment. **(T-0)**

3.10. Medical Information Management.

3.10.1. All patient encounters will be documented. All operational medical units must deploy with and use the laptop based Theater Medical Information Program (TMIP) to document electronic healthcare records (EHR) with the Armed Forces Health Longitudinal Technology Application—Theater (AHLTA-T) application, OR similarly approved EHR documentation system to collect and document all patient encounters. Failure to appropriately document patient encounters constitutes a serious breach in standard of care. **(T-2)**

3.10.2. Patient encounters collected in TMIP or other EHR system will be uploaded to the Theater Medical Data System from the deployed location. If the EHR system is connected via wired, wireless, or tactical connection, transmission is immediate and no action is required by the user. If no connectivity is available the laptop may be connected at the first area of available communications OR the AHLTA-T database containing the records will be

exported onto a government hard drive or CD and hand carried to home station for immediate upload to the Military Health System Clinical Data Repository. **(T-2)**

3.10.3. TMIP Training. Each operational medical unit must designate in writing, to AFSOC/SGRI, a primary and alternate Unit TMIP Administrator and at least five TMIP Users. AFSOC/SGRI will conduct initial training for unit identified TMIP Administrators and TMIP Users. Unit TMIP Administrators will ensure deploying members are trained and proficient to use TMIP and have reach-back support to the unit TMIP Administrator. Sustainment of training will be the responsibility of the unit TMIP Administrator and will include TMIP familiarity/usage, user training/proficiency, and system configuration/troubleshooting. **(T-2)**

3.10.4. All operational medical units will ensure UTC deployable computers are functional and loaded with TMIP before deploying. Any shortfalls or problems will be identified to AFSOC/SGX (see paragraph 1.9., this publication) or AFSOC/SGRI for technical assistance.

3.11. Infection Control Responsibilities.

3.11.1. Infection Control (IC) is managed IAW AFI 44-108, *Infection Prevention and Control Program,* and AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance*, which addresses IC in AFSOC Ambulatory Care Units (ACU).

3.11.2. In the deployed setting the lead medical provider will ensure an active and current Infection Control Point (ICP) at all deployed care locations. **(T-2)**

3.11.3. Report infection control discrepancies and inconsistencies to the flight commander, local MTF Infection Control Function (ICF) Chairperson, MTF SGH, and group or wing SG.

3.12. Directed Energy.

3.12.1. Laser activities and events will be managed IAW AFI 48-139, AFSOCSUP, *Laser and Optical Radiation Protection Program*. The USAF School of Aerospace Medicine maintains an updated Laser Injury Guidebook which has the most up-to-date questionnaire and procedures for providers to accomplish after a suspected laser exposure.

3.12.2. Evaluation of exposed personnel will be performed at the time of the exposure and 12, 24, and 48 hours post exposure. If the results of any of these evaluations are normal and the member is asymptomatic, the individual may be returned to unrestricted duty, to include flying duties (remaining evaluations must still be performed because latent symptoms may present). Keep in mind that injury from these exposures is exceedingly rare, personnel with persistent visual complaints or symptoms will be referred to an eye specialist. Aircrew with symptoms will be placed in DNIF status. Specific duty restrictions may be warranted based on personal and operational safety concerns. Refer to AFI 48-139, AFSOCSUP for more information. Consultations with laser eye injury specialists are available through Tri-Service Laser Hotline: 1-800-473-3549, DSN 312-798-3764. **(T-2)**

3.13. Use of Controlled Medications.

3.13.1. The clinical use of controlled medications will be IAW DOD policy; AFI 44-102, *Medical Care Management,* Chapter 10; and Public Law.

3.13.2. Fatigue management must be a consideration for day-to-day operations at home and in the deployed setting. Leadership must consider management tools including limiting day/night shift changes, monitoring of the duty day, and other measures to minimize fatigue. When all other measures used together are not sufficient to ensure alertness, commanders, in concert with local flight surgeons, may employ judicious use of counter fatigue medications. **(T-2)**

3.13.3. For use of counter-fatigue medications use only the forms on the Go No-Go Forms on the Kx. (**T-2**)

3.13.4. All currently approved Go/No-Go Pills are controlled under strict accountability procedures; unused medications will be returned to the appropriate authority upon completion of the mission. **(T-2)**

3.13.5. Each Flight Medicine Clinic will establish a program to ground test, dispense, and control pharmacological agents per Air Force fatigue management policy. **(T-2)**

3.13.6. Go/No-Go pill ground testing and operational use is voluntary. Ground testing for Go/No-Go pills to eligible aircrew must be accomplished prior to operational use. Documentation of successful ground testing or deferral is entered in the medical record of eligible aircrew. All aircrew are DNIF while ground testing both Go and No-Go pills. **(T-2)**

3.13.7. There is potential for Airmen using Go/No-Go Pills to become dependent on their use to the exclusion of all other non-pharmacological interventions. Flight surgeons must clinically supervise the use of any Go/No-Go medications and exercise careful judgment before dispensing. Go/No-Go medications are not intended to be a solution to manning shortages, to support a lifestyle of poor sleep habits or inappropriate prioritization of work and play activities, or for poor unit scheduling practices. **(T-2)**

3.13.8. No-Go Medication Use.

3.13.8.1. The approval authority and process for the operational use of No-Go pills (Temazepam, Zolpidem, and Zaleplon) by aircrew and Special Duty Personnel is described at Fatigue Mgmt and Go/No-Go Pill use. **(T-2)**

3.13.8.2. Members are verbally DNIF for 12 hours after taking Temazepam (Restoril), 6 hours after taking Zolpidem (Ambien), or 4 hours after taking Zaleplon (Sonata) in accordance with the Official Air Force Aircrew Medications list. **(T-2)**

3.13.8.3. No-Go pill use is limited to: Restoril, Ambien, and Sonata: Maximum of 7 consecutive days and no more than 20 days in a 60-day period. **(T-2)**

3.13.8.4. AFSOC/SG delegates approval authority for operational use of No-Go Pills to flight surgeons at the operational unit level; however, authority delegation is contingent upon strict compliance with all program requirements and documentation requirements. The senior flight surgeon at the unit level is responsible for implementation of this policy. **(T-2)**

3.13.8.5. No-Go pills are authorized at the time of deployment or redeployment to synchronize circadian rhythm in the deploying or redeploying crews. No-Go pills are also authorized to assist deployed crew members with fatigue and circadian rhythm problems. **(T-2)**

3.13.8.6. This policy for use of No-Go pills also applies to AFSOC Special Tactics Personnel. **(T-2)**

3.13.8.7. In-garrison operational use of approved No-Go pills in unmanned aerial systems crew is delegated to all AFSOC flight surgeons. For this policy, aircrew includes all Ground Control Station personnel (pilots and ground-based sensor operators). **(T-2)**

3.13.9. Go Pill use.

3.13.9.1. Flight surgeons must provide eligible aircrew counseling regarding the off-label use of Go Pills as a fatigue countermeasure, and obtain informed consent prior to prescribing them IAW 10 USC 1107(f), *Notice of Use of an Investigational New Drug or a Drug Unapproved for Its Applied Use*. Informed consent is required only once and documented in the Airman's medical record. **(T-2)**

3.13.9.2. The use of Dextroamphetamine (Dexedrine) is not authorized. Modafinil (Provigil) is the only authorized medication to increase alertness and only authorized for AFSOC Special Tactics Personnel. Use is not approved for parachute or diving operations. **(T-2)**

3.13.9.3. AFSOC/A3 and AFSOC/SG are the approval authority for the operational use of Go pills for aircrew other than AFSOC Special Tactics Personnel. The OG/CC (or deployed equivalent), working in concert with the local flight surgeon, will identify those missions that may require the use of Go pills. **(T-2)**

3.13.9.4. The approval authority for the operational use of fatigue management medication by AFSOC Special Tactics Personnel is a SOW or SOG/CC, STG/CC, or Special Operations Air Component Commander. **(T-2)**

3.13.9.5. AFSOC personnel will only receive Go pills from an AFSOC flight surgeon. In the absence of collocated AFSOC flight surgeon, an AFSOC physician assistant or independent duty technician may dispense Go pills with written approval of their in-theater preceptor. In the absence of any collocated AFSOC medical personnel, a military-credentialed provider may dispense Go pills with the written approval of the AFSOC theater surgeon. This includes AFSOC forces assigned to non-USSOCOM commanders. **(T-2)**

3.13.9.6. Flight surgeons report operational use of Go Pills, including adverse reactions during operational use, to MAJCOM/SGP. The format to report adverse reactions can be found on the Go No-Go Forms on the Kx link and will be forwarded to the ST unit commander, AFSOC/A3, and AFSOC/SGP. The MAJCOM/SGP will be provided, and maintain, a record of Go Pill use. **(T-2)**

3.13.9.7. Modafinil use is only permitted after all other non-pharmacologic fatigue countermeasures have been attempted and exhausted. Prior to a commander signing the approval form, a flight surgeon must review and verify that each individual has been ground tested, medically cleared to use modafinil, and that all documentation is in the medical record. Once the requirements have been verified the flight surgeon will sign a document stating the member is approved for operational use (see Attachment 2). The commander's approval of Go pills may be for a specific mission or for a specific period of deployment. A copy of the written approval will be forwarded to AFSOC/SGP and a

copy will be maintained by the ground combat operator's home station unit for a minimum of 3 years. The operator who obtains modafinil has the ultimate responsibility to ensure a copy of the written approval is submitted to their unit. **(T-2)**

3.13.9.7.1. After the appropriate commander approves the use of modafinil for operational fatigue management, a flight surgeon will prescribe the appropriate quantity of medication for the mission or deployment. The prescription will be documented in the member's medical record. **(T-2)**

3.13.9.8. The dosage of modafinil for operational fatigue management is 200 mg every 8 hours as needed for sustained wakefulness. Modafinil usage will not exceed a dosage of 400 mg in any 24-hour period. Maximum approved dispensing quantity is twelve 200 mg tablets for each 30 days of deployment. The use of modafinil for fatigue management should be limited to the fewest number of doses required to effectively complete a mission. The maximum approved period of continuous operational use of modafinil is 72 hours. **(T-2)**

3.13.9.9. Ground combat personnel who use modafinil during any mission will report use of the medication and the number of tablets via the end of mission report. Additionally, at the end of each deployment, ground combat personnel who obtained Modafinil will report the number of tablets of medication used during the deployment to the SOW/SG and AFSOC/SGP using the USAF/SG End of Operation Report form. The flying-oriented form may be adapted as needed for ground operations reporting. All unused medication will be returned to the dispensing unit. **(T-2)**

3.13.9.10. AFSOC ground combat personnel who have received informed consent, have successfully completed ground testing, and are attached to United States Army Special Operations Command (USASOC), United States Marine Corps Forces Special Operations Command (MARSOC) or Naval Special Warfare forces may obtain modafinil from those USSOCOM components. In that circumstance, AFSOC personnel will follow distribution and reporting procedures established by those components. Other theater specific policies may also regulate the use of these medications within the areas of responsibility (AORs). Reporting the use must still be in compliance with this instruction. **(T-2)**

3.13.9.11. The 24 SOW/SG will accomplish a 100% self-inspection of this program in February and August of each year noting compliance with this instruction and any variance. The self-inspection report of modafinil use will include a list of all modafinil prescribed to the unit members along with the supporting approval of use documentation. The self-inspection report will be forwarded to the AFSOC/SG and AFSOC/CV. **(T-2)**

3.14. Dietary Supplement Usage.

3.14.1. Dietary Supplement Usage is per USSOCOM Policy Memorandum 11-30, *Policy on Performance Enhancing Substance Use for Special Operations Forces (SOF) Personnel*, 7 January 2012. **(T-2)** An outstanding reference is the Human Performance Resource Center: **http://hprc-online.org/dietary-supplements/dietary-supplement-classification-system-1**. **(T-2)**

3.14.1.1. All AFSOC personnel on flight status must be granted prior approval by a flight surgeon for use of any dietary supplement.

3.14.1.2. Documentation of supplement usage in the medical record is a requirement of the approval process.

3.14.2. Specific unit requests for guidance should be routed through their respective medical functional leadership and operational chain of command.

3.14.3. Approval for use of dietary supplements does not authorize use of O&M funds to obtain approved products.

3.15. Blood Borne Agent Exposure Risk and Control Plan.

3.15.1. In accordance with US Public Health Service guidelines for the management of occupational exposures to human immunodeficiency virus (HIV) and recommendations for post-exposure prophylaxis (PEP), medical providers who are conducting high risk training or have a high expectation of exposure to HIV should deploy with PEP.

3.15.2. AFSOC medical operational units will establish an exposure control plan for care and evaluation of AFSOC assets and those that fall under their medical responsibility in the field who may have exposure to blood or body fluids in an austere environment. The protocol should not replace the standing post exposure protocol at the in-garrison MTF for the active duty member upon their return from the austere location. **(T-2)**

3.15.2.1. Local plans should include education of deploying forces with pre-deployment briefings on HIV, Hepatitis B Virus , and Hepatitis C Virus risks in theater. Education of line members should emphasize post exposure cleanup after self-aide/buddy care, the use of personal protective equipment (PPE), and the definition of exposure.

3.15.2.1.1. Significant exposures are considered blood or body fluids on mucous membranes or non-intact skin and/or blood or body fluids injected via a needle stick from a hollow or solid needle, or other sharp object.

3.15.2.1.2. Non-significant exposures are considered blood or body fluids on intact skin, casual contact with an HIV-infected individual or exposure to an animal's blood or body fluids.

3.15.2.2. Education of medical forces should emphasize universal precautions and use of PPE, as well as use of sharp instruments in a low light/combat environment which places SOF medics at increased risk.

3.16. Airsickness.

3.16.1. Students in Initial Qualification Training (IQT), Mission Qualification Training (MQT), and experienced aircrew transitioning to a new weapon system are more likely to experience episodes of airsickness. AETCI 48-102, *Medical Management of Undergraduate Flying Training Students,* provides excellent guidance for the management of airsickness. Airsickness management during training programs is outlined below.

3.16.2. At the first episode of airsickness (active or passive) aircrew members should report to a flight surgeon before their next flight to undergo evaluation for an underlying medical cause. If none is found, the flight surgeon or Aerospace and Operational Physiology Team (AOPT)will educate the aircrew member on diet, nutrition, sleep patterns, and mitigation of individual stressors. **(T-3)**

3.16.3. Subsequent episodes of airsickness may be treated with medications, physiologic adaptation, mental health counseling, or any combination of these. The flight surgeon, aerospace physiologist, mental health provider, and flying supervisor must coordinate efforts to ensure successful outcomes. Refer to the Aerospace Medicine Approved Medications guide, AFI 11-403, *Aerospace Physiological Training Program*, and any local operating instructions. **(T-2)**

3.16.4. If airsickness continues, all factors will be reexamined by a flight surgeon with particular attention to motivation for flying and possible Manifestation of Apprehension (MOA). Aircrew members suspected of MOA should be referred to the Mental Health Clinic. If it is deemed appropriate, the aircrew member will continue physiological adaptation, which concentrates on preventive training with the Barany chair, and the possible prescription of scopolamine or dextroamphetamine and scopolamine. Treatment will be limited to no more than three times unless approved by AFSOC/SGP. The principle behind its use is to prevent an aversion to flying based solely on airsickness and to allow the aircrew member to apply techniques learned during Barany chair treatment. Generally, medications will not be given when there have been fewer than three episodes of airsickness. The decision for the use of medications remains with the flight surgeon. **(T-2)**

Chapter 4

AFSOC OPERATIONAL MEDICINE

4.1. AFSOC Operational Medical Personnel Responsibilities. All AFSOC operational medical personnel will work toward the successful execution of the Aerospace Medicine Enterprise as defined in AFI 48-101.

4.1.1. AFSOC operational medical personnel deliver healthcare, both in-garrison and while deployed. Flight surgeons, SOST physicians, PAs, Certified Registered Nurse Anesthetist (CRNAs), nurses, Respiratory Technicians (RTs), IDMTs, and medical technicians assigned as operational medical personnel to AFSOC units have unique roles and responsibilities. When not deployed, and when not participating in mandatory squadron functions, training, or exercises, operational medical personnel are required to maintain clinical proficiency, medical training requirements, and clinical credentials and privileges. Meeting/sustaining the requirements contained herein qualifies AFSOC's operational medical personnel for deployment. Unit commanders need to employ their medical assets meaningfully; medical personnel will not be assigned duties that normally would be performed by non-medical personnel, (e.g., readiness manager). Bottom line: The primary purpose of AFSOC operational medical personnel is the delivery of world-class healthcare in both the in-garrison and deployed environment. **(T-2)**

4.1.2. AFSOC's operational medical personnel are prepared for operational deployment. Clinical competency and proficiency are the most important and critical qualifications AFSOC operational medics bring to the fight. These skills are extraordinarily perishable. All operational medical personnel, without exception, must meet/exceed all clinical competency and clinical currency requirements. In order to maintain these perishable qualifications, the primary emphasis of in-garrison activities will be directed to this end, i.e., the delivery of healthcare in clinic and hospital settings. In order to meet the standard, AFSOC operational medical personnel must complete the clinical exposure requirements listed in the appropriate table in the Training Tables, as well as AFSC specific requirements. These are minimum requirements to maintain clinical currency; the goal is clinical proficiency.

4.1.2.1. Rules of Engagement while Deployed. AFSOC medical personnel must function within the parameters of the established mission set. No additional engagement activities will be conducted without appropriate approval. The chain of command will decide which requests will be channeled to the embassy and/or Department of State entities in the AOR.

4.1.2.2. When in garrison, AFSOC operational medical personnel should maximize their time in hospital/clinic/ACU settings, performing duties directly related to the hands-on delivery of healthcare services. Hospital and clinic settings include, but are not limited to: Flight Medicine, Family Practice, Emergency Department, Pediatrics, Radiology, and specialty clinics. Duty schedules will be developed and published for operational medical personnel. The schedule should be provided to, and coordinated with, the host SGP at least 30 days prior to clinical duties. Host MTF will ensure patients, examination rooms, surgical slots, etc., are scheduled for operational medical personnel. **(T-2)**

4.1.2.3. Each provider's clinic time will be reported by the OSM Flight Commander or designee to AFSOC/SGP quarterly within one week after the last day of the quarter. Clinic time will be reported as the number of half-days of patient care performed by the provider for that quarter. The number of patients seen by each provider will be included in this report. **(T-2)**

4.1.2.4. Clinic time for ST providers will be reported to the 24 SOW/SG designee, who will then consolidate the information for CONUS ST providers and send to the AFSOC/SGO. For ST providers overseas the information will be reported to the OSM Flight Commander who will forward to the AFSOC/SGO. **(T-2)**

4.1.3. All AFSOC operational medical personnel will comply with USAF, AFMS, Air Force Medical Operations Agency (AFMOA), and host MTF requirements that govern the delivery of healthcare. To remain in good standing with the host MTF, healthcare providers (including those assigned directly to line units), must complete all training and credentialing requirements. Additionally, operational medics who are considered professional staff must attend host MTF professional staff meetings. Unit Commanders will ensure assigned operational medical personnel meet clinical exposure requirements. AFSOC medical personnel who fail to meet clinical competency and currency requirements may be subject to medical privilege abeyance and/or credentials action IAW AFI 44-119, *Medical Quality Operations*. **(T-2)**

4.1.4. All AFSOC medical personnel will comply with AFI 44-102, *Medical Care Management*, when seeking or engaging in off-duty employment. Patients seen in off-duty employment settings will not be counted toward clinical currency requirements. Privileged AFSOC medics must obtain written permission from the credentialing/privileging MTF before any off-base employment. **(T-2)**

4.1.4.1. For line assigned medics on AFSOC bases, this section fulfills the requirement for a written agreement between the MTF/CC and the line commander as noted in AFI44-102 2.27.2.1.

4.1.4.2. In addition to obtaining permission for off-duty employment from the MTF/CC all line assigned healthcare personnel must first obtain the written permission of the line squadron or group CC. This written permission must include information required in AFI44-102.

4.1.4.3. AFSOC medics on non-AFSOC bases must establish a written agreement between the line unit and the MTF which will describe the process for completing the requirements for off-duty employment.

4.1.4.4. For line-assigned medics, the MTF/CC or the line CC may rescind permission for off-duty employment at any time.

4.1.5. IDMTs will provide paraprofessional support in the aerospace medicine clinic setting as outlined in the 4N0X1 Career Field Education and Training Plan (CFETP). Flight Surgeons and IDMTs will also perform aerospace medicine administrative functions (aeromedical waivers, shop visits, safety reviews, etc.) while in-garrison. **(T-2)**

4.1.6. AFSOC operational medical logistics personnel and Medical Service Corps (MSC) officers will ensure medical equipment and supplies are ready for immediate deployment.

Additionally, the medical logistics Point of Contact (POC) for each operational medical element will coordinate with the host MTF medical logistics section to ensure proper calibration, maintenance, and repair of medical equipment. **(T-2)**

4.1.7. AFSOC MSCs assigned or attached to operational medical elements will directly participate in mission planning as the primary medical planner. Operational medical personnel will participate in mission train-up and mission rehearsal as required. **(T-2)**

4.1.8. Operational medical personnel will assist the host MTF regarding pre-deployment preparation and readiness of AFSOC personnel. IAW USAF policies/instructions/directives the host MTF retains primary responsibility for medical readiness for all assigned personnel; however, AFSOC operational medical personnel will assist.

4.1.9. Operational medical personnel not assigned to a SOW or an installation with an AFSOC MTF will review, track, and maintain Preventive Health Assessments and Aerospace Information Management System (ASIMS) mobility requirements, assist in pre-/post-deployment medical screening/interviews, and coordinate with host MTF force health management regarding assigned AFSOC members. In these instances, AFSOC operational medical personnel will report Preventive Health Assessment and Individual Medical Readiness (IMR) data to the appropriate AFSOC unit commander(s). **(T-2)**

4.1.10. After completing the immunization backup technical course operational medical personnel will assist host MTF with the administration of immunizations to deploying AFSOC forces. They will take the lead to provide immunizations for their assigned/attached units. **(T-2)**

4.1.11. Flight surgeons attached to a flying squadron or special tactics unit will develop an ongoing relationship similar to Squadron Medical Element (SME) flight surgeons directly assigned to an operational squadron.

4.2. Operations Support Medical (OSM/OSZ) Flights. OSM medics are the primary providers of medical support of deployments for their units. OSM flights focus on operational support medicine: deployed medical support, trauma care, and CASEVAC; home-station flight medicine for the flying community and their dependents; and the operational planning processes. OSM flight personnel are UTC-specific, trained and equipped to support both the AFSOC flying mission as well as the medical support needs of deployed SOF units. OSMs also work closely with their local base medical group to support Preventive Health Assessment (PHA), Deployment Resiliency Assessments (DRA), aviation psychology, immunizations, deployment surveillance, and health promotion/prevention programs. **Note:** "OSZ" is the UDM code for OSMs. For the sake of brevity, "OSM" includes "OSZ," and will be used throughout this publication.

4.2.1. OSM flights have a combination of flight surgeons, physician assistants, IDMTs, AOPTs, public health and bioenvironmental engineering technicians, plans and operations officers, and medical logistics support. OSM flights vary depending on location, but may have several complimentary medical components. OSMs may also be augmented by the local medical group for any personnel or capability shortfalls.

4.2.2. The OSM flights establish a comprehensive deployment medicine program to support routine care and provide a trauma response capability for deployed forces. OSM flights centrally manage the medical assets assigned to their respective groups. They provide

oversight of personnel management, training requirements, WRM assets, Status of Resources and Training System (SORTS), Medical Readiness Decision Support System (MRDSS), Air Expeditionary Force (AEF) Reporting Tool (ART), Defense Readiness Reporting System (DRRS), and other reporting requirements. **(T-2)**

4.3. Special Operations Force Medical Element (SOFME). Special Operations Force Medical Elements (SOFMEs) are the deployable units within the OSM. They provide initial combat trauma stabilization, Advanced Trauma Life Support (ATLS), Advanced Cardiac Life Support (ACLS), and SOF CASEVAC for injured/ill, joint/coalition, and SOF/conventional forces as mission circumstances and requirements dictate at austere forward locations.

4.3.1. SOFME personnel are first and foremost members of the aeromedical community and will provide full-spectrum aerospace medicine support to AFSOC aircrew members, special duty personnel, and their families. SOFME flight surgeons will have a flying squadron of attachment (to include Remotely Piloted Aircraft squadrons). This should be the unit where the bulk of line support (in the form of mission essential tasks) is accomplished, such as attendance at flight safety meetings, waiver support, medical consultation, human factors and human systems integration consultation, etc. Each flying unit should be well aware of whom their medical consultant is within the OSM structure—the on-call clinic flight surgeon should not be the default response.

4.3.2. SOFME personnel perform the following functions as part of deployed operations, conducting:

4.3.2.1. Baseline occupational and environmental health site assessments.

4.3.2.2. Baseline/ongoing assessments and mitigation of potential environmental and occupational health hazards and water vulnerability assessments. SOFME personnel will document environmental and occupational health exposures, known or potential exposure to chemical, biological, radiological nuclear and explosives (CBRNE) agents, or other health risk exposures, IAW DOD and USAF directives, and file in the DD Form 2766 if required. Use of pyridostigmine tablets, CBRNE defensive auto-injectors, or other similar agents that may be dispensed to SOF personnel will also be appropriately documented.

4.4. Line Embedded Medical Care Units. This applies to AFSOC's Ambulatory Care Units (ACU) and Medical Aid Stations (MAS)**.** Primary guidance is found in AFI 48-149. ACUs/MASs provide office-based medical and limited-scope mental health care, as well as spiritual and mental health resiliency support within designated squadrons, groups, and wings. The intent of the ACU is to provide medical and mental healthcare to SOF where the SOF operators are located. The advantages of this care model include improved access to care, enhanced understanding by the providers of the unique nature of the SOF mission and operations tempo, and an improved patient-provider therapeutic relationship resulting in enhanced trust. ACUs/MASs are medically staffed areas in line units where care is provided, treating active duty personnel only. ACUs/MASs, although not a component of an MTF, will rely on support from the local MTF.

4.4.1. A Defense Medical Information System (DMIS) has been created for each base on which an ACU is located. This single DMIS will be used for all ACUs on a given base.

4.4.1.1. Pope - DMIS ID 0355

4.4.1.2. McChord - DMIS ID 0395

4.4.1.3. AFSOAWC - DMIS ID 5592

4.4.1.4. 724th STG - DMIS ID 5594

4.4.1.5. 1st SOW - DMIS ID 5595

4.4.1.6. 353rd SOG - DMIS ID 5596

4.4.1.7. 352nd SOG - DMIS ID 5597

4.4.1.8. 27th SOW - DMIS ID 5598

4.4.1.9. 22nd STS - DMIS ID 5599

4.5. Medication Dispensing Devices (MDDs). MDDs will not be used for storage or dispensing of controlled substances. **(T-2)**

4.6. Ancillary services. All lab and radiology services needed as a result of care provided in the ACUs will be provided at the local MTF.

4.7. Relative Value Units (RVUs). Although providers in the ACUs will be providing care and will be generating production measured in RVUs, there are no RVU goals for care provided in the ACUs.

4.8. Non-privileged ACU assets. ACU assets discussed in this document refer only to the privileged providers. The work provided by the nonmedical assets is overseen by the line squadron chain of command.

4.9. Self-Inspections. Self-inspection will be completed in Management Internal Control Toolset (MICT)following AF, AFMOA, and AF Inspection Agency (AFIA) guidance. ACUs will undertake self-inspections at the frequency and in a manner as directed by AFIA guidance and instructions. At a minimum, two self-inspections are required annually. Line medical leaders will perform a self-inspection within 60 days of assuming the leadership role. This self-inspection will consist of all applicable MICT elements and other self-inspection items as appropriate. The self-inspection in MICT is one part of the Quality Program but does not cover all guidance applicable to the provision of medical care. All guidance applicable to the provision of medical care by Air Force providers applies to the care provided by embedded medical assets.

4.10. Funding for Supplies. Funding as needed for medical supplies for the ACU may be provided using Defense Health Program (DHP) funds as permitted by Air Force policy or through line funding. ACU medical supplies are ordered through the MTF supply chain. The MTF will assist with ordering and procuring medical equipment/supplies as needed. The expectation is that non-disposable ACU medical supplies and equipment are funded using Line sources, and day-to-day disposable medical supplies are funded through DHP sources. WRM funding is for deployed medical care. WRM supplies will be used in compliance with all guidance for WRM supplies and will not be used for ACU patients for in-garrison care (expendable stock, such as medications, may be rotated out of WRM and used before its expiration date). Regarding use of funds, ensure compliance with Air Force guidance or other appropriate directives.

4.11. Special Operations Surgical Team (SOST). SOST personnel provide surgical support, post-surgical critical care management, and critical care transport at austere forward locations.

The SOST includes a General Surgeon (45S3), Nurse Anesthetist (46M3), Critical Care Nurse (46N3), Emergency Physician (44E3A), Surgical Technician (4N1), and Cardiopulmonary technician (4H0). Suitable substitutions are Anesthesiologist (45A3) for Nurse Anesthetist (46M3) or Emergency Physician (44E3A) and Emergency Room Nurse (46N3J) for Critical Care Nurse (46N3E).

4.11.1. Deployment. SOSTs are not configured to support enduring missions, and downrange surgical procedures are fortunately not common. SOSTs should only be deployed in 90-day increments. IMAs will deploy for 30-45 days IAW AFRC directives. Waivers for longer deployments must be approved by AFSOC/SG. **(T-2)**

4.12. Air Force Special Operations Air Warfare Center (AFSOAWC) . Medical personnel assigned to AFSOAWC plan and execute Irregular Warfare and Medical Stability Operations (IW/MSO) missions, which assess, train, advise, and assist foreign military personnel. These missions include typical AFSOAWC missions as the medical member of an Operational Aviation Detachment (OAD) and Global Health Engagements (GHE). Medical providers are required to achieve qualification as a Combat Aviation Advisor (CAA) and be proficient in a foreign language. Previous experience as a SOF or combat search and rescue medic is highly desirable due to the extensive CAA training pipeline in addition to the AFSOC Medical pipeline, and the requirement to serve as a subject matter expert while working with Partner Nation (PN) SOF personnel. AFSOAWC medics are often the sole medical provider to their OAD and other SOF personnel in austere locations and must be proficient at both combat casualty care and full spectrum aerospace medical care. Other personnel assigned or augmenting this unit will receive training as outlined in this instruction (FFQE2 and FFQET) which will allow them to support AFSOAWC Medical Operations missions.

4.13. Special Operations Forces Psychologist (SOFPSY). The primary responsibility of SOFPSY is to provide operational support to SOF missions and personnel. SOFPSY have specialized training in the areas of human performance, personnel selection, survival and captivity, influence and strategic communication, and human intelligence. SOFPSY apply behavioral science principles to enable key decision makers to more effectively understand, develop, target, and/or influence an individual, group or organization to accomplish tactical, operational, or strategic objectives. Although the provision of healthcare is not the primary support mission of SOFPSY, there may be instances when it is appropriate for SOFPSY to provide clinical support or triage in order to secure definitive care for a service member.

4.13.1. SOFPSY provide, consult, and advise commanders and SOF personnel on conventional and unconventional behavioral science principles affecting a variety of in-garrison and operational activities. These activities include, but are not limited to: assessment and selection of personnel, unit and individual performance optimization, stress inoculation, leadership coaching, oversight for Survival, Evasion, Resistance, and Escape (SERE) training and exercises, post-mishap consultation, combat stress control measures and return-to-duty support, reintegration of recovered personnel after isolation or capture, human factors consultation to aircraft and incident mishap investigations, consultation to interrogation and detention operations, support for Influence operations and strategic communication, adversary profiling, and support to HUMINT collection activities.

4.13.2. All SOFPSY must maintain active credentials at a DOD-approved MTF and should sustain an appropriate level of operational and clinical currency to support their credentials as

well as their primary duties and responsibilities as outlined above. When providing healthcare support within the MTF, the SOFPSY will adhere to the requirements of the base MTF. (**T-2**)

4.14. Special Operations Physician Assistants (PA).

4.14.1. PA Employment and Utilization.

4.14.1.1. All AFSOC PA positions must be filled by PAs with no less than three years of clinical PA experience and must have attained and maintained appropriate credentials on their privilege list. AFSOC PAs assigned to ACUs may support deployment missions and operations, although their main role is to provide primary care services and support, preventive healthcare services, and healthcare continuity for in-garrison AFSOC aircrews, special duty personnel, and their families. PAs assigned to an OSM flight, especially those on FFQEK and FFQE8 UTCs, will support deployment missions and operations. **(T-2)**

4.14.1.2. When PAs deploy, they function under MTF privileges and through physician consultation at all times either in person, by phone, or electronic means.

4.14.1.3. A physician preceptor must be identified, in writing, for each PA. This information will be placed in Section 1 of each PA's credential file.

4.14.1.4. PAs will not deploy to an area likely to require skills outside of credentialed scope of PA medical practice.

4.14.1.5. IAW USAF policy, PAs may not precept IDMTs.

4.15. Special Operations Independent Duty Medical Technicians (IDMT).

4.15.1. All IDMT/ EMT Paramedics (NRPs) assigned to AFSOC will comply with AFI 44-103, and AFMAN 44-158, *The Air Force Independent Duty Medical Technician Medical and Dental Treatment Protocols*.

4.15.2. All AFSOC IDMTs will maintain NRP.

4.16. AFSOC IDMTs Without a Co-located AF Military Treatment Facility (MTF).

4.16.1. There are a number of AF IDMTs located on facilities without an AF MTF. This has resulted in challenges with oversight of the IDMT program at these locations, and a myriad of difficulties for the IDMTs to complete and document training and ensure trained preceptors are available. AFSOC/SG provides oversight for the IDMT program at locations where there is no co-located AF MTF. A member of the AFSOC/SG staff is appointed to function as the SGH for AFSOC IDMTs located on facilities without an Air Force MTF. **(T-2)**

4.16.2. The following guidance applies to AFSOC IDMTs on facilities without an AF MTF and fulfills the requirement, per AFI 44-103 for the MTF Operating Instructions for these IDMTs:

4.16.2.1. Preceptors and functional area representatives approved for IDMT training will be appointed by the AFSOC IDMT Certification Authority or as appointed by the AFSOC/SG. **(T-2)**

4.16.2.2. The AFSOC/SG 4N Functional Manager will act as the IDMT Coordinator and may delegate certain functions of the IDMT Coordinator to other AFSOC/SG staff or to IDMTs at the IDMTs' location. Any delegation of IDMT Coordinator functions from the AFSOC/4N Functional to an IDMT at the distant site will require a letter so appointing the local IDMT and defining the tasks required. **(T-2)**

4.16.2.3. AFSOC IDMTs without an MTF may see patients independently in-garrison in local clinic settings to include ACUs with the following restrictions:

4.16.2.3.1. All care provided in-garrison by IDMTs will be reviewed, and this review documented in the IDMTs training records and the medical record within 24 hours. The physician review will include written comments on the care provided **(T-2)**. These comments will be on the form approved and provided by AFSOC Command 4N Functional Manager. **(T-2)**

4.16.2.3.2. If the IDMT provides care for any DD Form 2992 holder, aeromedical disposition by a flight surgeon will occur before the patient departs from the care encounter. **(T-2)**

4.16.2.3.3. All care by the IDMTs will be in accordance with IDMT protocols with deviations requiring advanced approval by an approved preceptor prior to deviation from protocol.

4.16.2.4. IDMTs and unit leadership should expect decertification for IDMTs who do not maintain training currency.

4.16.2.5. Documentation of IDMT training, for IDMTs at locations without an AF MTF and certified by AFSOC will be forwarded to the AFSOC SG IDMT Coordinator and to AFSOC SGP. **(T-2)**

4.16.2.6. All IDMT training will be documented in AFTR and in the IDMT's hardcopy training record until such time as AFTR eliminates the need for duplicate documentation in the training folder.

4.16.2.7. Any patient care or training events occurring in the deployed setting will be documented, reviewed by an in-theater IDMT Preceptor (preferably an AFSOC physician) as available or upon return, and documented in the IDMT's training records. If a physician (non-IDMT Preceptor) is available in the deployed location, the TSOC/SG will attempt to provide IDMT Preceptor training to the physician.

4.16.2.8. IDMT availability for in-garrison and deployed care will be coordinated locally by the senior IDMT in each unit with oversight by the senior flight surgeon.

4.16.2.9. All IDMTs newly assigned to units covered by this instruction will undergo initial certification per AFI 44-103. On a case-by-case basis, IDMTs transitioning to units covered by this policy may be certified by the AFSOC/SGO based upon experience at another AFSOC unit. Request for this certification should be made by the senior IDMT at the unit of assignment to AFSOC/SGO.

4.16.2.10. Training requirements for IDMTs will be completed locally to the maximum extent practical. If training cannot reasonably be completed locally, coordinate with the AFSOC IDMT Coordinator to arrange for training options.

4.16.2.11. IDMTs covered in this policy will use the host MTF or 1 SOMDG Pharmacy and Therapeutics Committee approved IDMT Authorized Drug List. Any changes or additions to this list will be approved by the AFSOC SGO.

4.16.2.12. Medical in-processing for new IDMTs will be in accordance with current unit policy for in-processing new medics.

4.16.2.13. IDMTs will report all bloodborne pathogen (BBP) exposures IAW local infection control and BBP guidance.

4.16.2.14. For any concerns not specifically addressed in this document, not addressed in local operating instructions, not addressed in AFIs, or the inability to comply with AFIs due to the nature of the host-tenant relationship, IDMTs covered by this policy will seek guidance from unit flight surgeons, AFSOC IDMT Coordinator, or AFSOC/SG SGO.

4.17. AFSOC PJ Medical Program.

4.17.1. PJs are combatants, and thus are not protected as medical personnel by the Geneva Conventions or International Law.

4.17.1.1. PJs are rescue specialists with NRP training/certification. AFSOC PJs are trained and tasked to provide emergency medical care at the paramedic level. NRP currency is required for service in the PJ 1T2X1 AFSC.

4.17.2. PJs are not authorized to provide sick call medical care in garrison or while deployed. PJs are not permitted to diagnose illnesses/injuries or to dispense medications in these circumstances. PJs will defer requests for medical care to the appropriate local medical treatment system.

4.17.3. PJ Medical Program Management. Overarching USAF PJ medical program management is contained in AFI 10-3502, Volume 1, *Pararescue and Combat Rescue Officer Training*. PJ medical training and qualification will be extensively documented and maintained in the member's AF Form 623, *Individual Training Record Folder*. For convenience, medical training records may be maintained geographically separated from the AF Form 623 record; refer to AFI 10-3502V1 for guidance.

4.17.4. Air Combat Command (ACC) is the lead MAJCOM for PJ medical scope of practice. ACC/SGP addresses medical qualifications, requirements, and PJ medication and procedures handbook issues. Changes to training, protocols, medications, and equipment are coordinated through the ACC PJ Medical Operations Advisory Board (MOAB). PJ MOAB conferences are conducted twice yearly. AFSOC/SGP, STG/SG and PJ representatives will attend MOABs.

4.17.5. Medical Director and Medical Control. The ST medical director is responsible for medical oversight of assigned AFSOC PJs. The medical director will be a credentialed physician appointed in writing by the ST unit commander. A copy of the appointment letter will be forwarded to host base MTF SGH and to AFSOC/SGP. Additionally, a copy will be filed in each PJ's medical training record. If the ST medical director is not present during deployed operations, the senior AFSOC flight surgeon is responsible for AFSOC PJ medical oversight.

4.17.5.1. USAF, DOD, and Department of Transportation (DOT) directives mandate appointment of a physician medical director to oversee the medical training,

qualification, and practice of NRPs to include PJs. The PJ medical director must have expertise in operational medicine, trauma medicine, delivery of medical care in field environments and wilderness medicine, pre-hospital medical care, and medical transport/evacuation systems and equipment.

4.17.5.2. The medical director will provide clinical supervision, oversight, and guidance to the ST unit Non-Commissioned Officer of medical training (NCOMT).

4.17.5.2.1. The medical director will review/audit PJ medical training status to ensure PJs remain fully current. Additionally, the medical director will conduct unannounced medical proficiency exercises and evaluations to ensure PJs and other appropriate ST personnel meet medical and Tactical Combat Casualty Care (TCCC) proficiency standards. The medical director will assist in planning and conducting PJ Medical Situation Exercises (MEDEX) and Medical Evaluations (MEDEVAL).

4.17.6. PJs assigned above squadron level (e.g., Group or Higher Headquarters) will fall under the medical direction of the local ST squadron medical director.

4.17.7. NCO of Medical Training (NCOMT). The NCOMT will be designated by the unit commander in writing and will manage the PJ medical program. The NCOMT will use AFI 10-3502V1 series as medical program guidance. The NCOMT must work closely with the medical director and senior team PJ to produce a robust PJ medical program.

4.17.7.1. The NCOMT will be a fully-qualified IDMT, preferably with an operational background. The NCOMT should have at least two years' experience as an IDMT and should be an experienced Basic Life Support (BLS), Self-Aid and Buddy Care (SABC), and TCCC instructor.

4.17.7.2. The NCOMT's secondary duties will include conducting required medical classes and training for unit operators and personnel. Additionally the medical director and NCOMT will provide emergency medical coverage for unit training.

4.17.8. Operational Medical Guidance. AFSOC PJs will follow approved published guidance for medical treatment protocols to include AFSOC Handbook 48-1, USSOCOM Tactical Medical Emergency Protocols (TMEPs), and additional appropriate paramedic level pre-hospital continuum of care as defined in current Brady or Mosby paramedic texts.

4.17.9. Operational Medical Reporting. The ST medical director and/or PJs will complete Guardian Angel Consolidated Mission Reports (GA CMRs) for all missions. Medical treatment information will be extracted for submission and legacy database input.

4.17.9.1. The ST medical director or deployed AFSOC flight surgeon will submit the GA CMR to AFSOC/SGP. Ensure submission of the GA CMR to AFSOC/A3J, Command Personnel Recovery PJ Superintendent occurs via appropriate secure communication channels.

4.17.10. PJ Medical Qualification. The following qualifications and certifications are mandatory requirements for tactically operating PJs assigned to AFSOC:

4.17.10.1. Current NRP certification and all associated certification requirements, including BLS, Pediatric Advanced Life Support (PALS) and ACLS.

4.17.10.2. AFSOC PJs will be follow SOCOM training requirements as currently specified *USSOCOM Directive 350-29*.

4.17.11. Non-standard medications. Non-standard medications are defined as medications administered by PJs that are not included within the AFSOC Pararescue Medication and Procedure Handbook, the USSOCOM Tactical Medical Emergency Protocols (TMEPs), or AFSOC Handbook 48-1. Any administration of non-standard medications by PJs must be strictly IAW DOD, USAF and USSOCOM policy, and must be unequivocally justified by mission requirements. Additionally, non-standard medication administration must be approved by the PJ's medical director, STG/SG, AFSOC/SGP and AFSOC/SG prior to use. Appropriate training must be completed and documented prior to PJ administration of non-standard medications. If non-standard medication training is completed for PJs while deployed, the training must be thoroughly documented and a copy of the documentation must be forwarded to ACC/SGP and AFSOC/SGP (and AFRC/SGP if applicable), the PJ's home station medical director, and NCOMT for placement in the PJ's medical training record. If non-standard medication use is formally approved, the PJ who administers it will report this (include patient's name, age, medication, dosage and indications) to the supervising/authorizing physician, ST medical director, STG/SG, ACC/SGP, and AFSOC/SGP. **(T-2)**

4.17.12. Experimental medical materials and equipment. Use of experimental medical materials and equipment is not authorized unless formally approved via standard DOD, USSOCOM, USAF, and AFSOC mechanisms. **(T-2)**

4.18. SOF Aerospace and Operational Physiology Team (AOPT). The SOF AOPT enhances human operational performance through analyses of SOF facilities, equipment and operations, provides critical aircrew/operator training, and support mishap prevention and investigation efforts. While the Chief, AFSOC Aerospace and Operational Physiology retains oversight of all functions, Command and Control of these responsibilities are ultimately assigned to different AFSOC Directorates. AFSOC/A3T has oversight of all SOF AOP training programs in accordance with AFI 11-403, *Aerospace Physiological Training Program*, AFSOC/SGP has oversight of the SOF human performance research initiatives,, and AFSOC/SE continues to oversee AOPT-related mishap prevention and investigation efforts in accordance with AFI 91-series instructions.

4.18.1. SOF AOPT's primary mission is to provide training support to all wing, transient, and joint service aircrew/operators as required by AFI 11-403. Examples include Reduced Oxygen Breathing Device (ROBD) hypoxia familiarization training, fatigue countermeasures/sleep hygiene, and Night Vision Goggles (NVG) instruction. (**T-2**)

4.18.2. SOF AOPs integrate into the Special Tactics community by providing AFI 11-409 required in-flight physiological support to aircrews and Special Tactics Personnel performing unpressurized airdrop operations above 20,000 feet mean sea level, or other altitudes by request. These airdrops are not limited to: DOD Special Operations High Altitude Low Opening (HALO)/High Altitude High Opening (HAHO) personnel and equipment drops, Military Information Support Operations (MISO, formally PsyOps), equipment testing and research operations, and humanitarian aid operations. In addition, SOF AOP will provide enhanced human performance support to operations, training, equipment, and guidance.

4.18.3. SOF AOPT will expand its AOPT mission to meet the changing demands of the SOF mission. This includes delivery of pre-flight briefings on the physiological/physical hazards of the mission, pre-breathing procedures, effects of environmental stresses, proper use of in-flight supplemental oxygen equipment, and any other special physiological considerations depending on the mission profile to all aircrew, parachutists, and additional personnel, prior to the mission execution.

4.18.4. SOF AOPT coordinates with unit leadership, and performs human factors analyses of SOF operations, training, and systems to identify capability gaps and potential solutions. Findings should be submitted to the Chief, AFSOC Aerospace & Operational Physiology, for proper dissemination. **(T-2)**

4.18.5. SOF AOPT provides Safety Investigation Board (SIB)/Accident Investigation Board (AIB) support for any AFSOC mishaps.

4.18.6. SOF AOPT fly on all AFSOC aircraft and perform unit shop visits in order to support local flying and ground units. With MAJCOM approval, may perform appropriate High Altitude Airdrop Mission Support (HAAMS) for any AFSOC mishaps. Contact the HAAMS center via email at **19mdg.sgsi@us.af.mil** or via phone at DSN 731-6093 (commercial 501-987-6093) (**T-2**)

4.19. Special Tactics Medical Logistics.

4.19.1. The AFSOC Medical Logistics Technician/4A1XX Functional Manager is responsible for the organization, training, and the coordination of 4A personnel assignments to AFSOC operational units. The 4A1XX functional will ensure compliance with AF and AFSOC instructions/policies. **(T-2)**

4.19.1.1. All Medical Logistics Technician assigned to an STG or OSM will attend 8 hours of documented Readiness Skills Verification Training quarterly. If training cannot be accomplished at the local MTF, in-service training is acceptable with prior approval from the 4A1XX Functional Manager.

4.19.2. AFSOC/SGXL is responsible for Manning and Equipment Force Packaging (MEFPAK) related requirements. Any proposed changes to MEFPAK allowance standards will be routed to AFSOC/SGXL. After validation and approval by AFSOC/SG, AFSOC/SGXL will forward medical allowance standard changes to ACC/SGXM.

4.19.3. Medical Logistic technicians are responsible for ST unit WRM and associated medical logistics functions. Changes to medical logistics related policies/procedures will be coordinated with AFSOC/SGXL and approved by AFSOC/SG. **(T-2)**

4.19.4. STG and OSM logistics may use all WRM assets for JCET/JCS training missions, Humanitarian Assistance/Disaster Relief (HA/DR) missions, and local sustainment training for Deployed Aircraft Ground Response Element (DAGRE), SERE, and IDMTs. The appropriate line of accounting must be established in order to perform non-routine issues.

4.19.5. The AFSOC Medical Logistics Technician or in-garrison CACI contractors are responsible for inventorying WRM no less than 24 months from the previous inventory (the actual due date for inventory completion is the final calendar day of the anniversary month). IAW AFI 41-209.

4.19.5.1. An inventory is not considered closed until all actions outlined in AFI 41-209 paragraph 8.16.4.5. are complete and documented.

4.19.5.2. A signed copy of the Inventory Summary Report will be forwarded to the 4A1XX Functional Manager.

4.20. Bioenvironmental (BE) personnel Roles and Responsibilities.

4.20.1. Shall train OSM personnel on Bioenvironmental Engineering (BEE) tactics, techniques and procedures. Training will include familiarity with the Water Protection and Industrial Hygiene Programs. BE personnel will also serve as reach-back support for deployed OSM members.

4.20.2. Will maintain their skills and proficiency by coordinating tasks listed below with the host Medical Group. Tasks/surveys that must be completed at an operational squadron should be completed at the member's unit.

4.20.2.1. Two routine industrial hygiene surveys including Defense Occupational and Environmental Health Readiness System (DOEHRS)entry. **(T-2)**

4.20.2.2. Water Sampling. **(T-2)**

4.20.2.3. Three special surveys. **(T-2)**

4.20.2.4. Participate in an emergency management exercise.

4.20.2.5. Maintain 100% currency on RSV program. **(T-2)**

4.20.2.6. Participate in the equipment proficiency analytical testing program. **(T-2)**

4.20.2.7. Attend host MTF's Occupational and Environmental Health Working Group meeting when AFSOC specific shops or issues are discussed.

4.20.3. Will have documentation the completion of paragraph 4.22.2. tasks annotated in their individual AF IMT 1098 *Special Task Certification and Recurring Training* within the AFTR database. Quarterly training summary shall be emailed to AFSOC/SGPB no later than 15 days after the end of each quarter. **(T-2)**

4.20.4. Shall be the OPR for performing BEE support to the OSM for all elements relating to the Industrial Hygiene Program. Responsibilities and tasks will be transferred to the host Medical Group when there is a conflict with ASFOC mission operations. **(T-2)**

4.21. Public Health Personnel Roles and Responsibilities.

4.21.1. Act as primary Public Health trainer for OSM personnel.

4.21.2. Maintain current health threat briefs for the OSM's mission IAW DOD Instruction 6490.03 *Deployment Health* p E2.14.

4.21.3. Act as primary liaison for unit members for the following host MTF programs: Medical Employee Health Program, BBP, and Communicable Disease (sexually transmitted diseases, rabies, tuberculosis, etc). Act as supporting liaison with the unit's DRHA program. Unit is defined as: 352 SOW in USAFE and SOG in CONUS and PACAF locations.

4.21.4. Conduct the unit's pre/post-deployment processes IAW host MTF deployment guidance.

4.21.5. Monitor the unit's Individual Medical Readiness and ensure unit leadership is briefed a minimal of a monthly basis. OSM Public Health will assist the host MTF with the training the unit's Unit Health Monitors and Unit Deployment Managers.

4.21.6. Request host MTF 4E Functional review of their AFTR on a quarterly basis. If the local 4E Functional is not available, OSM Public Health personnel will send the request to AFSOC SGPM.

4.21.7. Submit a quarterly training status report on to AFSOC SGPM regarding the following information. The template will be provided by AFSOC SGPM.

4.21.7.1. Maintain currency with RSV training conducted at the host MTF. Attend training events while in garrison.

4.21.7.2. Maintain HIPAA training currency IAW host MTF policy

4.21.7.3. While in garrison, the following tasks are the expected minimum in order to maintain the skill level currency:

4.21.7.3.1. Attend host MTF's OEHWG and AMC

4.21.7.3.2. Complete one food facility inspection each month

4.21.7.3.3. Complete one public facility inspection each quarter

4.21.7.3.4. Complete one childcare facility inspection each quarter

4.21.7.3.5. Complete one swimming pool, sauna, or hot tub inspection each year

4.21.7.3.6. Complete one receipt inspection each year

4.21.7.3.7. Complete one entomology surveillance each year

4.21.7.3.8. Complete one ration inspection every 24 months; may be done while deployed or attending exercises

4.21.7.3.9. Complete one Category 1 or Category 2 shop inspection each quarter

4.21.7.3.10. Participate in the annual Food Vulnerability Assessment

4.21.7.3.11. Participate in exercises with biological scenarios **(T-2)**

Chapter 5

TRAINING

5.1. Training Requirements. In order to provide the very best medical and preventive health care, AFSOC Operational Medical Personnel are trained to a level far exceeding their non-SOF colleagues. AFSOC Medical UTC Training and Currency Requirements (which will be referred to as the Training Table throughout this instruction). This table includes AFSC specific requirements as well.

5.1.1. The Training Table is located at: **https://kx2.afms.mil/kj/kx5/AFSOCCommandSurgeon/Documents/Forms/ShowFolders.aspx**

5.1.2. The Training Table will be used IAW AFSOCI 48-1010.

5.1.2.1. The AFSOC Chief of Aerospace Medicine (SGP) is the OPR for any changes and can be contacted for any recommendations. **(T-2)**

5.2. Administration of Medical Training (MTM). AFSOC/SG is responsible for validating medical training requirements and clinical currency requirements. Unit commanders will ensure assigned operational medical personnel meet training requirements.

5.2.1. Medical Training Manager. All commanders of AFSOC units with medical personnel assigned will appoint a primary and alternate MTM. The MTM will serve as unit POC for medical training.

5.3. Formal Training. AFSOC/SGXT manages the medical pipeline training slots and coordinates with unit commanders and/or their MTMs in order to fill training slots with operational medical personnel (to include AFSOC ANG/AFRC medical personnel who fill AFSOC UTCs) who require this UTC/AFSC specific training. AFSOC/SGXT will monitor MRDSS on a weekly basis.

5.3.1. AFSOC/SGXT will maintain a current training database that includes the status of all AFSOC operational medical personnel and will report, in writing, any discrepancies or noncompliance to AFSOC/SG and the appropriate unit commander.

5.3.2. The unit MTM will submit to AFSOC/SGXT the full name, grade, SSN, and RNLTD of individuals selected for assignment to operational medical units in order to permit scheduling of required training. Whenever possible, required training should be accomplished en route to unit of assignment.

5.4. Formal Training Waivers. Requirements apply to all AFSOC operational medical personnel. However, if newly assigned personnel have previously served in a similar position in an AFSOC unit, portions of stated mission qualification requirements may be waived by AFSOC/SG on an individual basis. Waiver requests will contain the following: member's name, rank, position, unit, reason member already meets requirement(s), justification for waiver, and impact if waiver disapproved, (see Attachment 5 for format). Waiver requests must be endorsed by member's squadron and group commander.

5.5. AFSOC Medical Training Pipeline. All newly assigned AFSOC operational medical personnel are required to successfully complete AFSOC's medical training pipeline. The

AFSOC Medical Training Pipeline is specific to each AFSC in a designated AFSOC UTC. Each training requirement has been placed into a phase of instruction to better identify sequential courses for unit MTMs as they prioritize training requirements. While it is preferred individuals follow the required phase of instruction order, it is not mandatory.

5.5.1. Phase I. Courses related to the Introduction to Special Operations and Special Operations Medicine;

5.5.2. Phase II. Courses primarily combat/field skills related;

5.5.3. Phase III. Courses which provide advanced AFSC or UTC training.

5.5.4. Special Operations Command Medical Officer Special Experience Identifier (SEI). While not mandatory, all AFSOC Medical Officers are encouraged to pursue the SEI for their career field. See the Training Table and the Air Force Officer Classification Directory (AFOCD) for the requirements.

5.5.5. AFSOC/SGXT will manage/administer sections of all three phases of instruction. For courses administered by USAF Special Operations School (USAFSOS), unit MTMs may coordinate directly with them. Medical Readiness Decision Support System (MRDSS) Ultra is the tracking database for all medical readiness training completion. Unit commanders will ensure operational medical personnel meet all training requirements. Full mission qualification status will be granted (at unit level) when personnel are clinically current and have completed all required training in the AFSOC medical training pipeline.

5.5.6. UTC Specific Training Tables. Refer to the appropriate table to find required training for personnel assigned to specific AFSOC medical UTCs.

5.5.7. Cancellation policy for required courses. A required training pipeline course must be cancelled as follows:

5.5.7.1. 1st cancellation—Flight Commander will submit request for cancellation to AFSOC/SGXT with justification.

5.5.7.2. 2nd cancellation for same member/same course—SQ/CC will submit request for cancellation to AFSOC/SGP and/or AFSOC/SGX with justification.

5.5.7.3. 3rd cancellation for same member/same course—Group CC will submit request for cancellation to AFSOC/SG with justification.

5.6. Approved Training Platforms.

5.6.1. NRP. The initial and refresher (every two years) NRP training for 4N0X1Cs are accomplished only by training platforms approved by AFSOC/SG.

5.6.2. Trauma Training. FFQEK, FFQE3 and FFQE4 UTC personnel will complete/maintain Trauma Skills Sustainment and trauma related Continuing Medical Education (CME).

5.6.3. Trauma Skills Sustainment. In addition to aforementioned clinical competency and clinical currency requirements, FFQEK, FFQE3 and FFQE4 UTC personnel require periodic exposure to hands-on human trauma patient management in a controlled environment where current best practices in trauma care can be refreshed. AFSOC personnel who are unable to meet the American College of Surgeons' recommendation to operate and manage 35 multi-

trauma patients per year must attend Center for Sustainment of Trauma and Readiness Skills (C-STARS) or other approved Trauma Sustainment Program every 24 months. AFSOC personnel who meet the 35 multi-traumas a year, in addition to further requirements for certain AFSCs, will follow the 24 month C-STARS exemption process as outlined in AFI 41-106, *Medical Readiness Program Management*. Approved methods for acquiring additional trauma patient experience are:

5.6.3.1. A training program similar to C-STARS. Alternate programs will require formal approval by AFSOC/SG and must provide significant exposure to human trauma patients.

5.6.3.2. While deployed appropriately documented trauma patient management may be counted for up to 50% of this trauma skills sustainment requirement. The documented trauma patient care must be subject to, and available for, the formal peer-review process and be approved by AFSOC/SGO, then filed in the individual's training folder.

5.6.3.3. Graduate Medical Education (GME). Members reporting to AFSOC directly from residency training programs meet this trauma skills sustainment requirement if member successfully completed the program and if member reports to AFSOC within two years from the last routine exposure to significant numbers of trauma patients (trauma surgery, emergency department at a trauma center, anesthesia at a trauma center, etc.). Members reporting to AFSOC directly from an intern-only training program must be evaluated by the OSM Flight Commander and be approved by AFSOC/SGO, to determine if they will need immediate trauma skills sustainment training at C-STARS.

5.6.3.4. See Training Table for all required Trauma Related CME training. Other CME trauma courses may be substituted, but must be approved in writing by AFSOC/SGO.

5.7. Flying Training Requirements. All personnel required to perform flying duty on a frequent or recurring basis must ensure all flying training requirements are accomplished and sustained (e.g. egress, survival, crew resource management, altitude chamber, ROBD, helicopter/CV-22 underwater egress, etc.). Training will be documented and maintained per local policies, and will be monitored by the unit training manager.

5.7.1. All SOFME, SOST, and AOPT personnel must complete aircrew block training requirements as determined by base of assignment per local Operations Group policies.

5.7.2. AFSOC operational medical personnel must meet at a minimum medical standards for operational support duties in Aviation Service Code (ASC) 9C prior to assignment.

5.8. Additional Training Requirements. AFSOC operational medical personnel will meet additional training requirements associated with mobility and the core training requirements indicated in AFI 41-106.

5.9. Other Training . SOW/ CCs, SOG/CCs, STG/CCs, and SOMDG/CCs may add additional training events based upon mission requirements; however, requirements contained herein may not be modified or deleted without AFSOC/SG written concurrence via waiver letter.

5.9.1. USAF Readiness Skills Verification Program (RSVP) Currency/Proficiency. All AFSOC operational medical personnel must complete all required AFSC RSVP training.

5.10. Mission Qualification Training. This section establishes the minimum medical training requirements to attain initial mission qualified status.

5.10.1. Special Operations Force Medical Element (SOFME) personnel are mission qualified after completing formal AFSC awarding courses/programs, RSVP training and the AFSOC medical training pipeline. SOFME personnel also must complete the mission-ready clinical currency requirements as shown in the Training Table before their deployment.

5.10.2. AFSOAWC Medical Operations providers are mission qualified after completing formal AFSC awarding courses/programs, RSVP training, AFSOC medical training pipeline, and the and the CAA pipeline. Personnel also must complete the mission ready clinical currency requirements as shown in the Training Table before their deployment. **(T-2)**

5.10.3. Special Operations Surgical Team (SOST) personnel are mission qualified after completing formal AFSC medical/surgical training programs/courses, RSVP training, and AFSOC medical training pipeline. SOST personnel must be in good standing with host MTF and must be clinically competent and current in order to retain mission qualification.

5.10.3.1. SOST personnel will maintain clinical competency and clinical currency IAW requirements/guidelines set by AFMS, functional area managers, AFMS corps chiefs, AF/SG specialty consultants, applicable professional standards to include licensure, board certification, continuing medical education requirements and those contained herein. Additionally, general/orthopedic surgeons, anesthesiologists, emergency medicine specialists are expected to obtain specialty board certification. Certified registered nurse anesthetists and critical care nurses will maintain all certifications and will maintain a robust clinical schedule. Surgical technicians and respiratory therapy technicians will also maintain all certifications and will maintain a robust clinical schedule. AFSOC physicians are expected to obtain specialty board certification.

5.10.3.2. SOST clinical currency requirements are listed by AFSC in the Training Table. The clinical caseload is the minimum requirement; additional clinical experience is encouraged in order to maintain a high proficiency. Credit for clinical currency caseloads will be pro-rated when a surgeon is deployed to include approved reconstitution time.

5.10.3.3. AFSOC/SG may delegate waiver authority for SOFME mission-ready clinical medical requirements to AFSOC/SGP, and to AFSOC/SGO for SOST mission-ready clinical medical requirements.

5.11. SOST UTC Training.

5.11.1. SOST initial training will be IAW this instruction and applicable Mission Capability (MISCAP).

5.11.2. SOST sustainment and currency will be maintained by completing a minimum of one documented SOST mission or one documented SOST exercise semiannually. Exercises will be conducted in accordance with MISCAPs/TTPs.

5.12. Physician Assistant (PA) Training, 42GX.

5.12.1. AFSOC PAs will comply with training and recertification requirements as defined by AFI 44-102.

5.12.2. AFSOC operationally (OSM/AFSOAWC) assigned PAs assigned to operational medical units must audit the Air Force AMP 101/201 course within the first year assigned to AFSOC. Additionally, AFSOC PAs assigned as operational medical personnel will comply with aforementioned AFSOCI 48-1010 requirements and Training Table requirements. **(T-2)**

5.12.3. AFSOC PAs assigned as operational medical personnel will coordinate with the host MTF SGH to update their PA privilege list to document the appropriate scope of practice IAW AFI 44-119 requirements.

5.13. Special Operations Independent Duty Medical Technicians (IDMT) Training, 4N0X1C.

5.13.1. AFSOC IDMTs will comply with training and recertification requirements as defined by AFI 44-103.

5.13.2. Additionally, AFSOC IDMTs assigned as operational medical personnel must complete training IAW 4N0X1C CFETP SEI 455 (Special Operations Command Medic) and requirements contained herein. **(T-2)**

5.14. Pararescueman (PJ) Medical Training. AFSOC PJs will maintain National Registry EMT Paramedic (NRP) certification and training as directed by SOCOM. PJ continuing medical education is described in AFI 10-3502V1. PJ training status reports will be accomplished quarterly. AFSOC CROs will meet all requirements as outlined by applicable DOD/SOCOM/AF/AFSOC policies, directives and instructions. **(T-2)**

5.14.1. The following certifications, qualifications, evaluations and training are mandatory for AFSOC PJs:

5.14.1.1. NRP certification is required during initial PJ training. This certification is obtained prior to the first phase of the 3-level PJ apprentice course. **(T-2)**

5.14.1.2. NRP core requirement re-certification is required every two years. Completion of the Special Operations Forces Medical Skills Sustainment Course (SOFMSSC) is a mandatory SOCOM requirement for AFSOC PJs. **(T-2)**

5.14.1.3. Patient contact/trauma sustainment is required each two year period. Missions completed in the execution of combat, military, civil, or humanitarian operations may be used for time and contact accumulation. Documented hospital emergency department/trauma department performance may also serve this purpose. The 24 SOW/SG manages the University of Alabama (UAB) hospital and ambulance ride-along program for PJs and IDMT/NRPs. AFSOC/SGXT manages the USAF C-STARS at University of Maryland Shock Trauma, Baltimore. These programs provide PJs with the opportunity to treat patients in field and trauma center settings. When performing biennial patient contact/trauma sustainment rotations, PJs will review and follow all local protocol instructions. PJs will not perform tasks outside their scope of practice.

5.14.1.4. Refer to AFSOCPAM 48-2, *Tactical Combat Casualty Care Training Program* for training frequency. **(T-2)**

5.14.1.5. Medical Situational Exercise (MEDEX) and Evaluation (MEDEVAL) Requirements. IAW AFI 10-3502V2, *Pararescue and Combat Rescue Officer Standardization and Evaluation*, PJs will perform a minimum of one MEDEX every 90 days and one MEDEVAL every 17 months.

5.14.2. Additional and advanced formal medical training and education courses. STG/CCs and special tactics medical directors are highly encouraged to maximize PJ participation in formalized medical training venues to enhance medical capability. A listing of PJ Medical Operations Advisory Board (MOAB) approved Advanced Medical Training and Seminars

are available on the Guardian Angel community of practice web site at **https://afkm.wpafb.af.mil/community/views/home.aspx?Filter**. Recommended courses and seminars include Special Tactical Operations Advanced Life Support (STOALS), and Special Operations Medical Association (SOMA). Courses and seminars approved by AFSOC/SG are also recommended.

5.14.3. Unit lectures and CME. Unit medical directors are encouraged to conduct routine medical classes, lectures, and seminars for unit PJs. Furthermore, unit medical directors will schedule/coordinate PJ medical training by guest physicians and specialists. Unit CME hours will be documented in PJ training records.

5.14.4. Additional medical skills instruction, validation, and continuum of practice certification will be documented and placed in PJ medical training records. This instruction includes topics such as dental skills, blood administration/transfusion, and Packed Red Blood Cells (PRBC) protocols.

5.14.5. Clinic sick call. PJs may NOT provide medical care in out-patient clinic/sick call settings except while in a student capacity under the direct supervision of a physician. STG/SG and unit medical directors will ensure clinic training is documented in PJ medical training records and directly supervised by a physician. Medical skills training documentation must include operating parameters, re-qualification, or currency standards, and a skill practice expiration date.

5.15. Combat Controller and Combat Weatherman Medical Training. Combat Controllers and Combat Weathermen are required to maintain current SOCOM Tactical Combat Casualty Care (TCCC) training status. Additional medical training programs for combat control and combat weather personnel must be approved by STG/SG and AFSOC/SGO. **(T-2)**

5.16. Special Operations Combat Medic Skills Sustainment Course (SOCMSSC).

5.16.1. SOCMSSC satisfies all SOCOM recertification for AFSOC PJs and IDMTs for their NRP.

5.16.2. All AFSOC operational medics and PJs must attend SOCMSSC. USSOCOM Directive 350-29 specifies biennial recertification of these medical requirements through either SOCMSSC or an alternative form of SOCMSSC-level refresher training that must be approved by the USSOCOM Command Surgeon only on a case-by-case basis, with no blanket approval authorizations. **(T-2)**.

5.16.3. Requests to attend SOCMSSC should be submitted by unit MTMs to AFSOC/SGXT as early as possible (requests may be submitted up to one year before course start date, but must be submitted by unit MTMs no later than 45 days before course start date). AFSOC/SGXT will schedule operational medical personnel and PJs via the US Army Training Requirements and Resources System (ATRRS). **(T-2)**

5.16.4. Additions or deletions to the projected SOCMSSC schedule must be coordinated through AFSOC/SGXT. MTMs, operational medics and PJs are not authorized to coordinate additions, deletions, or name changes directly with SOCMSSC cadre. **(T-2)**

5.16.5. Required medical training for operational medics (excluding PJs) will be certified and reported via MRDSS.

5.17. AFSOC Casualty Evacuation (CASEVAC) Training.

5.17.1. Refer to the Training Table for FFQEK, FFQE3, FFQE4 and FFQE6 training requirements. **(T-2)**

5.17.2. SOFME CASEVAC sustainment and currency will be maintained by completing one in-flight CASEVAC mission (real world or training) with an evaluation, every six months; more frequent hands-on, scenario-based training is encouraged. In the rare instance of no aircraft availability this training may be accomplished on a static airframe and/or a training simulator. All CASEVAC training either simulated or in flight must be accomplished in accordance with appropriate UTC MISCAPs/TTPs. Enlisted members will document this training in the AFTR. Officers will document this training in their Competency Assessment Folder. Noncurrent members will be evaluated for proficiency regarding CASEVAC equipment and procedures using appropriate standards of medical care, and the approved CASEVAC checklist. **(T-2)**

5.17.3. AFSOC Medical Field Skills Training. The goal is to graduate medical personnel with the basic field skill abilities to both operate in typical SOF environments and execute operational support to any of the USSOCOM core activities. To achieve this, there are six main areas of instruction that must be covered: Map, Compass, GPS and Land Navigation; Field Craft and Survival; Communications; Small Unit Tactics; Vehicle Convoy and Defensive Driving; Tactical Force Protection. AFSOC/SG can grant Field Skills Training credit, but the course must be approved prior to attendance. Successful completion of the AFSOC Medical Field Skills training meets the requirements of Field Training as outlined in AFI 41-106, Table A3.5. **(T-2)**

5.17.4. Operational medical personnel perform duties outside the wire and will maintain weapons qualifications/proficiencies and field skills/tactical skills commensurate with these duties, to include live fire training exercises. Weapons qualifications/training will be IAW AFI 41-106 and will be consistent with the maintenance of appropriate status under the Geneva Conventions. Unit commanders are responsible for sustaining and maintaining these skills. **(T-2)**

5.18. Advanced Medical Training (AMT)

5.18.1. All AMT will meet the requirements prescribed in USSOCOM Directive 350-29, Special Operations Forces (SOF) Baseline Interoperable Medical Training Standards. (T-0)

5.18.2. Units will make the maximum use of didactic, moulage, mannequin, simulator, and other training alternatives. (**T-2**)

5.18.3. **(DELETED)**

5.19. Medical Readiness Reporting Calculations.

5.19.1. All AFSOC Medical Groups and OSMs will use SORTS and DRRS to report training statistics. AFSOC Medical Groups and OSMs will use an average of those personnel on UTCs that are 100 percent trained (numerator) and those assigned (denominator). Example: of 40 people assigned to standard AFSOC UTCs (do not include FFZZZ UTCs), only 30 are 100 percent trained, therefore the unit would report a training percentage of 30/40 = 75% in SORTS. **(T-2)**

5.19.2. All AFSOC medical units with WRM will report the number of items possessed divided by the number of items required, multiplied by 100 to give a percent. Example:

package 1=15/15 items, package 2=15/15 items, package 3=12/15 items; package 4=10/15 items, then the unit would report their WRM as 52/60 = 87% in SORTS. **(T-2)**

MORRIS E. HAASE, Major General, USAF
Vice Commander

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

DODI 6490.03, *Deployment Health*, 11 August 2006

USSOCOM Directive 350-29, *Special Operations Forces (SOF) Baseline Interoperable Medical Training Standards*, 7 September 2012

AFI 10-206, *Operational Reporting*, 11 June 2014

AFI 10-3501, *Air Force Diving Program*, 9 February 2009

AFI 10-3502V1, *Pararescue and Combat Rescue Officer Training*, 16 February 2011

AFI 11-401, *Aviation Management*, 10 December 2010

AFI 11-403, *Aerospace Physiological Training Program*, 20 November 2012

AFI 16-1301, *Survival, Evasion, Resistance, and Escape (SERE) Program*, 6 September 2006
AFI 40-101, *Health Promotion*, 17 October 2014

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

AFI 44-102, *Medical Care Management*, 17 March 2015

AFI 44-103, *The Air Force Independent Duty Medical Technician Program*, 6 December 2013

AFI 44-108, *Infection Prevention and Control Program*, 11 December 2014

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

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

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

AFI 48-101, *Aerospace Medicine Enterprise*, 19 October 2011

AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance*, 1 March 2005

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

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

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

AFI 48-139, AFSOCSUP, *Laser and Optical Radiation Protection Program*, 22 October 2013

AFMAN 33-363, *Management of Records*, 1 March 2008

AFMAN 48-154, *Occupational and Environmental Health Site Assessment*, 28 March 2007

AFPD 40-1, *Health Promotion*, 17 December 2009

AFI 48-137, *Respiratory Protection Program*, 15 July 2014

AFPD 48-1, *Aerospace Medicine Enterprise*, 23 August 2011

AFPD 91-2, *Safety Programs*, 24 July 2012

AFTTP 3-42.6, *USAF Medical Support for Special Operations Forces (SOF)*, 9 January 2012

AFSOCI 48-102, *Pandemic Influenza Medical Response Plan for Deployed Operations*, 16 February 2007

SS521-AG-PRO-010, 0910-LP-106-0957, *U.S. Navy Diving Manual*, Revision 6, 15 October 2008, Ch 1 15 October 2011

Prescribed Forms

No forms are prescribed in this publication.

Adopted Forms

AF Form 55, *Employee Safety and Health Record*

AF Form 623, *Individual Training Record Folder*

AF Form 765, *Medical Treatment Facility Incident Statement*

AF Form 847, *Recommendation for Change of Publication*

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

CDC Form 731, *International Certificate of Vaccination or Prophylaxis* (Yellow shot record)

DD Form 2766, *Adult Preventive and Chronic Care Flow Sheet*

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

DD Form 2796, *Post-Deployment Health Assessment*

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

Abbreviations and Acronyms

ACC—Air Combat Command

ACLS—Advanced Cardiac Life Support

ACS—Aeromedical Consultation Service

AETC—Air Education and Training Command

AF—Air Force

AFCITA—Air Force Complete Immunization Tracking Application (AFCITA)

AFMOA—Air Force Medical Operations Agency

AFMSA—Air Force Medical Support Agency

AFRICOM—Africa Command

AFSC—Air Force Specialty Code

AFSOC—Air Force Special Operations Command

AFTR—Air Force Training Record

AHLTA-T—Armed Forces Health Longitudinal Technology application-Theater

AIB—Accident Investigation Board

AIMWTS—Aeromedical Information Medical Waiver Tracking System

AMP—Aerospace Medicine Primary Course

AMS—Aeromedical Summary

AOPT—Aerospace and Operational Physiology Team

AOR—Area of Responsibilities

ARC—Air Reserve Components

ASC—Aviation Service Code

ATCN—Advanced Trauma Care for Nurses

ATLS—Advanced Trauma Life Support

ATRRS—Army Training Requirements and Resources System

BLS—Basic Life Support

C2—Command and Control

C4—Combat Casualty Care Course

CAF—Combat Air Forces

CASEVAC—Casualty Evacuation

CC—Commander

CC-EMTP—Critical Care Emergency Medical Technician Paramedic Course

CCATT—Critical Care Aeromedical Transport Team

CDC—Centers for Disease Control and Prevention

CENTCOM—Central Command

CI—Compliance Inspections

CJSOAC—Combined Joint Special Operations Air Component

CME—Continuing Medical Education

COCOM—Combatant Commanders

CRNAs—Certified Registered Nurse Anesthetists

CRO—Combat Rescue Officer

CRT—Certified Respiratory Therapist

C-STARS—Center for Sustainment of Trauma and Readiness Skills

CV—Vice Commander

DMO—Diving Medical Officers

DNIC—Duties Not Including Controlling

DNIF—Duties Not Involving Flying

DOD—Department of Defense

DRA—Deployment Resiliency Assessments

ECAC—Evasion and Conduct After Capture

EEHS—Emergency Evacuation Hyperbaric Stretcher

HAAMS—High Altitude Airdrop Mission Support

IAW—In Accordance With

ICC—Infection Control Committee

ICTB—Interfacility Credentials Transfer Brief

ICP—Infection Control Program

IDMT—Independent Duty Medical Technician

IO—Information Operations

IPR—Installation Personnel Readiness

JSOACC—Joint Special Operations Air Component Commander

LAUMET–—Live Animal Use in Medical Education Training

MARSOC—Marine Corps Forces Special Operations Command

MEDEVAL—Medical Evaluation

MEDEX—Medical Situational Exercise

MISCAP—Mission Capability

MOAB—Medical Operations Advisory Board

MTF—Military Treatment Facility

MRDSS—Medical Readiness Decision Support System

MSC—Medical Service Corps

NAEMT–—National Association of Emergency Technicians

NBC—Nuclear, Biological, Chemical

NCOMT—Non-Commissioned Officer of Medical Training

NRP—National Registry EMT Paramedic

NVG—Night Vision Goggle

OCONUS—Outside the Continental United States

OEHED—Occupational and Environmental Health Exposure Data

OSM—Medical Operations Flight

PA—Physician Assistants

PALS—Pediatric Advanced Life Support

PIMR—Preventative Health Assessment and Individual Medical Readiness

PJ—Pararescueman

POEMS—Periodic Occupational and Environmental Measurement

PRBC—Packed Red Blood Cells

PPE—Personal Protective Equipment

QA—Quality Assurance

ROBD—Reduced Oxygen Breathing Device

RSVP—Readiness Skills Verification Program

SABC—Self-Aid and Buddy Care

SERE—Survival, Evasion, Resistance and Escape

STO—Special Tactics Officer

STOALS—Special Tactical Operations Advanced Life Support

SIB—Safety Investigation Board

SITREP—Situation Report

SG—Surgeon General

SGH—Chief, Medical Staff

SGP—Chief, Aerospace Medicine

SIPRNET—Secret Internet Protocol Router Network

SOCMSSC—Special Operations Combat Medic Skills Sustainment Course

SOF—Special Operations Forces

SOFME—Special Operations Force Medical Element

SOFPSY—Special Operations Forces Psychologist

SOG—Special Operations Group

SOMA—Special Operations Medical Association

SOMDG—Special Operations Medical Group

SORTS—Status of Resources and Training System

SOST—Special Operations Surgical Team

SOW—Special Operations Wing

STG—Special Tactics Group

STS—Special Tactics Squadron

TACP—Tactical Air Control-Party

TCCC—Tactical Combat Casualty Care

TMDS—Theater Medical Data System

TMEP—Tactical Medical Emergency Protocols

TMIP—Theater Medical Information Program

TSOC(s)—Theater Special Operations Command(s)

UAB—University of Alabama

US—United States

USASOC—United States Army Special Operations Command

USSOCOM—United States Special Operations Command

UTC—Unit Type Code

WRM—War Reserve Materiel

Attachment 2

AFSOC SPECIAL TACTICS MODAFINIL AUTHORIZATION FOR USE (SAMPLE)

Figure A2.1. MODAFINIL AUTHORIZATION FOR USE (SAMPLE)

Date: 1 Jan 20XX

From (Unit/CC): 398th SOW/CC

To: AFSOC/SGP

Subject: Fatigue Management Medication Use

The following personnel have been authorized the use of Modafinil for deployment operations:

	Last Name	First Name	Unit	Projected Dates of Use (6 months maximum)
1.	Doe	John	398th	1 Jan XX to 1 Mar XX
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

I have verified that each individual listed above has been ground tested, cleared for use, and all documentation is in their medical record.

Rank, Name, Title (Validating Flight Surgeon)

Use of fatigue management medications is approved for the personnel listed above. I certify the use of these medications is appropriate, and all other fatigue management tools have been considered and will be used to the maximum extent possible. Use is approved for ground operations, not for parachute or diving operations. The use of Modafinil is completely voluntary and at the discretion of the ground combat personnel.

Rank, Name, Title (SOW/SOG/SGT or SOAC/CC)

Provide copy of this approval form to AFSOC/SGP, and home station Special Tactics Squadron.

Attachment 3

DEPLOYED QUALITY ASSURANCE (QA) OVERSIGHT DOCUMENTATION (SAMPLE)

Table A3.1. DEPLOYED QUALITY ASSURANCE (QA) OVERSIGHT DOCUMENTATION (SAMPLE)

Authority: 10 U.S.C. 55, *Medical and Dental Care*; 10 U.S.C. 8013, *Secretary of the Air Force*; and E.O 9397 Purpose: To document quality assurance reviews of chart reviews. Routine Uses: Internal review, no disclosure outside DOD. Disclosure: Voluntary, failure to provide requested information may result in delay of training requirements.										
1		2	3	4	5	6	7	8	9	10
Reviewer (Name, Unit)										
Lt Col Doe, 378 SOW										
Provider (Name, Unit)	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Capt Smith 467 SOW	10/22									
	Pt Initials	Pt Initials	Pt Initials	Pt Initials	Pt Initials	Pt Initials	Pt Initials	Pt Initials	Pt Initials	Pt Initials
	jdr									
Chart Documentation	Y									
Prevention Addressed	Y									
Was Pain Assessed	Y									
If yes, was pain managed	Y									
Antibiotic Usage	Y									
List Antibiotic	N									
Radiological Utilization	Y									
Consult Utilization	Y									
Drug Utilization	N									
Lab Utilization	N/A									
Grounding Management	N/A									
Legend: Y = Yes-item used or ordered and met criteria; N = No- item did not meet criteria or was indicated and not used; N/A = Not applicable – not used or ordered and was not indicated										
Documentation of Discrepancies – All items marked N require Explanation										
Chart #	Discrepancy – Give brief explanation of how criteria are not met. Note if Discussed with provider									

Attachment 4

OSM EXECUTIVE ACTIVITY AND CLINICAL CURRENCY QUARTERLY REPORT (SAMPLE)

Figure A4.1. OSM EXECUTIVE ACTIVITY AND CLINICAL CURRENCY QUARTERLY REPORT (SAMPLE)

Unit Name
AFSOC Operational Medical Unit Quarterly Executive Summary X Quarter CYXX

Flight Commander's/ Element OIC's Overview Completed Deployments/Exercises (UNCLASS)
List dates, supported mission/name of exercise (if not classified), UTCs

Upcoming Deployments/Exercises (UNCLASS)
Logistics
Personnel Training
Clinical: (See paragraphs 4.3.3.2 through 4.3.3.3.7.3 for additional information on requirements)

Not-Mission Qualified/Not Mission Ready and Mission Ready Clinical Currency in tables on following page

Current Issues

//SIGNED//
Flight Commander/Senior Flight Surgeon/Element OIC

Table A4.1. OSM CLINICAL CURRENCY OPERATIONAL MEDICAL UNIT EXECUTIVE REPORT (SAMPLE)

Not-Mission Qualified/Not Mission Ready													
Name		AFSC	Reason for non-currency								Expected get well date		
Mission Ready Clinical Currency													
FS, IDMT/NRP, PA													
NAME	AFSC	Patient Encounters	Annual flight physical exams	Para. flight physical exams	AF 1041 review mtgs	A/C waiver package completions	A/C waiver package reviews	Occ health shop visits	PH sanitation inspection	AMC mtgs	ATC tower visits	Eye exams	Occ health work group meetings
45S3, 45B3, 46M3/45A3													

NAME	AFSC	# of cases	# of major cases (surgeons)	List any additional clinical activity
44E3A, 46N3E/J, 4H0X1				
NAME	AFSC	# of Clinical shifts (shift=standard time period worked by MTF peers)	List any additional clinical activity	
4N1X1				
NAME	Number of cases	# of clinical shifts (central sterilization, OR supply, etc)	List any additional clinical activity	

Attachment 5

AFSOC OPERATIONAL MEDICAL PERSONNEL TRAINING REQUIREMENT WAIVER REQUEST (SAMPLE)

Figure A5.1. AFSOC OPERATIONAL MEDICAL PERSONNEL TRAINING REQUIREMENT WAIVER REQUEST

(Unit letterhead) Date

MEMORANDUM FOR SQUADRON/CC
GROUP/CC
AFSOC/SGXT
AFSOC/SGP
AFSOC/SG
IN TURN

FROM: OSM Flight CC or Equivalent
Mailing Address

SUBJECT: AFSOCI 48-101 Waiver Request

Waivers to AFSOCI 48-101 must include:

Paragraph number and name defining requirement to be waived. Reason for inability to comply with requirement.

If waiver is a follow-on to a previous waiver, explain why another waiver is required.

Description of the plan to attain compliance.

Date of expected compliance.

OSM flight commander (or equivalent officer) from the originating unit must sign AFSOCI 48-101 waiver requests and forward it to AFSOC/SG. (Waivers may be submitted electronically by email)

Approved waivers will expire at expected compliance date or 90 days from approval date, whichever occurs first.

OSM Flight Commander

Attachment 6

AFTER ACTION REPORT TEMPLATE

Table A6.1. AFTER ACTION REPORT TEMPLATE

PLACE ON UNIT LETTERHEAD

DEPLOYMENT, IW/MSO, Site Survey – AAR Guide

Overall Classification (Secret, Confidential, Unclassified)

*****If something does not apply, put N/A and move on.*****

MEMORANDUM FOR UNIT/GROUP CC
OTHERS (as your unit requires)

FROM: UNIT/INDIVIDUAL

SUBJECT: (CLASSIFICATION) Deployment After Action Report (AAR) for Trip Report, Exercise name/Deployment Name/Mission Name

DERIVED FROM: Single Source [Cite the Title and Date of Source Document] or Multiple Sources
DECLASSIFY ON: List the declassify date from the single source, or the most stringent for multiple sources or add 25 years to the date the document was created.
**note: Each paragraph needs to have its own classification, S=Secret, U=Unclassified, C=Confidential
– If this is a classified report, type, update and submit in SIPR.

1. (CLASSIFICATION) **NAME AND LOCATION:** Update this information

2. (CLASSIFICATION) **INCLUSIVE DATES:** 30 Jan – 27 Feb 2012
2.1. (CLASSIFICATION) **PREDEPLOYMENT TRAINING:** Attended T1G training from DD MMM to DD MMM, LTT at DD MMM to DD MMM, etc.
2.2. (CLASSIFICATION) **DAYS OF TRAVEL TO LOCATION:** Travel from CONUS to Location took 4 days, plane delay at LOCATION, arrived at Base X on DD MMM YY.
2.3. (CLASSIFICATION) **DAYS AT DEPLOYED LOCATION (AND OTHER TRAVEL LOCATIONS/DATES):** 45 days at deployed site, forward deployed to FOB XYZ, etc.
2.4. (CLASSIFICATION) **REDEPLOYMENT TRAVEL:** Redeployed via space-a on helicopter from place Y to Place Z. Manifested on rotator from Base ZYX to CONUS. Arrived home station on DD MMM YY.

3. (CLASSIFICATION) **MISSION OBJECTIVE(S), CONOPS AND UNIT(S) SUPPORTED:** These were our mission objectives, our conops were and we supported the 123 unit while they did blank blank blank missions.
3.1. (CLASSIFICATION) Expound as necessary especially for multiple missions objectives, CONOPS etc.
3.2. (CLASSIFICATION)
3.3. (CLASSIFICATION)

4. (CLASSIFICATION) **PERSONNEL AND EQUIPMENT**
4.1. (CLASSIFICATION) **MISSION COMMANDER:** Col So-and-So was mission commander, medical commander was Maj Such-and-such
4.2. (CLASSIFICATION) **NUMBER OF DEPLOYED PERSONNEL:** Total PAR was ## (## AD, ##

Contractors, ## Local Nationals/TCNs)
4.3. (CLASSIFICATION) **Personnel in Reporting Set:** 1 48R3, 1 – 4N071C

5. (CLASSIFICATION) **OPERATIONS OVERVIEW:** We did this and that, supporting XYZ. On stand-by for CASEVAC missions.
5.1. (CLASSIFICATION) **TOTAL MISSION FLYING TIME AND SORTIES FLOWN**: 230 hours total mission flying time, 95 sorties flown.
5.2. (CLASSIFICATION) **FLYING TME AND SORTIES FLOWN BY MEDICAL PERSONNEL:** 120 hours total mission flying time, 30 sorties flown.
5.3. (CLASSIFICATION) **PATIENTS TREATED DURING FLYING:** Summary of patients treated during flight. Reference appropriate AARs already completed do not duplicate what has already been reported via CASEVAC AARs etc.

6. (CLASSIFICATION) **MISSION ESSENTIAL TASK LIST (METL) EVENTS ACCOMPLISHED (to include AFSOCI 48-101 REQUIREMENTS):** What METLS were completed, what was accomplished IAW 48-101 requirements, that you should get credit for.

7. (CLASSIFICATION) **HOST NATION SUPPORT:**
7.1. (CLASSIFICATION) **LODGING:** Lodging provided by FSS while at base XYZ. Lodging during forward operations was…
7.2. (CLASSIFICATION) **MEDICAL:** What type of host nation medical facilities were available, NATO/Military Treatment Facilities…
7.3. (CLASSIFICATION) **FOOD/WATER SUPPLIES:** Any specific, good to know information for someone who is going to be going to that location.

8. (CLASSIFICATION) **TRANSPORTATION:**
8.1. (CLASSIFICATION) **MEDICAL TEAM TRANSPORTATION:** What type of vehicles (if any), airframe used, local national ambulances etc.
8.2. (CLASSIFICATION) **PATIENT TRANSPORTATION:** How did patients get to you, how did they get to definitive care whether via AE, host-nation ambulance to a hospital.

9. (CLASSIFICATION) **COMMUNICATION:** What communication challenges did you experience? What did you have available. What would have been good to have as well. NIPR and/or SIPR? Satellite phones etc.

10. (CLASSIFICATION) **FACILITIES:**
10.1. (CLASSIFICATION) **BILLETING:** Was lodging available, did you stay in a building of opportunity, what would have been good to know prior to leaving or what changed while you were there.
10.2. (CLASSIFICATION) **OPERATIONS FACILITY:** Where did you work out of? Was there a hardened building/facility etc.

11. (CLASSIFICATION) **MEDICAL SPECIFICS:**
11.1. (CLASSIFICATION) **WATER SUPPLY:** Bottled water supplied by a contractor? Used self brought water purification system.
11.2. (CLASSIFICATION) **SEWER AND DISPOSAL:** Burn pits? Trailers managed by a contractor?
11.3. (CLASSIFICATION) **LOCAL RESTURANTS:** Good, bad and the ugly regarding restaurants. On base and off base if applicable.
11.4. (CLASSIFICATION) **INSECTS AND ANIMALS:** What do individuals need to be aware of.
11.5. (CLASSIFICATION) **PATIENTS WORKLOAD/PAR:** What was the population at risk?
11.5.1. (CLASSIFICATION) **TOTAL PATIENT ENCOUNTERS:** Total patients treated by you/your team
11.5.2. (CLASSIFICATION) **MINOR PROCEDURES:** How many and what kind.
11.5.3. (CLASSIFICATION) **FLYING MISSION:** What was the flying mission, how frequent?
11.5.4. (CLASSIFICATION) **OTHER MEDICAL MISSIONS**: Other medical missions, i.e. FOB build up, host-nation education etc.
11.5.5. (CLASSIFICATION) **MEDICAL EVACUATIONS:** How many? What kind, etc.
11.5.6. (CLASSIFICATION) **PATIENTS ROTATED HOME EARLY FOR MEDICAL REASONS:** Short

synopsis of why and how many.

12. (CLASSIFICATION) **SAFETY:** Safety concerns, environmental? Equipment?

13. (CLASSIFICATION) **MEDICAL MODERNIZATION OPPORTUNITIES:** Use this section to identify equipment needs, problems or shortcomings. Include ideas or observations where improved capabilities could have been improved: mission effectiveness, quality of life, time/manpower savings, risk mitigation or cost savings. Please describe as much detail as possible of the idea and potential benefits. Do not use this section to address logistical shortfalls unless they may be addressed through a research and/or developmental effort.

14. (CLASSIFICATION) **TURNOVER/END OF DEPLOYMENT:** Challenges faced while waiting on replacement. Was overlap time appropriate for familiarization to mission and coordination, etc.

15. (CLASSIFICATION) **LESSONS LEARNED**
15.1. (CLASSIFICATION) Observation Item:
Discussion:
Recommendation:
Is this an item for Higher HQ Action?

15.2. (CLASSIFICATION) Observation Item:
Discussion:
Recommendation:
Is this an item for Higher HQ Action?

16. (CLASSIFICATION) SUMMARY OF MISSION: Overall summary of the mission, what went well, what could have been improved changed etc. Overall review of medical capabilities, support etc.

I D. Ployed, Maj, FS, USAF
123 Unit

cc: AFSOC/SGX
Others as your unit requires (Clinics)

*****If something does not apply, put N/A and move on.*****